Lakeview Unit, Naas General Hospital

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mental health commission

Annual Inspection Report 2023

LAKEVIEW UNIT, NAAS GENERAL HOSPITAL

Craddockstown Road, Naas, Co Kildare, W91AE76

Date of Publication: 21st June 2024

ID Number: AC00147

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care / Long Stay
Psychiatry of Later Life
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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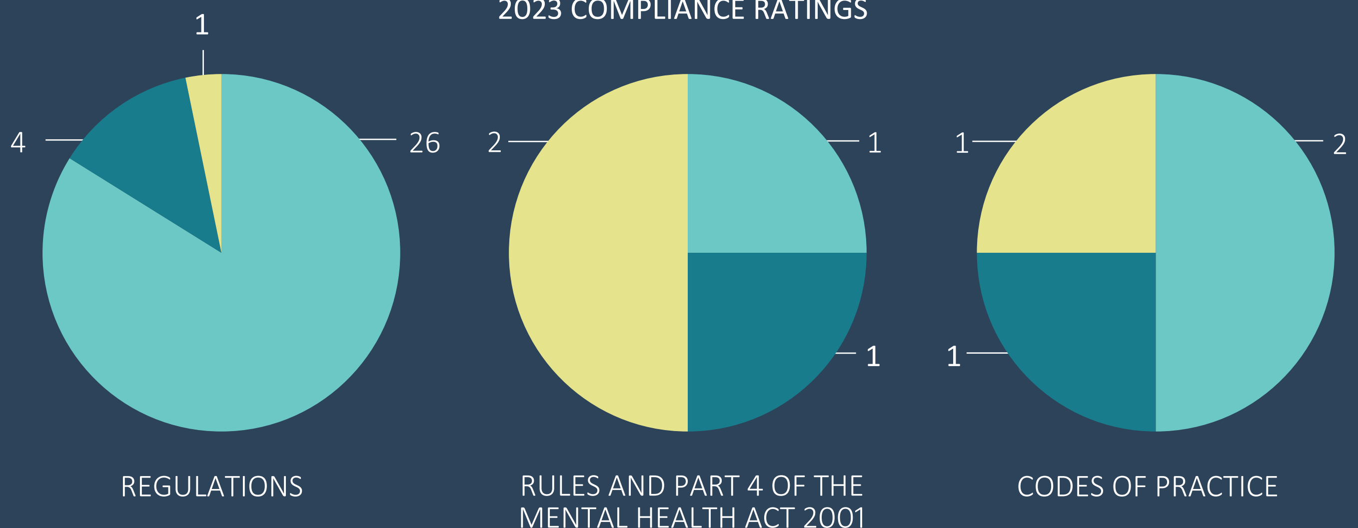
Professor James V Lucey MCRN000646

Inspection Date:
12 – 15 December 2023

Previous Inspection date:
4 – 7 October 2022

Inspection Type:
Announced Annual Inspection

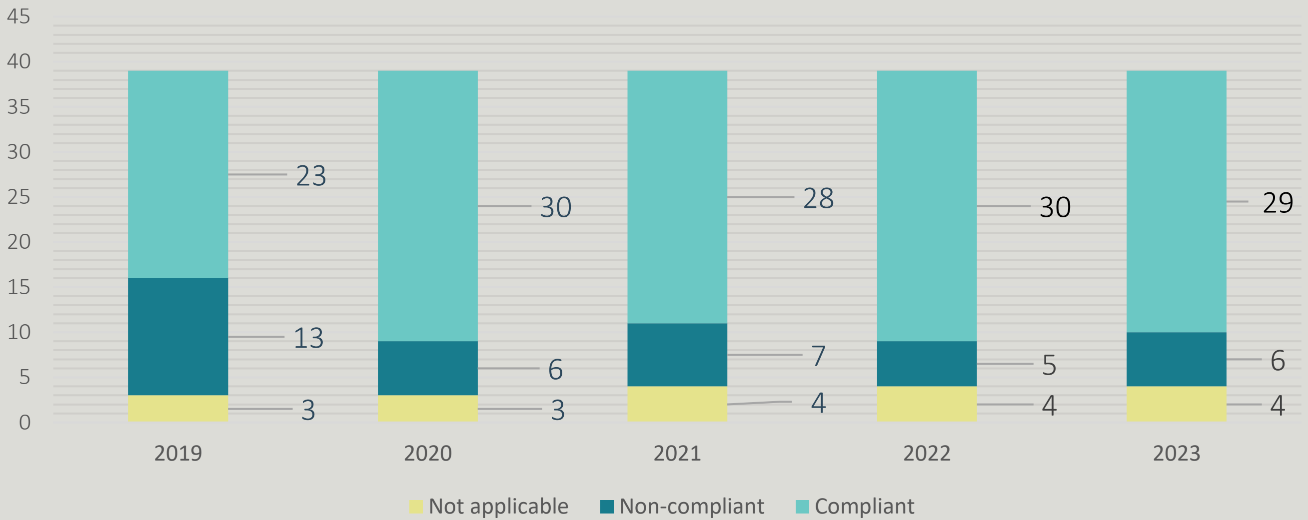


Compliant   Non-Compliant   Not applicable

RATINGS SUMMARY 2019 – 2023

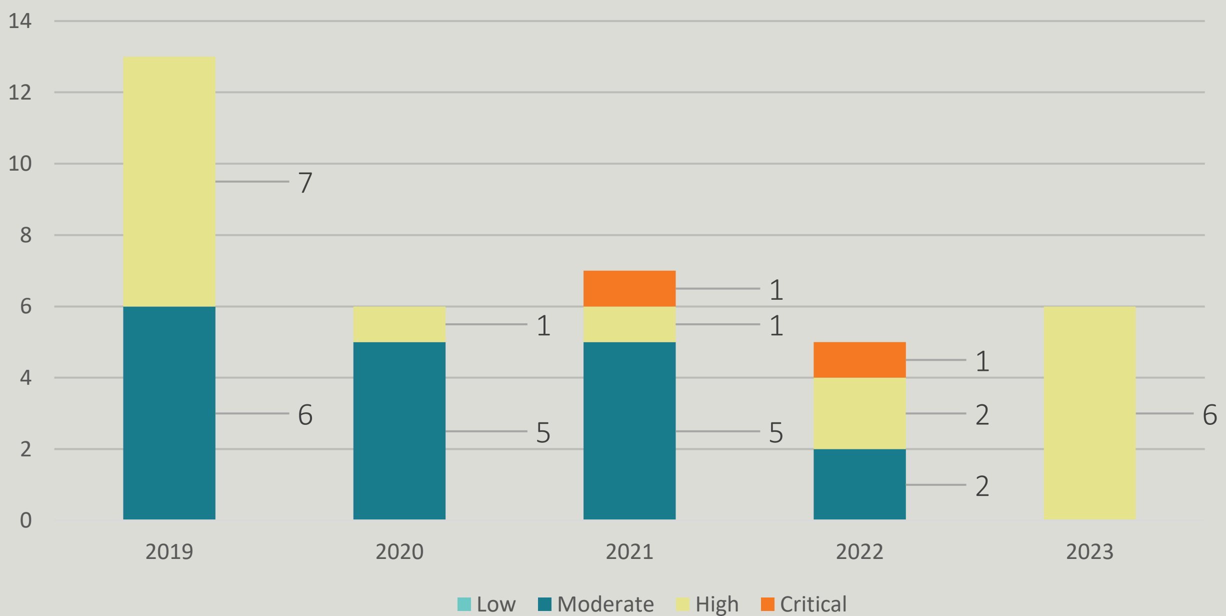
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services | Professor James V Lucey

In brief

Lakeview Unit was located in Naas General Hospital. The approved centre consisted of two floors, and access to the approved centre was through the upper level from the main hospital. Eight consultant-led community mental health teams, a Rehabilitation and Recovery team and a Psychiatry of Later Life team admitted to the approved centre.

Accommodation in the approved centre consisted of a mixture of single bedrooms and four- or six-bed dormitories. Plans for a new 50-bed unit were underway, and due to restricted capacity of beds serving the population of County Kildare and West Wicklow, the approved centre had a service level agreement with the Department of Psychiatry, Portlaoise for the admission of residents requiring higher levels of observation. Up to ten beds were available for this purpose.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	64%	83%	80%	86%	83%

Conditions to registration

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

Conditions	Findings
Condition 1: *The registered proprietor shall develop and implement a costed, funded, timebound plan, in line with the timelines submitted to the Mental Health Commission (MHC) on 19 May 2022, for the development of a new approved centre to provide residents with suitable and appropriate accommodation. This plan is to be developed by a date specified by the MHC. The registered proprietor*	The approved centre was not in breach of Condition 1.

shall submit updates on the progression of this plan in the form and frequency prescribed by the MHC.	
Condition 2: *The registered proprietor shall implement a programme of maintenance to ensure the premises are safe and meet the needs of the resident group. The registered proprietor shall submit updates in the form and frequency prescribed by the Mental Health Commission (MHC).*	The approved centre was not in breach of Condition 2.

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*5/07/2022*	*To provide a responsive plan to mitigate the risks of a serious reportable event that occurred in the approved centre.*	*Approved centre submitted a response in advance of a regulatory compliance meeting.*
Regulatory compliance meeting	*7/07/2022*	*To provide a plan to mitigate against the reoccurrence of serious reportable events of this nature.*	*Plans were discussed at the regulatory compliance meeting. The MHC continue to monitor this issue closely.*
Immediate enforcement action	*17/11/2022*	*To provide a plan to address critical non-compliances identified on inspection.*	*Approved centre submitted a response and the MHC continued to monitor throughout the year.*

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.
- ***Number of registered nurses in the approved centre***: There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Assessment and management of individual risk***: All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***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:

- ***Fire safety:*** A fire door on the corridor on the upper floor was damaged along the strip in the middle of the door.
- ***Mandatory training:*** All staff were trained in fire safety, basic life support and the management of violence and aggression.
- ***Medication safety:*** The approved centre had not implemented appropriate and suitable practices relating to the administration of medicines to residents.
- ***Ligature anchor points:*** Ligature points were not minimised to the lowest level, based on individual risk assessment.
- ***Seclusion facilities:*** The construction of the seclusion room was not designed to withstand high levels of violence with the potential to damage the physical environment as damage was remedied by Perspex. in some areas, staples were noted to hold the wall lining in place. The seclusion room did not have an anti-barricade door.

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. Residents had access to their own GP and in reach from specialist, medical and surgical teams in the linked general hospital for any treatments required during admission.

- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT). 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 residents' individual care plan. Therapeutic activities included Recovery Through Activity, care-plan guidance, decider skills, a baking and cooking group and a relaxation group.
- ***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. The courtyard on level 1 was dirty and littered with cigarette butts. The wood veneer to window ledges in bedrooms and group rooms was chipped. There was graffiti on chairs on the lower floor and in the courtyard. Walls, curtains and windows across the unit were stained. Whilst new flooring had been installed on the upper corridor, damaged flooring was observed in the TV rooms, recreational rooms and bedrooms.
- ***Individual care plans:*** Each resident had an individual care plan (ICP); however, not every ICP was appropriately completed. Not ICPs identified resident goals, required care and treatment for resident goals or required resources for resident goals. One ICP was not reviewed by the multi-disciplinary team and five ICPs were not updated following seclusion or physical restraint debriefs.

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:*** Bedrooms consisted of five single rooms, one being en suite, three four-bed rooms and two six-bed rooms.
- ***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 was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Use of restrictive practices:*** The approved centre was not compliant with the code of practice on physical restraint or with the rules governing the use of seclusion. Individual care plans were not updated to reflect the outcome of the debrief following each episode of seclusion or physical restraint. One seclusion care plan was incompletely filled out. Staff involved in physical restraint had not undertaken appropriate training.

Responsiveness to residents' needs

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

- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Residents had access to a priest who visited the unit.
- ***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, including DVDs, mindful colouring, board games, puzzles, books and both broadcast and interactive television.
- ***Support groups:*** Group activities for residents included a walking group, visits to the oratory, mindful colouring, social outings, self-care and body-scan relaxation.
- ***Residents' feedback:*** The residents were complimentary about the environment and the care they received. They said that they received information on their treating teams and their individual care plans, were aware of their key workers and were able to give feedback about their care to staff. All feedback was complimentary toward the staff and service provided. One resident praised the staff as 'fantastic'. Residents gave feedback on aspects of their care they were not happy with.

However:

- ***Environment:*** Window magnets were not able to keep windows open to appropriately ventilate the premises. Radiators were not guarded and when inspected were very hot to the touch.

Governance, Leadership and Accountability

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

- ***Structure in place:*** Lakeview Unit was part of the Kildare West Wicklow Mental Health Services. The governance of the overall Kildare West Wicklow sector comprised a series of committees who met regularly and contributed to the management of the approved centre, including operational

meetings, compliance meetings, local Quality and Patient Safety meetings and audit committee meetings.

- ***Leadership:*** The Kildare West Wicklow Mental Health Services Executive Management team met monthly. Integrated management meetings with Naas General Hospital took place regularly.
- ***Clinical governance:*** Heads of disciplines included the Clinical Director, Director of Nursing, Principal Psychologist, Principal Social Worker, Occupational Therapy Manager, Risk Advisor and the Head of Service. Each discipline outlined an active role in the overall governance process within the approved centre.
- ***Restrictive practices reduction:*** The approved centre had policies in place to reduce, or where possible eliminate, the use of restrictive practices.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. A risk register was maintained.
- ***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.
- ***Complaints:*** A complaints process was in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement. Residents were involved with the care planning process and knew staff by name.
- ***Advocacy services:*** Residents had access to a peer advocacy representative.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last four years of 83%. It has two conditions on its registration regarding development of a new approved centre to provide residents with suitable and appropriate accommodation and the implementation of a programme of maintenance to ensure the premises are safe and meet the needs of the resident group. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Staff training:*** Not all staff had received mandatory training in fire safety, basic life support and the management of violence and aggression. The mandatory nature of training in relation to seclusion was not specifically recorded in the policy.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had introduced a Safewards programme which was a model of care to reduce conflict and containment within mental health services. Calm down boxes and a tree of hope had been introduced as part of the programme to assist residents.

2. Social and Therapeutic Horticulture sessions had been introduced to link residents with plants and gardening to improve physical and mental health and in particular communication and thinking skills.

3. As part of the activities programme a reading group had commenced for residents in the approved centre.

4. A smoking cessation programme had commenced, this was co-facilitated with the HSE Health Promotion Department.

5. The approved centre had commenced an individual care plan (ICP) review group with the view to improving the ICP process.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Lakeview Unit was in located in the Naas General Hospital and was opened in 1992. The approved centre consisted of two floors and access to the approved centre was through the upper level from the main hospital. At the time of inspection entry doors were secured with swipe access.

The first floor of the approved centre comprised of the therapy area, dining room, recreation room, offices and an electroconvulsive therapy (ECT) suite. The resident sleeping accommodation and the nurses office were located downstairs. Bedrooms consisted of a mixture of single rooms (five, one being en suite) and shared rooms (three 4-bed rooms and two 6-bed rooms). There was a total of five showers available to residents.

There was an internal paved courtyard garden located on the ground floor and a roof top garden was situated on the first floor. The roof top garden could only be utilised under staff supervision. There was limited communal space in the approved centre. There was one very small sitting room on the lower floor, which could not accommodate 29 residents. The approved centre had created colourful, homelike break out areas in the corridors to enhance communal space for the residents. Minor capital works had been completed since the last inspection.

The approved centre had plans for a new 50 bed unit on the grounds of the hospital campus, capital funding had been secured. Staff interviewed stated that the project was progressing very slowly. The proposed building has been designed but due to increased building costs a redesign of the new building will commence in 2024.

Eight consultant-led community mental health teams, a Rehabilitation and Recovery team and a Psychiatry of Later Life team admitted to the approved centre. Due to restricted capacity of beds serving the population of County Kildare and West Wicklow, the approved centre had a service level agreement with another approved centre (Department of Psychiatry, Portlaoise) for the admission of residents requiring higher levels of observation and they could access up to ten beds for this purpose.

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

Resident Profile	
Number of registered beds	***29***
Total number of residents	**27**
Number of detained patients	7
Number of wards of court	2
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

Lakeview Unit was part of the Kildare West Wicklow Mental Health Services. There was evidence of well-structured governance arrangements and processes in place. Heads of Discipline were asked to complete a Governance Questionnaire. Completed questionnaires were received from the relevant senior managers. As part of the inspection process, the following Heads of Disciplines were interviewed: Clinical Director, Director of Nursing, Principal Psychologist, Principal Social Worker, Occupational Therapy Manager, Risk Advisor and the Head of Service. Each discipline outlined an active role in the overall governance process within the approved centre.

Copies of the monthly minutes of the Kildare West Wicklow Mental Health Services Executive Management team meetings and Quality and Patient Safety (QPS) meetings were provided to the inspection team. They showed that the management team actively and comprehensively addressed items such as finance updates, staffing and staff training, clinical programmes updates, HR and operational processes, Mental Health Commission updates, incidents and trends, action plans and audits, risk assessments and risk registers, complaints and complements, health and safety, service user engagement and service user feedback. Integrated Management Meetings with Naas General Hospital took place regularly. Serious Incident Management (SIM) meetings took place where necessary.

The governance of the overall Kildare West Wicklow sector comprised of a series of committees who met regularly and contributed to the management of the approved centre, these included: fortnightly Operational Meetings, monthly Compliance Meetings, monthly Local QPS Meetings, Quarterly Audit Committee Meetings. The approved centre had comprehensive auditing processes in place at the time of inspection.

It was evident that the approved centre maintained a culture of incident reporting and risk management. Risk assessments were completed and a risk register was maintained and was reviewed on a monthly basis at the approved centre's QPS meeting or as required. Risks were escalated through the appropriate channels which were collated and analysed.

At the time of inspection not all staff in the approved had completed mandatory training as required by the Mental Health Commission. Staff reported that the approved centre had nursing post vacancies, these vacancies were filled with the use of overtime and agency staff. At the time of inspection, all other disciplines reported a full complement of staff.

At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement. There were no outstanding complaints at the time of inspection.

Residents had access to advocacy services when required; advocacy contact details were displayed within the approved centre. The Area Lead for Mental Health Engagement was part of the Executive Management team.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 15: Individual Care Plan	✓		✓		✗	Moderate	✗	High	✗	High
Regulation 22: Premises	✗	High	✗	High	✗	Critical	✗	Critical	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	Moderate	✓		✓		✓		✗	High
Regulation 26: Staffing	✗	High	✓		✗	Moderate	✗	Moderate	✗	High
Rules Governing the Use of Seclusion	✗	High	✓		✗	High	✗	Moderate	✗	High
Code of Practice on the Use of Physical Restraint	✗	Moderate	✓		✗	Moderate	✓		✗	High

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

4.2 Areas that were not applicable on this inspection

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

Four questionnaires were returned, and the inspection team spoke with four residents. Feedback from the service user experience questionnaires suggested that two residents understood their individual care plans (ICPs), one said they ‘didn’t’ and one didn’t respond. One said they were involved in setting their own goals and two said they were ‘sometimes’ involved in setting their own goals, one resident didn’t respond. Three respondents said they were able to discuss worries or concerns with members of staff, one didn’t respond. One resident said they always felt safe in the approved centre and two said they did ‘sometimes’, one resident didn’t respond to the question.

Comments from the service user questionnaires included:

1. The nurses are very kind and care.
2. I find it difficult to communicate with my consultant, even when I try hard.
3. At times the roaring and shouting is over the top, peace is needed.

The residents were asked to rate their overall experience of the care and treatment in the approved centre on a scale of 1-10 (1 being poor and 10 being excellent). One resident responded with a 1 rating, one with a six rating, and two residents responded with an eight rating.

General feedback from the resident’s interviews:
One resident was unhappy that the inspectors couldn’t investigate historic concerns. The resident was aware of the complaints process, they stated that they had complained but ‘nothing had been done’.

Another resident said that the staff were fantastic, 'they treat me very well'. The resident attended their multi-disciplinary team meetings (MDT) regularly and they were offered a copy of their ICP. One resident stated that there were areas in the centre to make private phone calls and that there was a great selection of activities in the unit. One resident stated that they would like access to nature, more walks, organic food and space to grow organic food. They would also like more fruit and vegetables and more access to aromatherapy. They would like smoking banned in Lakeview Unit.

The fourth resident said that the staff were very good and their bedroom was very comfortable. They said that the staff were very good at stopping the spread of infection in the unit, as there had been a recent outbreak. The resident said the food was 'really good', and there was plenty of choice. The resident stated that they saw their team weekly, they were involved in their ICP meetings, and they enjoyed the therapy groups. The resident said they would like more access to walks around the lake. They had no complaints about Lakeview Unit, 'Staff make a big effort to help me, I am happy to be here, I feel safe'.

5.2 Advocacy

Residents in the approved centre had access to the Peer Advocacy in Mental Health Service (formally known as the Irish Advocacy Network). The inspectors received a report for 2023 from the Peer Advocacy in Mental Health representative during the inspection.

The following positive comments were reported by service users:

- Service users reported being happy with the care they received.
- Service users spoke positively of the activities provided in Lakeview Unit and the care from the occupational therapy team.
- Service users with addiction issues were giving information on what help was available to them.
- Service users had access to information on medications.
- Service users enjoyed having access to music on the TVs and having access to Netflix etc. on their personal devices.
- Service users regularly reported how tasty the food was and special dietary needs were catered for.
- Advocacy services were welcomed service by patients and staff.
- In general service user issues that were brought to the attention of the staff are resolved quickly.
- Service users appreciated the use of the outdoor space/smoking area.
- Service users mentioned that they got better care in Lakeview Unit compared to other units they had attended.
- Service users appreciated having access to personal devices.

Areas in need of improvement as reported by the service users:

- Some service users reported having limited access to their social worker. They were unaware that their social worker could assist them with financial and housing issues post discharge and they were unaware of other supports they could provide.

- Service users felt that at times residents were on the unit longer due to lack of housing/accommodation after discharge.
- Service users reported not telling the doctor the full extent of their illness as they feared an over reliance on medication while treating their illness.
- Service users who were placed in seclusion describe it as ‘very traumatic experience’. They felt they should have been debriefed after the episode. They stated that they would like a written explanation regarding the treatment they had received in seclusion from the staff who had initiated it. Two service users wondered if there was a need for so many staff to be with the person when moving them into seclusion.
- Service users requested more intellectually stimulating activities. While they appreciated the activities that were available to them, they reported becoming bored with them.
- Some service users commented that they would like more access to private rooms as sharing with multiple people can impact their recovery.
- Several service users couldn’t differentiate between their psychiatrist and their psychologist, nor did they understand the differences in their roles.
- Several service users stated that they did not know their multi-disciplinary team (MDT).

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:

- Clinical Director
- Head of Service
- Acting Operations Manager
- Director of Nursing
- Assistant Director of Nursing
- Principal Psychologist
- Principal Social Worker
- Occupational Therapy Manager
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 2
- Pharmacist

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.

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with appropriate emergency personal clothing that considered their preferences, dignity, bodily integrity, religious and cultural practices.

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 August 2021.

A resident’s personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Safes 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, as appropriate, except where this posed a danger to the resident or others, as indicated in their individual care plan and in accordance with the approved centre’s policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities were accessible on weekdays and during the weekend.

Self-directed activity resources included DVDs, mindful colouring, board games, puzzles, books and both broadcast and interactive television. A recreational room that was locked when not in use had a new pool table. Residents also had access to a treadmill and exercise bike during the week.

Group activities included a walking group, visits to the oratory, mindful colouring, social outings, self-care and body-scan relaxation.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Residents had access to a priest who visited the unit.

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 April 2021.

Visiting times were appropriate and reasonable. 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.

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 October 2021.

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

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in March 2022, and included all requirements related to:

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

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

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

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and protocols for care of residents who are dying. The policy was last reviewed in March 2023.

The clinical file of one individual who had died while a resident in the approved centre was inspected. Representatives, family, next of kin and friends were involved, supported and accommodated during end-of-life care.

The Mental Health Commission were notified of the death as soon as is practicable and, in any event, no later than 48 hours after the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

Fifteen 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.

Not all the ICPs identified appropriate goals for the resident; three did not. Five ICPs did not identify the care and treatment required to meet the goals, including the frequency and responsibility required for implementing the care and treatment. Four ICP did not identify the resources required to provide the care and treatment identified. The ICPs were not all reviewed by the MDT in consultation with the resident as one lacked such a review. Five ICPs were not updated following a resident's seclusion or physical restraint debrief.

The approved centre had established an ICP working group and developed a comprehensive new ICP booklet, which was due to be rolled out the following year.

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

a) **Three individual care plans did not identify appropriate goals for the residents.**
b) **Five individual care plans did not identify the care and treatment required to meet the goals identified.**
c) **Four individual care plans did not identify the resources required to provide the care and treatment identified.**
d) **One individual care plan was not reviewed by the multi-disciplinary team.**
e) **Five individual care plans were not updated following a resident's seclusion and physical restraint debrief.**

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 meet 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.

Residents had access to one-to-one occupational therapy based in the approved centre and social workers and psychologists through in-reach community teams. Therapeutic activities included Recovery Through Activity, care-plan guidance, decider skills, a baking and cooking group and a relaxation group. Appropriately qualified external professionals facilitated additional groups such as mindfulness, an African drumming workshop, yoga, art, social and therapeutic horticulture and pet therapy with Wicklow Dogs for Friends.

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 June 2023.

The clinical file of one resident who had been transferred to another facility were inspected. Full and complete written information on the resident was transferred when they moved from the approved centre. This information consisted of a letter of referral, including a list of current medications, and a resident transfer form. It was sent in advance, or at least accompanied the resident upon transfer, to a named individual.

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 July 2022. The approved centre had an emergency trolley on each floor and staff had access at all times to an automated external defibrillator (AED).

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

Four clinical files were examined in relation to the provision of general health services during the inspection process. Three residents declined six-monthly general health assessments; numerous attempts were made to engage with the residents, as documented in clinical files. 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 breast check, cervical screening, retina check for diabetics and 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 May 2021.

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

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to personal space and appropriately sized communal rooms. Heating in day areas and bedrooms was suitable and sufficient. 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. However, not all rooms were adequately ventilated as some magnets on windows were not connecting. As a result, the windows could not be left open to allow air to move.

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. Anti-ligature works had been carried out since the last inspection; however, ligatures were still noted throughout the approved centre.

The approved centre was not kept in a good state of repair externally and internally. The courtyard on the first level was dirty, stained and littered with cigarette butts. Curtains in the television room upstairs were stained. Windows across the unit were stained internally and externally. Some flooring had been upgraded but flooring in the television rooms, the recreational room and some bedrooms evidenced pitting and heavy wear and tear. The wood veneer on window ledges in bedrooms and group rooms was chipped. Graffiti was present on chairs on the lower floor and attempts to remove it had been unsuccessful. Graffiti was also visible in the courtyard. A fire door on the corridor of the upper floor was damaged.

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. Current national infection control guidelines were followed. Rooms were centrally heated but radiators did not have appropriate covers and a radiator in the upper-level interview room emitted demonstrably high levels of heat.

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

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

a) **The premises were not maintained in good structural and decorative condition as staining and graffiti was evident in various locations, the courtyard on level 1 was dirty and littered, and a fire door on the upper-floor corridor and flooring in the television rooms, recreational rooms and bedrooms were damaged, 21(1)(a).**
b) **The premises were not appropriately ventilated as not all window magnets worked to keep windows open, 21(1)(b).**
c) **Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(3).**
d) **Radiators were not adequately guarded or guaranteed to have surface temperatures no higher than 43°C, 22(3).**

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

NON-COMPLIANT

Risk Rating HIGH

(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 March 2021, and included the following requirements:

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

All residents had a Medication Prescription and Administration Record (MPAR). Ten MPARs were examined on inspection. All MPARs contained a record of any allergies or sensitivities to medications, the frequency of administration, but four of the ten MPARs inspected did not record all medications administered and five of the MPARs inspected did not record 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. Because four of the ten MPARs had empty fields for the recording of medications administered, it was not possible to tell if the medication had been not given or had been withheld. No justification for withholding medication was noted in the MPARs or documented in the clinical files.

The pharmacist was consulted about the type of preparation to be used.

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 non-compliant with this regulation because the approved centre did not implement appropriate and suitable practices relating to the administration of medicines to residents, 23(1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and processes for the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in September 2022 and included the purpose and function of using CCTV, in relation to the observation of a resident.

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

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

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in December 2022, 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. An appropriately qualified staff member was on duty at all times. The approved centre had a dedicated occupational therapist and other allied health disciplines from the eight consultant led teams fed into the approved centre where necessary.

Not all healthcare staff were trained in basic life support, fire safety, and the management of violence and aggression. 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. See the table below for a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (64)	64	100%	56	88%	61	95%	64	100%
Medical (32)	25	78%	32	100%	21	66%	32	100%

Occupational Therapist (11)	8	73%	10	91%	7	64%	11	100%
Social Worker (12)	12	100%	12	100%	10	83%	12	100%
Psychologist (14)	10	71%	10	71%	10	71%	14	100%

The approved centre was non-compliant with this regulation because not all healthcare staff had received education and training in basic life support, fire safety, and the management of violence and aggression to enable them to provide care and treatment in accordance with best contemporary practice, 26(4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for the maintenance of records. The policy was last reviewed in June 2021. The policy covered the following provisions:

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

Residents' records were secure, up-to-date and in good order, and were stored together where possible. All resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were in good order. Records were appropriately secured from loss or destruction, tampering and unauthorised access or use.

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

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 December 2022, and included the following:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff 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. Structural risks, including ligature points, were removed or effectively mitigated.

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

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during resident seclusion, physical restraint, 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 and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered for public liability, employer's liability, clinical indemnity and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

An up-to-date certificate of registration, with two conditions relating to the certificate of registration attached to it, was prominently displayed in the approved centre foyer.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It 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 June 2023 and addressed:

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

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

- Who would receive training based on the identified needs of patients who are secluded and staff.
- The areas to be addressed within the training programme.
- The identification of appropriately qualified persons to give the training.

However, the policy did not address 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. The patient had sight of a clock displaying the time, day and date. 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 room and monitor the heating. The room was large enough to support the patient and a team of staff. 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.

However, the seclusion room was not constructed to withstand high levels of violence: there was evidence of Perspex sheets being used to cover damaged areas on the walls. There was no anti-barricade door. The seclusion was not set apart from bedrooms and communal areas as it was located next to bedrooms.

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

The RMP medically examined the patient and assessed and recorded 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 medically examined the patient and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The patient was informed of the reasons for, likely duration of, and circumstances which lead to the discontinuation of seclusion. In accordance with the patient's wish and their ICP, the patient's representative was informed of their seclusion and a record of this communication was entered in the clinical file.

The patient was secluded in their own clothing which respected their right to dignity, bodily integrity and privacy. The patient was directly observed by a RN for the first hour of seclusion and continuously observed them and stayed within sight and sound of the seclusion room thereafter. Following risk assessment, a nursing review of the patient took place every two hours. During this review, a minimum of two staff members entered the seclusion room and assessed the patient to determine whether to end the episode of seclusion.

For each episode of seclusion, a seclusion care plan for the patient was developed by a RN. In one of the episodes of seclusion, however, the seclusion care plan did not include details such as recognising signs that the patient's behaviour was no longer deemed an unmanageable risk nor how potential risks may be managed.

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).

Seclusion was ended by a RMP or the most senior RN on duty and the CP responsible or the duty CP was notified. The patient was informed of the ending of an episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date seclusion was ended.

An in-person debrief followed every episode of seclusion. The debrief was person-centred and gave the patient the opportunity to talk about the seclusion, but neither debrief inspected gave the patient the option of having their representative or nominated support person attend. One individual care plan (ICP) was not updated to reflect the outcome of the debrief. No goal or intervention was identified in relation to reducing restrictive practices for the patient.

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

Each episode of seclusion was reviewed by members of the multi-disciplinary team (MDT) involved in the person's care and treatment and documented in the clinical file as soon as practicable. The MDT review was documented, and recorded actions decided upon and follow-up plans to eliminate, or reduce, restrictive interventions for the patient.

The registered proprietor appropriately notified the Mental Health Commission of the start time and date, and the end time and date of each episode of seclusion. The registered proprietor appointed a named senior manager responsible for the approved centre's reduction of seclusion.

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

a) **The mandatory nature of training in relation to seclusion was not specifically recorded in the policy, 11.2(d).**
b) **The construction of the seclusion room was not designed to withstand high levels of violence with the potential to damage the physical environment as damage was remedied by Perspex. In some areas, staples were noted to hold the wall lining in place, 8.1(1).**
c) **The seclusion room did not have an anti-barricade door, 8.1(iii).**
d) **The seclusion room was located near bedrooms and was not in an area away from communal sitting rooms and sleeping accommodation, 8.1(ix).**
e) **One seclusion care plan did not include recognising signs that the person's behaviour was no longer deemed an unmanageable risk towards themselves or others or how potential risks may be managed, 5.7(v)(vi).**
f) **Two individual care plans were not updated following the outcome of the debrief, 7.8.**

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

A written record of consent detailed the following:

- The name 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 a discussion with the patients, including the nature and purpose of the medications, the effects of medications such as the risk and benefits and any views expressed by the patient.

- Any supports provided to the patient in relation to the discussion and their decision-making.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

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

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

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

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

The approved centre had a policy and procedures regarding staff training in the use of physical restraint which addressed the following:

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

Training and Education: A record of attendance at training was maintained but the written record indicating that staff involved in the use of physical restraint had read and understood the policy was not complete. Some staff involved in the three episodes of physical restraint inspected were not among those who had read and signed off on the policies. Not all staff who participated in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures.

Monitoring: A multi-disciplinary review and oversight committee in the approved centre met at least quarterly to determine compliance, identify areas of improvement and assure the nominee that each use of physical restraint was in accordance with the Mental Health Commission's code of practice. The committee produced a report following each meeting.

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. Physical restraint was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) and a consultant psychiatrist (CP) was notified as soon as was practicable. The RMP completed a medical examination of the resident no later than two hours after the start of the episode of physical restraint. No order lasted longer than ten minutes.

The resident was informed of the reasons and circumstances for discontinuing physical restraint unless the provision of such information might be prejudicial to the resident's mental health, well-being or emotional condition. A record of this communication, or an explanation why it did not occur, was placed in the resident's clinical file.

The Mental Health Commission was notified of the start time and date and the end time and date of each episode of physical restraint in the format specified.

There was documented evidence that the principles of trauma-informed care were used during the restraint. Staff members of the same gender were present at all times during the episode but not all staff involved in the episode of physical restraint had undertaken appropriate training in accordance with the approved centre's policy.

The resident was appropriately monitored during the physical restraint and the person who led the restraint ended the restraint. The time, date and reason for ending the physical restraint was recorded in the clinical file.

An in-person debrief with the resident who was restrained follow every episode of physical restraint. The debrief was person-centred and gave the resident the opportunity to discuss the physical restraint with members of the multi-disciplinary team (MDT) involved in their care. In two of the incidents inspected, the timing, structure, topics and options provided during the debrief were appropriate but in one of the incidents inspected, the resident was not given the option of having their representative or a nominated support person attend the debrief with them and no explanation was recorded in the clinical file. In none of the incidents inspected was the resident's individual care plan updated to reflect the outcome of the debrief and, in particular, their preferences in relation to restrictive interventions going forward.

Appropriate emotional support was provided to the resident following the episode of physical restraint and support was offered to other persons who may have witnessed the restraint. The episode of physical restraint was recorded in the clinical file.

The MDT reviewed the episodes of physical restraint within five working days from the date of the restraint and recorded actions decided upon and follow-up plans to eliminate, or reduce, restrictive interventions for the resident.

A named senior manager had responsibility for the approved centre's reduction of physical restraint.

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

a) **In one episode of restraint there was no record of the resident being given the option of having their representative or nominated support person attend the debrief with them or an explanation as to why this did not occur in the resident's clinical file, 5.3(vi).**
b) **In three episodes of restraint inspected the resident's individual care plan was not updated to reflect the outcome of the debrief and, in particular, the resident's preferences in relation to restrictive interventions going forward, 5.5.**
c) **In three episodes of physical restraint, staff members involved in the use of physical restraint and subsequent monitoring did not undertake appropriate training in accordance with the policy outlined in section 8.2. of the code of practice on the use of physical restraint, 4.4.**

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 August 2023. It contained protocols that were developed in line with best international practice, including

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

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

Evidence of Implementation: No ECT had been administered since the last inspection. While the approved centre had a designated ECT suite, due to issues with aerosol transmission in the suite, residents in need of ECT were transferred to the main theatre in Naas General Hospital or, if necessary, to University Hospital, Tallaght.

ECT machines were regularly maintained and a record of maintenance and confirmation of servicing of machines were kept. No medications were being held in the ECT suite at the time of inspection.

A named consultant psychiatrist had overall responsibility for ECT management and a named consultant anaesthetist had overall responsibility for anaesthesia.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one individual who had been admitted to the approved centre was inspected. The admission had been on the basis of a mental illness or mental disorder. A key worker system was in place and an admission assessment was completed, which included the individual's presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances and current mental health state. It also included a risk assessment, a full physical examination and any other relevant information such as their work situation, education or dietary requirements.

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 inspected. The discharge was coordinated by the key worker and a discharge plan had been made which included an estimated date of discharge, documented communication with the relevant healthcare provider, a follow-up plan and a reference to early warning signs of relapse and risks. A discharge meeting

was held and attended by the resident, key worker, relevant members of the resident's multi-disciplinary team and a family member, carer or advocate, where appropriate.

The discharge assessment addressed the resident's psychiatric and psychological needs, current mental state examination and informational needs. It also included a comprehensive risk assessment and risk management plan. A preliminary discharge summary was sent to the resident's healthcare provider within three days and a comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge and outstanding health or social issues. It also included follow-up arrangements, the names and contact details of key people for the follow-up and risk issues such as signs of relapse. A family member, carer or advocate was involved in discharge process, where appropriate. 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 15: Individual Care Plan					
Reason ID : 10005394		Three individual care plans did not identify appropriate goals for the residents.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Email communication sent to all MDT members regarding requirements of regulation 15. MDT members advised that appropriate goals were not identified for their patients. Bi-Monthly ICP audits results with specific recommendations on identifying goals provided to each MDT.	Bi-Monthly Audits of ICPs.	Achievable	10/06/2024	CNM3
Preventative Action	New ICP pathway developed following engagement and collaboration with an MDT working group and Service User feedback. New ICP Pathway launched in May 2024. Education sessions & MDT	Bi-Monthly audit of ICPs. Results presented to the monthly compliance committee and circulated to all MDTs.	Achievable/Realistic	30/08/2024	MDT members/ CNM3/ ADON

	support ongoing with roll out of new ICP document. The MDT member who writes the ICP shall check the ICP following completion to ensure all areas completed to required standard. A newly devised Staff Guidance Booklet shall prompt and guide All MDT staff in the formulation of an ICP in collaboration with the Patient.				
Reason ID : 10005395		**Five individual care plans did not identify the care and treatment required to meet the goals identified.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Email communication sent to all MDT members regarding requirements of regulation 15. MDT members advised that the care and treatment required was not identified to meet the goals specified in the ICP.	Bi- Monthly audit of ICPs.	Achievable/ Realistic	31/12/2024	MDT members/ CNM3/ ADON

	Audit results with specific recommendations on documenting accurately the care and treatment required to meet the goals circulated to the appropriate CMHT/ MDT.				
Preventative Action	New ICP pathway developed following engagement and collaboration with an MDT working group and Service User feedback. New ICP Pathway launched in May 2024. Education sessions & MDT support ongoing with roll out of new ICP document. The MDT member who writes the ICP shall check the ICP following completion to ensure all areas completed to required standard. A newly devised Staff Guidance Booklet	Bi- Monthly audit of ICPs. Results presented to the monthly compliance committee and circulated to all MDTs.	Achievable	31/12/2024	CNM3/ ADON

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
	shall prompt and guide All MDT staff in the formulation of an ICP in collaboration with the Patient.				
Reason ID : 10005396		**Four individual care plans did not identify the resources required to provide the care and treatment identified.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Email communication sent to all MDT members regarding regulation 15 and responsibility of those writing the ICP to identify the resources required to provide the care and treatment specific to meet the goals identified in the ICP. ICP audits results circulated to MDTs with specific recommendations on documenting accurately the resources required to provide the care and treatment required to meet the goals identified in the ICP.	Bi- Monthly Audits of ICPs.	achievable	10/06/2024	CNM3/ ADON

Preventative Action	New ICP pathway developed following engagement and collaboration with a MDT working group and Service User feedback. New ICP Pathway launched in May 2024. Education sessions & MDT support ongoing with roll out of new ICP document. The MDT member who writes the ICP shall check the ICP following completion to ensure all areas completed to required standard. A newly devised Staff Guidance Booklet shall prompt and guide All MDT staff in the formulation of an ICP in collaboration with the Patient.	Bi- Monthly Audits of ICPs.	achievable	31/12/2024	CNM3/ ADON
Reason ID : 10005397		**One individual care plan was not reviewed by the multi-disciplinary team.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Email communication sent to all MDT members	Bi- Monthly Audits of ICPs.	Achievable	10/06/2024	Senior Management Team/ Clinical Director/ CNM3/ ADON/ MDT members

	of the CMHT regarding regulation 15 and the requirement for MDT involvement in the weekly reviews of the ICP				
Preventative Action	New ICP pathway developed following engagement and collaboration with a MDT working group and Service User feedback. New ICP Pathway launched in May 2024. Education sessions & MDT support ongoing with roll out of new ICP document. The MDT member who writes the ICP shall check the ICP following completion to ensure all areas completed to required standard. A newly devised Staff Guidance Booklet shall prompt and guide All MDT staff in the formulation of an ICP in	Bi- Monthly Audits of ICPs.	Achievable	31/12/2024	Senior Management Team/ Clinical Director/ CNM3/ ADON/ MDT members

	collaboration with the Patient. IT peripherals provided in 2 rooms of the approved centre to facilitate hybrid/virtual attendance to MDTs.				
Reason ID : 10005398		**Five individual care plans were not updated following a resident's seclusion and physical restraint debrief.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Email communication sent to all MDT members that ICPs were not updated following an episode of physical restraint or Seclusion. Staff advised of their responsibilities under regulation 15, the Code of Practice on physical restraint and the Rule governing the use of Seclusion.	Audit of each episode – real time.	Achievable	10/06/2024	MHA/A CNM3/ ADON
Preventative Action	The MHA/A sends an email to alert the responsible Consultant Psychiatrist and MDT members of the occurrence of a	Audit of each episode – real time. Results presented to the monthly compliance committee and circulated to all	Achievable	31/12/2024	MHA/A CNM3/ ADON/ MDT members

	restrictive practice at the time of episode and the timeline they have to adhere to MHC guidance on post restrictive practice debrief and MDT review. Prompt sticker developed May 2024 to place in unit diary for Nurse in Charge to communicate with treating Consultant Psychiatrist and MDT members to advise that the 2 day Debrief and 5 Day MDT review is due for completion in the next 24hrs. New ICP pathway incorporates prompts to alert if a Restrictive Practice has occurred. This prompt advises the MDT to include in ICP further interventions to support the goal of reducing/ eliminating need for	MDTs. Audit results and Trends in non compliances shall be noted by the Quarterly Review & Oversight committee. Action plans will be devised to mitigate reoccurrences.			

	the use of restrictive interventions in the future.				

Regulation 22: Premises					
Reason ID : 10005388		The premises were not maintained in good structural and decorative condition as staining and graffiti was evident in various locations, the courtyard on level 1 was dirty and littered, and a fire door on the upper-floor corridor and flooring in the television rooms, recreational rooms and bedrooms were damaged, 21(1)(a).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A number of issues identified during Dec 2023 inspection addressed immediately and completed; 1.courtyard power washed 2. Fire door strip replaced. Level 1 garden area walls will be painted in 2024 as approved from minor capitol request.	Quarterly premises meeting and Daily environmental checklist will observe note and escalate issues for maintenance.	Achievable/ Realistic	05/01/2024	Operations Manager/ ADON
Preventative Action	Annual Programme of Maintenance amended to increase cleaning and power washing of coble lock in level 1 garden. Cleaning Schedule updated and supervisor attends the Quarterly premises meeting	Monthly Hygiene Audits will include Courtyard on level 1. Naas General Hospital use a computerised logging system to log reactive maintenance jobs	Achievable/ Realistic	31/12/2024	Operations Manager/ ADON

Reason ID : 10005389		The premises were not appropriately ventilated as not all window magnets worked to keep windows open, 21(1)(b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A full review of all window openings on level 1 was conducted post MHC inspection. Remedial works planned to ensure a window opened in each single bedroom. New Magnets and Restrictors sourced in May 2024. Due to be installed shortly	Daily environmental checklist	Achievable	30/08/2024	Maintenance Manager/ Operations Manager/ ADON
Preventative Action	Daily Environmental Checklist for completion by CNM1/ nurse in charge. The checklist documents that all rooms are checked for adequate ventilation/ window opening correctly	Daily environmental checklist saved and reviewed by the CNM2 weekly. All Actions escalated to appropriate departments	Achievable	31/12/2024	CNM2/ Operations Manager/ ADON
Reason ID : 10005390		**Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Funding secured to proceed with anti-ligature works in 2024. Details of upgrades since Dec 2023 inspection; 1.	Bi-annual Ligature Audit	Achievable	10/06/2024	HSE Estates/ Maintenance Manager /Operations Manager/ ADON

	Ironmongery upgraded on both level 1 & 2 to include Door Handles, thumb turns and lock mechanisms. 2. Assisted Bathroom upgraded to Anti-Ligature standard.				
Preventative Action	Anti-Ligature programme commenced in Lakeview unit in 2023. HSE Estates will continue to manage this in conjunction with the service. Provision of a new 50 bed standalone unit will provide an environment with lower practicable level of ligature points.	Bi-annual Ligature Audit	Achievable with Supports from HSE Estates to provide expertise in Anti-lig works on current unit	31/12/2024	HSE Estates/ Operations Manager/ ADON
Reason ID : 10005391		**Radiators were not adequately guarded or guaranteed to have surface temperatures no higher than 43°C, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of inspection Maintenance Department were requested to review the level of heating	Via staff and Patient feedback	Achievable	10/06/2024	Operations Manager/ ADON

	provided to Lakeview Unit in order to ensure surface temperature could not exceed 43 degrees.				
Preventative Action	Minor Capitol Requests for 2024 have included the Anti- ligature radiator covers on level 1 as per Anti-Ligature programme. Maintenance Department provided assurance max water temperature provided to radiators does not exceed 39 degrees.	Quarterly premises meeting will include a walk around to observe and note issues for escalation to maintenance.	Achievable/Realistic	31/12/2024	HSE Estates/Maintenance Manager/ Operations Manager/ ADON

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10005392		**The approved centre did not implement appropriate and suitable practices relating to the administration of medicines to residents, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Nursing staff informed at weekly staff meeting that the approved centre did not implement appropriate and suitable practices relating to the administration of medicines to patients. ISBAR Nursing Clinical Handover document updated with a section after each medication round to reflect medication related items for action.	Monthly Medication Audit carried out by Senior Pharmacist with Medical or Nursing assistance	Achievable/Realistic	10/06/2024	CNM1/ CNM2/ CNM3/ ADON/ Senior Pharmacist
Preventative Action	The update of the ISBAR Nursing Clinical Handover document shall ensure all staff are aware of medication needs of all patients and reduce gaps in medication administration. All	Monthly Medication Audit carried out by Senior Pharmacist with Medical or Nursing assistance. Incident report forms completed by Nursing/ Pharmacist when non-	Achievable	31/12/2024	CNM1/ CNM2/ CNM3/ ADON/ Senior Pharmacist

	Nursing staff shall complete Medication Management on HSEland. Induction teaching for new medical and nursing staff by the Senior Pharmacist to highlight their responsibility with Regulation 23	compliances observed with Regulation 23. Medication reports completed by Senior Pharmacist and escalated to local monthly QSSI committee including report on trends and actioned required to mitigate further errors/ non compliances.			

Regulation 26: Staffing					
Reason ID : 10005393		**Not all healthcare staff had received education and training in basic life support, fire safety, and the management of violence and aggression to enable them to provide care and treatment in accordance with best contemporary practice, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Heads of Discipline to review staff training compliance and advise staff in their areas to complete all mandatory training.	Annual audit of training records completed by Each Head of Discipline	Achievable	30/08/2024	Senior Management Team
Preventative Action	The ADON lead for Training formulates and co-ordinates an annual training calendar for KWWMHS to ensure Mandatory Training of all Healthcare Staff is provided and offered. The ADON Lead then circulates via memos to line managers when training is scheduled and when staff can be booked in. Each Head of Discipline completes Annual staff Training plans in collaboration with all staff. Staff are	Attendance at each training session will be monitored via production of certificates and/or attendance records. Annual audit of training records.	Achievable/Realistic	31/12/2024	Senior Management Team

	aware of the expiry dates of training. Staff are offered dates by their line managers and are provided with prompts when they are due to attend.				

Rules Governing the Use of Seclusion					
Reason ID : 10005402		**The mandatory nature of training in relation to seclusion was not specifically recorded in the policy, 11.2(d).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of inspection Dec 2023, policy was updated to include the mandatory nature of training in relation to seclusion	Policy for annual review	Achievable	10/06/2024	CNM3/ ADON lead for Policies
Preventative Action	The Policy is reviewed annually against MHC guidance and a review and evaluation of Evidence Based Practice	Policy for annual review	Achievable	31/12/2024	CNM3/ ADON lead for Policies
Reason ID : 10005403		**The construction of the seclusion room was not designed to withstand high levels of violence with the potential to damage the physical environment as damage was remedied by Perspex. In some areas, staples were noted to hold the wall lining in place, 8.1(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A design team was commissioned by HSE estates to review the existing seclusion room and provide a design and spec for full upgrade of seclusion room	Design sign off	Achievable	30/08/2024	HSE Estates/Maintenance Manager/ Operations Manager/ ADON

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Preventative Action	Funding is secured for a newly refurbished Seclusion Room in Lakeview unit to replace current facility	Quarterly Premises Committee Meetings	Achievable with Support from HSE Estates	31/12/2024	HSE Estates/Maintenance Manager/ Operations Manager/ ADON
Reason ID : 10005404		**The seclusion room did not have an anti-barricade door, 8.1(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A design team was commissioned by HSE estates to review the existing seclusion room and evaluate potential upgrade solutions	Design sign off	Achievable	30/08/2024	HSE Estates/Maintenance Manager/ Operations Manager/ ADON
Preventative Action	Funding is secured for a newly refurbished Seclusion Room in Lakeview unit to replace current facility. Door will be Anti-barricade	Quarterly Premises Committee Meetings	Achievable with supports of HSE estates	31/12/2024	HSE Estates/Maintenance Manager/ Operations Manager/ ADON
Reason ID : 10005405		**The seclusion room was located near bedrooms and was not in an area away from communal sitting rooms and sleeping accommodation, 8.1(ix).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Until the New Build is completed the location of the current Seclusion room cannot be changed and loss of Room 12 (	Design Team feedback	Not currently achievable or realistic	31/12/2030	HSE Estates/Maintenance Manager/ Operations Manager/ ADON

	Bedroom) is not achievable due to clinical demands and bed occupancy levels remain over 95%				
Preventative Action	A standalone new build has been approved and a project team is in place to progress this. This will provide for a Seclusion room away from communal sitting rooms and sleeping accommodation	Project Team feedback to SMT	Achievable/Realistic	31/12/2030	HSE Estates/Maintenance Manager/ Operations Manager/ ADON
Reason ID : 10005406		**One seclusion care plan did not include recognising signs that the person's behaviour was no longer deemed an unmanageable risk towards themselves or others or how potential risks may be managed, 5.7(v)(vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Nursing Staff informed at weekly staff meeting that all seclusion care plans to be fully completed, including recognising signs that the person's behaviour was no longer deemed an unmanageable risk	Audit each episode – real time	Achievable	10/06/2024	CNM3/ CNM2

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
	towards themselves or others or how potential risks may be managed				
Preventative Action	Seclusion pathway updated since inspection which incorporates prompts on documenting all aspects required of a Care plan	Audit each episode – real time	Achievable	10/06/2024	CNM3/ CNM2
Reason ID : 10005407		**Two individual care plans were not updated following the outcome of the debrief, 7.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Email communication sent to all MDT members of the CMHTs advising them that not all ICPs were updated following the outcome of the debrief.	Audit each episode – real time	Achievable	10/06/2024	CNM3/ ADON/ MDT members
Preventative Action	The Seclusion Pathway prompts MDT members post Debrief to update ICP with the patient's preference in relation to restrictive interventions going forward. New ICP pathway	Audit each episode – real time	Achievable	31/12/2024	CNM3/ ADON/ MDT members

	incorporates prompts to alert if a Restrictive Practice has occurred. This prompt advises the MDT to include in ICP further interventions to support the goal of reducing/ eliminating need for the use of restrictive interventions in the future				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10005399		**In one episode of restraint there was no record of the resident being given the option of having their representative or nominated support person attend the debrief with them or an explanation as to why this did not occur in the resident's clinical file, 5.3(vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Nursing Staff informed at weekly staff meeting that a record must be maintained whereby they have provided the patient with the opportunity to have their representative or nominated support person attend the debrief, or if the patient has declined this.	Audit of each episode – real time.	Achievable	10/06/2024	CNM3/ CNM2
Preventative Action	Prompt added to the Physical Restraint Pathway to ensure with the consent of the patient their representative or nominated support person has been offered to attend the debrief	Audit of each episode – real time. Audit Results presented to the monthly compliance committee and circulated to all MDTs.	Achievable/Realistic	31/12/2024	CNM3/ ADON

Reason ID : 10005400		In three episodes of restraint inspected the resident's individual care plan was not updated to reflect the outcome of the debrief and, in particular, the resident's preferences in relation to restrictive interventions going forward, 5.5.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Email communication sent to all MDT members of the CMHTs regarding regulation 15 and the requirement for MDT involvement in the weekly reviews of the ICP	Audit of each episode – real time.	Achievable	10/06/2024	Senior Management Team/ Clinical Director/ ADON
Preventative Action	The Physical Restraint Pathway prompts MDT members post Debrief to update ICP with the patient's preference in relation to restrictive interventions going forward. New ICP pathway incorporates prompts to alert if a Restrictive Practice has occurred. This prompt advises the MDT to include in ICP further interventions to	Audit of each episode – real time.	Achievable/Realistic	31/12/2024	CNM3

	support the goal of reducing/ eliminating need for the use of restrictive interventions in the future				
Reason ID : 10005401		**In three episodes of physical restraint, staff members involved in the use of physical restraint and subsequent monitoring did not undertake appropriate training in accordance with the policy outlined in section 8.2. of the code of practice on the use of physical restraint, 4.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Staff involved in the 3 episodes identified were prioritised for the next course of TMVA	Training Audit	Achievable	10/06/2024	ADON lead for Training/ CNM3/ADON
Preventative Action	The ADON lead for Training completes Annual staff Training plans in collaboration with all Nursing staff. Staff are aware of the expiry dates of training. The Training is scheduled regularly. Staff are offered dates and are provided with prompts when they are due to attend.	Training Audit	Achievable	31/12/2024	ADON lead for Training/ CNM3/ADON

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.

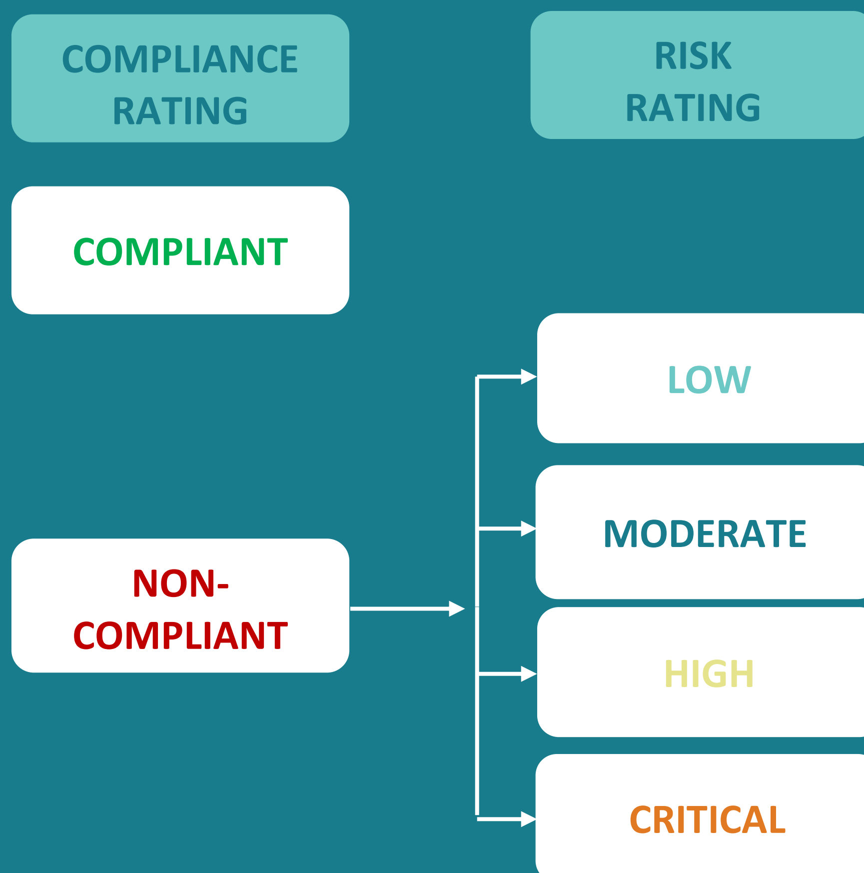
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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



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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.