Acute Psychiatric Unit, Ennis Hospital

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

Acute Psychiatric Unit, Ennis Hospital

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Ennis, Co. Clare

Date of Publication: 21st June 2024

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2023 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
None

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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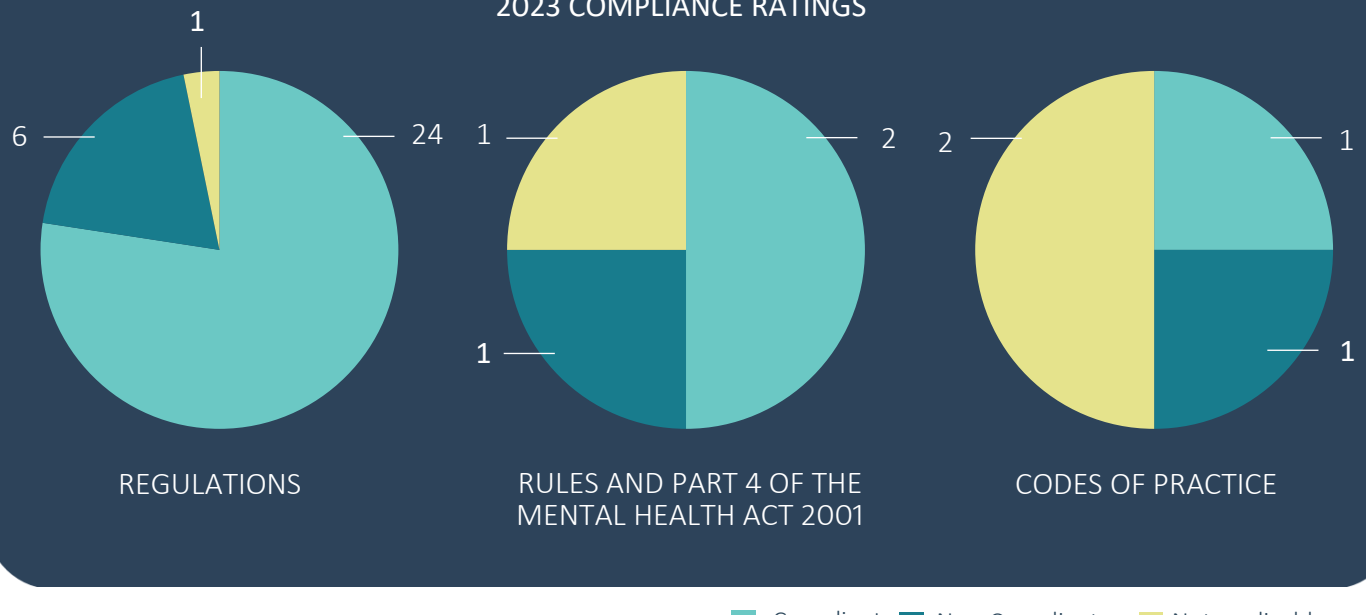
Inspection Date:
7 – 10 November 2023

Previous Inspection date:
9 – 12 August 2022

Inspection Type:
Announced Annual Inspection

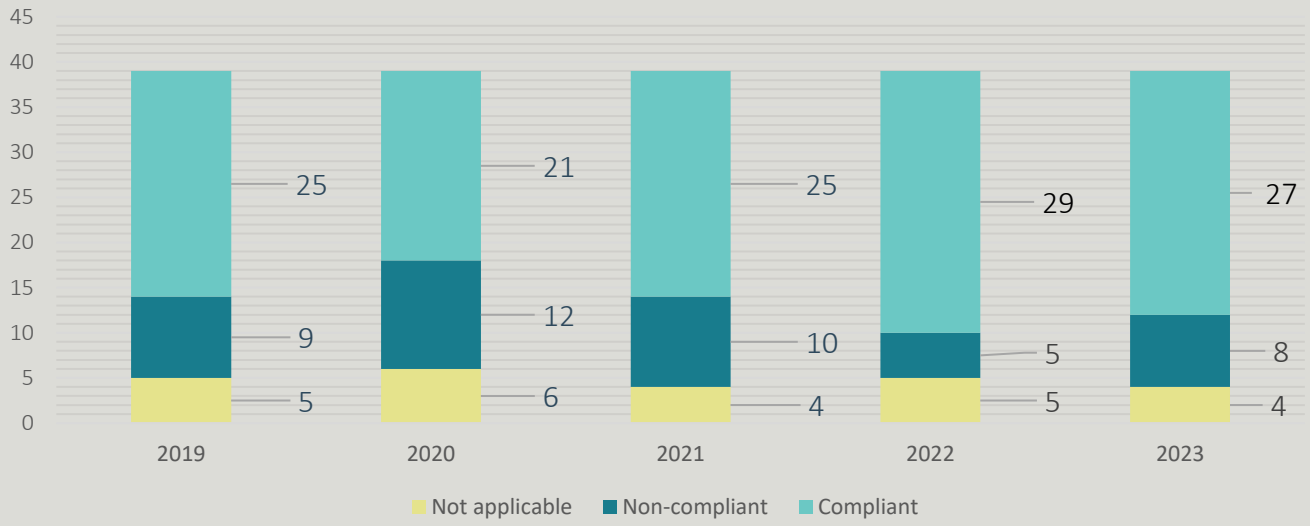
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

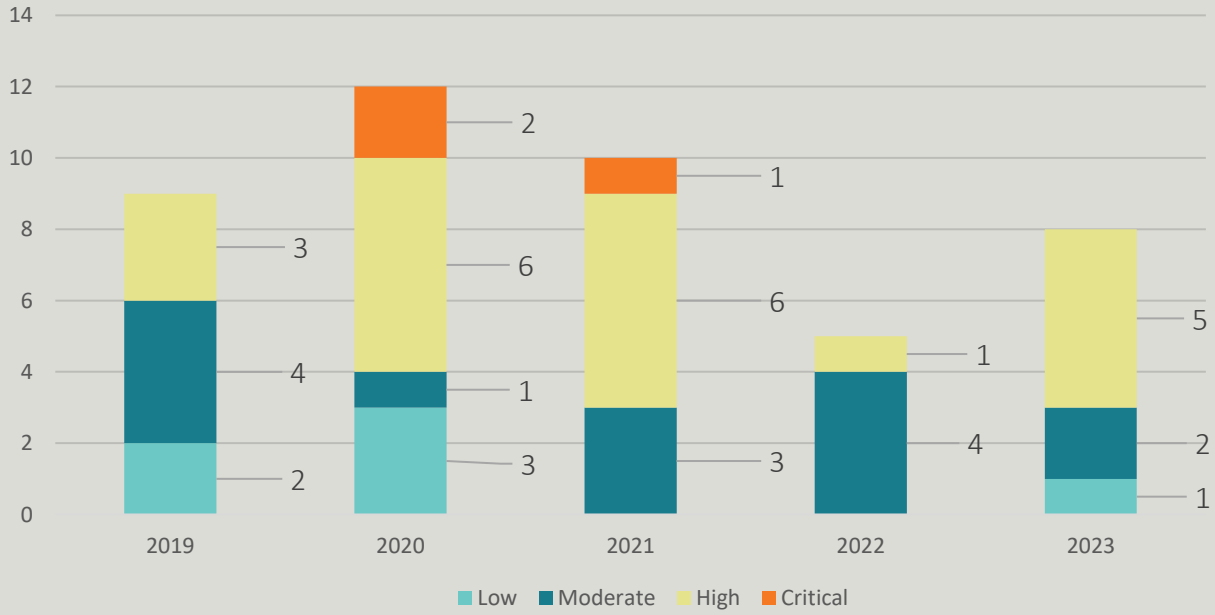
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Professor James V Lucey

In brief

The approved centre was located on the grounds of Ennis General Hospital. It provided acute adult mental health care, psychiatry of later life, mental health rehabilitation and mental health care for people with intellectual disability services to residents of North Tipperary and the county of Clare. The approved centre was registered to accommodate 39 residents. Sleeping accommodation consisted of single, two bed, three-bed and four-bed rooms across three separate sub-units. Admission were referred into the approved centre from nine multi-disciplinary teams (MDTs), two of which were specialist Psychiatry of Later Life teams and one of which was a specialist Rehabilitation and Recovery team.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	74%	64%	71%	86%	77%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Number of registered nurses in the approved centre*:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Access to essential information*:** The clinical files were in order, and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Infection control*:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Fire safety:*** Fire doors were observed wedged open and leaves were not closed which compromised fire safety. Although new fire doors were to be installed. At the time of inspection, fire doors throughout the unit were damaged. Not all health and safety risks or control measures relating to fire safety such as fire doors being wedged open were documented within the unit risk register.
- ***Cleanliness***: Stains and dirt were observed in toilets, bathrooms, ceiling vents and in the approved centre foyer.
- ***Mandatory training:*** Not all staff were trained in fire safety, basic life support, the prevention and management of challenging behaviours and the Mental Health Act.
- ***Ligature anchor points:*** Ligature points were not minimised to the lowest level, based on individual risk assessment.
- ***Medication safety:*** Medication administration records were not complete in all situations. There was no evidence of pharmacist consultation regarding alternative preparations or routes of administration for one resident on crushed medications.
- ***Maintenance:*** The physical structure and overall environment were not maintained with due regard to safety and the specific needs of the residents and patients as all hazards were not minimised.
- ***Bed capacity:*** The service had admitted patients and residents over the registered bed numbers on 15 occasions.

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 a medical team and the local hospital for assessment and any treatment required.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed weekly on a regular basis.
- ***Multi-disciplinary team working:*** Residents has access to a multi-disciplinary team (MDT) consisting of psychiatry, nursing, occupational therapy, social work and psychology staff. There were regular

multi-disciplinary team meetings to discuss residents' care plans. There was a social worker, occupational therapist and psychologist on the team. Residents also had access to addiction counsellors and tenancy support workers.

- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan. Therapeutic groups included ARIES recovery workshop, Irish therapy dog, occupational therapy groups such as arts and crafts, baking, Peer Support GROW and a Wellness Recovery Action Plan group and a psychology group facilitated by the psychologist.
- ***Access to other medical services:*** Specialist therapeutic interventions were available to residents by referral.

However:

- **Appropriateness of environment:** The approved centre was not kept in good decorative condition as doors, ceilings and walls throughout the approved centre were damaged.
- ***Discharges:*** The discharge letter of one resident did not address signs of relapse.

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 in the approved centre consisted of mainly three-bed and four-bed rooms with some single and two-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.
- ***Use of restrictive practices:*** The approved centre was compliant with the code of practice on physical restraint and the rules on the use of seclusion. The approved centre had a reduction of restrictive practices strategy.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Privacy and dignity:*** Resident's privacy and dignity were not appropriately respected at all times as the visiting room was monitored by CCTV and observation panels on bedroom doors on the high dependency unit were not fitted with blinds, curtains or opaque glass.
- ***Use of restrictive practices:*** Mechanical restraint was used in the approved centre but risk assessments were not continually undertaken or reviewed appropriately during its use. Not all care plans for persons restrained by mechanical means included information on attempts to reduce or eliminate the use of restraint for the person.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. The approved centre had access to a church in the adjoining hospital and multi-faith ministers were available to residents.
- ***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 activities such as a gym, pool table, music, a smart TV, arts and crafts, baking, gardening, mindfulness, social outings, movie nights and internet.
- ***Support groups:*** Residents had access to discussion groups and a self-care group.
- ***Residents' feedback:*** Residents were complimentary about the environment and the care they received. They reported feeling safe in the approved centre, that they received information on their treating teams and their individual care plans, were aware of their key workers and were happy with how staff interacted with them.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The Mid-West Mental Health Services (MWMHS) Management Team were responsible for the overall management and governance of the approved centre. Regionally, the approved centre was governed by the Clare & North Tipperary Management Team. Both met on a regular basis.
- ***Clinical governance:*** A local Acute Psychiatric Unit Management Team meeting convened monthly consisting of medical and nursing staff.
- ***Restrictive practices reduction:*** The approved centre had policies and procedures in place to reduce, or where possible eliminate, the use of restrictive practices.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. A Mid-West Mental Health Services (MWMHS) Quality and Patient Safety Committee convened on a monthly basis and on a regional level, the Clare North Tipperary Quality and Safety Committee also convened on a monthly basis and reported directly to the area committee.

- ***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. They reported that they could contact staff at any time.
- ***Advocacy services:*** A peer advocacy representative met with residents and contact details for this service were displayed in the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last four years of 75%. It has no conditions on its registration. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risk:*** Persons with responsibility for risk were known by staff and incidents were reported and risk assessed, but not all health and safety risks were identified, treated, reported or monitored appropriately and not all risk management procedures actively reduced identified risks to the lowest practicable level.
- ***Staff training:*** Not all staff had completed mandatory training in basic life support, fire safety, the prevention and management of challenging behaviours and the Mental Health Act.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of 5–10 minute safety pauses/huddles commenced in March 2023. This was introduced to increase safety awareness as highlighted on the day to help all teams be more proactive about challenges faced in providing safe, high-quality care for residents.

2. A smoking cessation officer commenced post in November 2022 to support residents who wished to quit smoking.

3. A new information screen had been installed in the main hub to provide ongoing information to residents in the unit.

4. Collaboration with the local library in June 2023 facilitated a donation of new books in the activation area.

5. Redevelopment of the seclusion suite was completed in April 2023.

6. A delayed Transfer of Care Group had been established by the approved centre to support a timely transition of complex clients to more independent living back in their local community. This supported the management of bed capacity.

7. Dialectical behaviour therapy decider skill training for staff commenced in February 2023.

8. Advanced Recovery in Ireland Education Service (ARIES) co-produced a recording for an educational piece for family members of service users of the approved centre.

9. A range of equipment to improve patient experience was purchased through the awarded Minister Butler Fund in December 2022. This included a display information screen in the foyer, new seating, mobile charging stations, bean bags, mood lighting, Snoezelen multi-sensory equipment, TVs, books, personal care items.

10. A new suite of care planning documents had been developed.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the grounds of Ennis General Hospital. It provided in-patient mental health care to residents of North Tipperary and the county of Clare. The approved centre was registered to accommodate 39 residents and consisted of three separate subunits; these included a 30-bed general acute unit, a five bed high observation unit, and a five bed Psychiatry of Later Life (POLL) unit. The general acute unit was comprised of four four-bedded rooms, three three-bedded rooms, one two-bedded room and three single rooms. The high observation area included three single rooms and one two-bedded room. The POLL unit included two two-bedded rooms and one single room. Each unit had access to a separate external garden space. The approved centre had a large recreational room, an art room, a therapy kitchen, a gym room, and multiple office spaces.

Nine multi-disciplinary teams, comprising of six general adult sector teams and three specialist teams, admitted residents into the approved centre. General adult sector teams were designated according to geographical area and included the Thurles team, the Nenagh team, the East Clare Sector team, the South Clare Sector team, the North Clare Sector team, and the West Clare Sector team. Specialist teams included the two Psychiatry of Later Life teams and the Rehabilitation and Recovery team.

Since the previous inspection the approved centre had completed a new seclusion suite. The approved centre was continuing to develop the full redesign of the two garden areas and the de-escalation space.

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

Resident Profile	
Number of registered beds	***39***
Total number of residents	**37**
Number of detained patients	11
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	12
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Mid-West Mental Health Services incorporated Clare, North Tipperary, and Limerick services. The Mid-West Mental Health Services (MWMHS) Management Team were responsible for the overall management and governance of the Acute Psychiatric Unit (APU), Ennis General Hospital. Regionally, the APU was governed by the Clare & North Tipperary Management Team, and this team reported directly to the MWMHS

Management Team forum. Both management team meetings convened on a regular basis and meeting minutes evidenced discussion and planning concerning key operational issues. Meetings were attended by the multi-disciplinary team. Locally, there was an APU Management Team meeting which convened monthly. This meeting was attended by medical and nursing staff only.

All heads of discipline had received training in risk management procedures. A risk register for the APU was maintained and reviewed by local management and included corporate, health and safety, and structural risks. There was a comprehensive risk management policy in place, however, not all elements of the policy were implemented with regard to identification, treatment and monitoring of health and safety risks within the approved centre. Over the course of the inspection, several issues were observed concerning the functionality of the fire doors. Instalment of new corridor fire doors was in place and procurement of new fire doors was in progress for the whole unit. This was documented and monitored on the head of Service risk register. Weekly fire checks of the environment were being undertaken and the outcomes were documented in the fire register. During the inspection, fire doors were wedged open or leaves of doors left open; not all fire safety practices, such as these, were identified on the local risk register for monitoring. In general, clinical risks were identified, assessed, and treated and monitored. However, in one instance, individual risk assessments were not reviewed during the use of mechanical restraint. The risk management procedures did not actively reduce identified risks to the lowest practicable level as the service had admitted patients and residents over the registered bed numbers by one or two persons on 15 occasions. These individuals were accommodated in a shared room with beds arranged from Ennis General when required. The service increased their bed management meeting to daily when the service had admitted over the registered bed numbers and had also established a Delayed Transfer of Care committee.

Six general adult sector teams and three specialist teams (two Psychiatry of Later Life (POLL) teams and the Rehabilitation and Recovery) admitted residents to the approved centre. These teams had adequate numbers and skill mix of staff to meet residents' needs. Cross cover or agency staff were utilised if there were vacancies across admitting teams. At the time of inspection, a full-time in-patient occupational therapy post was approved but had not been filled. A 0.5 whole time equivalent (WTE) was in post in the approved centre at the time of inspection. Vacant positions amongst the community teams who provided in reach care to the approved centre included one social worker post and two psychology posts. Operational risks reported across the disciplines included staff recruitment and retention.

The approved centre was dedicated to improving service quality. A Mid-West Mental Health Services (MWMHS) Quality and Patient Safety Committee, covering the entire service area (Clare, North Tipperary, and Limerick), convened on a monthly basis. On a regional level, the Clare North Tipperary Quality and Safety Committee also convened on a monthly basis and reported directly to the area committee. Agenda items for both forums included the review of service user feedback, complaints, risk registers, regulatory issues, safeguarding issues, incident trends and serious incidents. Individual incidents arising in the APU were reviewed at the local multi-disciplinary team meeting. The APU had a restrictive practices reduction committee which met quarterly. Episodes of physical restraint had reduced from 59 in 2022 to 27 in 2023. Episodes of seclusion had risen by one episode from 2022 to 2023. Both the rule governing the use of seclusion and the code of practice were found compliant on this inspection. Within the approved centre, a programme of audit was implemented. There were systems for performance appraisal and supervision processes for all disciplines within the approved centre.

Resident engagement in governance and quality improvement processes were facilitated throughout the service. The contact details for the Area Lead for Mental Health Engagement were provided to residents within the approved centre. The Area Lead for Mental Health Engagement post provided feedback to several governance forums including the MWMHS Management Team meeting, the Clare North Tipperary Management Team meeting and both the area and the regional Quality and Safety committee meetings. Locally, within the approved centre, regular resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Irish Advocacy Network contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre.

Infection Prevention Control processes were clearly outlined. COVID-19 was a standing agenda item at all the principal governance forums at an area, regional and local level. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.

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 11: Visits	✓		✓		✓		✓		✗	Moderate
Regulation 21: Privacy	✗	Moderate	✗	Critical	✗	High	✓		✗	High
Regulation 22: Premises	✗	Moderate	✗	High	✗	High	✗	High	✗	High
Regulation 23: Medication Management	✓		✗	Low	✓		✗	Moderate	✗	High
Regulation 26: Staffing	✗	Moderate	✓		✗	High	✗	Moderate	✗	Low
Regulation 32: Risk Management Procedures	✓		✗	High	✗	Critical	✗	Moderate	✗	High
Rule Governing the Use of Mechanical Restraint		N/A		N/A		N/A		N/A	✗	High
Code of Practice on Admission, Transfer and Discharge	✗	Moderate	✗	High	✗	Moderate	✗	Moderate	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

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

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The inspection team spoke with residents and two questionnaires were returned to the team. Both residents who interacted with the inspection team via interview or questionnaires reported feeling safe in the unit, and both questionnaires indicated staff explained what was happening in a way they could understand when they arrived. All respondents indicated they knew their individual care plan (ICP), and their multidisciplinary team, and were always involved in setting goals for their ICP. All respondents reported they were happy with how staff interacted with them and that there were enough activities for residents during the day.

When residents were asked to rate the service on their overall care and treatment experience from 1–10, 1 being poor and 10 being excellent, two questionnaires scored the service 8 and 10 respectively.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors did not receive a report from the Peer Advocacy in Mental Health representative but the inspector did speak with the advocate and their feedback has been represented above.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Head of Service/Registered Proprietor Nominee
- General Manager
- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker
- Senior Clinical Psychologist
- Mental health Engagement Lead
- Clinical Nurse Manager III
- Risk Advisor
- Business Manager
- Senior Executive Officer

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 in easily accessible locations throughout the approved centre.

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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 July 2023.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure 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.

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. The activities timetable was adapted to the needs of the residents. Activities included a gym, pool table, music, a smart TV, arts and crafts, baking, gardening, mindfulness, social outings, movie nights and internet. There were also discussion groups and a self-care group. A peer worker facilitated wellness recovery action plans and the ARIES organisation provided recovery-focussed educational input.

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.

The approved centre had access to a church in the adjoining hospital and multi-faith ministers were available to residents.

The approved centre was compliant with this regulation.

Regulation 11: Visits

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

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

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 separate 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. However, the visitors room which was also the assessment room/waiting area did not allow private meetings as it was monitored by a CCTV camera which clinical staff could view.

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 non-compliant with this regulation because the registered proprietor did not ensure that the privacy of a resident during visits was respected, in so far as was practicable, as there was a CCTV camera in the visiting room which monitored the visitors room and the monitor could be viewed by clinical staff, 11(4).

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 May 2022.

Residents had access to the internet, ward phones and personal mobile phones. Residents who had been risk-assessed with due regard to their well-being, safety and health had restrictions on communication.

The clinical director or the 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 June 2023, and included all requirements related to:

- The management and application of searches of a resident, their belongings and the environment in which they were 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. The residents' consent was sought and documented prior to the search taking place. Where consent was not received, this was documented and the process relating to searches without consent was implemented. Risk had been assessed prior to the search of the residents. Residents were informed by the person implementing the searches of what was happening during each search and why. 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.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and protocols for the care of residents who are dying. The policy was last reviewed in July 2022.

The end-of-life care provided to residents was appropriate to their physical, emotional, social, psychological and spiritual needs. This was documented in the resident's individual care plan. Religious and cultural practices were respected, insofar as is practicable. The privacy and dignity of residents was protected by the provision of a single room. Representatives, family, next-of-kin and friends were involved, supported and accommodated during end-of-life care.

The sudden death of a resident in the approved centre was managed in accordance with the resident's religious and cultural practices, with dignity and propriety and in a way that accommodated the resident representatives, family, next-of-kin and friends.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family and next of kin, as appropriate.

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided therapeutic services and programmes that were appropriate and 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. Groups included ARIES recovery workshop, Irish therapy dog, occupational therapy groups such as arts and crafts, baking, Peer Support GROW and a Wellness Recovery Action Plan group.

Services that were not provided internally were available to residents by referral. Access to speech and language therapy was available by referral to private service.

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 July 2023.

The file of one resident who had been transferred from the approved centre were inspected. Full and complete written information on the resident was transferred when they moved from the approved centre to another facility. This transfer letter 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 included procedures for responding to medical emergencies. The policy was last reviewed in March 2023.

The approved centre had an emergency grab bag 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.

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

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Access to a physiotherapist and dietitian were available by referral to the primary care service in Ennis General Hospital.

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 January 2023.

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

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

Residents were provided with written and verbal information on diagnosis, 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 interpreter service if needed.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Staff communicated respectfully 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. 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.

Not all observation panels on doors of treatment rooms and bedrooms adequately respected the residents' privacy, as all bedroom doors on the high dependency unit had strips of frosted glass however were not fitted with blinds, curtains or opaque glass.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents' privacy and dignity were appropriately respected at all times as observation panels on bedroom doors on the high dependency unit were not fitted with blinds, curtains or opaque glass.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards were not minimized in the approved centre; a wall-hung sink in the four-bed shared room was loose and identified as a hazard. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

A programme of general and decorative maintenance, cleaning, decontamination and repair of assistive equipment was recorded. Rooms were centrally heated with pipe work. Current national infection control guidelines were followed.

The approved centre was not kept in a good state of repair externally and internally. A ceiling tile in the entrance area was stained. Skirting boards and walls on the corridor were scuffed and there were stains under the fish tank. Overhead lights in the shared room were damaged. A ceiling tile in the Psychiatry of Later Life unit and the floor leading from it to the courtyard were damaged. Damage to door frames were evident in the high observation area. New vinyl wrap had been ordered for the High Observation area, as were new beds at the time of inspection. In the main garden, a vent in the ground was broken and hazardous. The main garden wall was marked. Bedroom doors were marked and damaged, as was a

bedroom floor in the high dependency unit and a ceiling on the corridor. A bathroom wall and door in the high observation area were damaged.

The approved centre was not clean. Dust and cobwebs were visible on top of a charging unit in the entrance area. Windows were not clean, and toilets were stained. Mirrors in the bathrooms were not clean. Two ceiling vents were not clean in the seating area of the corridor.

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

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

a) **The registered proprietor did not ensure that the environment was maintained with due regard to the safety of residents as ligature points were not minimised to the lowest practical level based on risk assessment, 22(3).**
b) **The registered proprietor did not ensure the approved centre's physical structure and overall environment were maintained with due regard to the specific needs and safety of the residents and patients, as hazards were not minimised, 22(3).**
c) **The registered proprietor did not ensure the approved centre was clean as dust, cobwebs, dirty windows, stained toilets, dirty bathroom mirrors and dirty ceiling vents were visible in the approved centre, 22(1)(a).**
d) **The registered proprietor did not ensure the approved centre was kept in good decorative condition as bedroom doors and floors, corridor ceilings and floors, overhead lights, garden vents and bathrooms walls and doors were damaged; corridor skirting boards and walls were scuffed; and ceiling tiles and corridor walls were stained, 22(1)(a).**

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, prescribing, storing and administration of medicine. The policy was last reviewed in October 2022, and included the following requirements:

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

All residents had a Medication Prescription and Administration Record (MPAR). Ten MPARs were examined on inspection. Eight MPARs contained a detailed record of appropriate medication management processes, including a record of any allergies or sensitivities to medications, the frequency of administration, all medications administered and the date of discontinuation of each medication.

One MPAR was missing an administration record on one occasion. One resident's MPAR did not clearly show whether an as-required medication was administered on one occasion; and on a second occasion did not contain a record of dose, time or, signature for an as-required medication.

The Medical Council registration number of every medical practitioner prescribing medication to the residents was recorded.

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

The direction to crush medication was only accepted from the resident's medical practitioner. However, the pharmacist had not been consulted on the types of preparations used; one resident's MPAR recorded that they were on crushed medication which the pharmacist was unaware of.

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 for the following reasons:

a) **On one occasion, one resident's Medication Prescription Administration Record was missing an administration record, 23(1).**
b) **On two occasions, one resident's Medication Prescription Administration Record did not clearly show whether as-required medication was administered, 19(1).**
c) **There was no evidence of a consultation with the pharmacist regarding alternative preparations or routes of administration for one resident on crushed medications, 19 (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 July 2023.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and processes for the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in December 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 LOW

(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 July 2023, 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. The approved centre had nine multi-disciplinary in-reach teams, which included psychiatry, nursing, occupational therapy, social work and psychology staff. Where there were staff vacancies within in-reach teams, cross cover was provided.

An appropriately qualified staff member was on duty at all times. Not all healthcare staff were trained in basic life support, fire safety, the management of violence and aggression or the Mental Health Act 2001.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre.

The following is a table of staff showing the numbers and percentages of staff trained in the four mandatory training topics:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (38)	36	95%	38	100%	34	89%	38	100%

Consultant Psychiatrist (13)	13	100%	13	100%	13	100%	12	92%
Medical (17)	15	88%	15	88%	17	100%	15	88%
Occupational Therapist (9)	9	100%	9	100%	9	100%	9	100%
Social Worker (6)	4	67%	6	100%	6	100%	6	100%
Psychologist (8)	8	100%	8	100%	8	100%	8	100%

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

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

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

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

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 September 2023 and included the process for managing complaints, including raising, handling and investigating complaints from any person regarding aspects of the services, care or treatment provided in or on behalf of the approved centre.

A nominated person responsible for dealing with all complaints was available to the approved centre. Information was provided about the 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, the results of any investigations into the complaints and any actions taken on foot of a complaint were fully and properly recorded. These records were in addition to and distinct from a resident’s individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in July 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. Clinical corporate and health and safety risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. The approved centre had admitted residents over the registered bed numbers 15 times.

Not all health and safety risks were identified, assessed, treated, reported or monitored by the approved centre in accordance with relevant legislation. At the time of inspection, fire doors remained damaged in the high observation units. These doors were due to be replaced and were at manufacturing stage. Fire-door side panels were observed open in bedrooms during the inspection. A bin was observed to wedge open the gym door. All cross doors were changed to new fire doors; however, one set at the entrance caught on the flooring, obstructing its ability to close.

Not all health and safety risks were documented within the unit risk register, as appropriate. The risk of fire safety was not documented on the local risk register therefore there were no documented monitoring or treatment measures at the unit level. The Head of Service risk register did document the damage to the fire doors and procurement of new doors alongside the fire report assessment control measures. The risk to damaged doors were identified, assessed, treated, reported and monitored by the approved centre.

Structural risks, including ligature points, were removed or effectively mitigated. A ligature audit was completed bi-annually and had effective mitigation measures, where the ligature was not minimised to the lowest level.

The approved centre implemented a plan to reduce risks to residents while any works to the premises are ongoing. Local works were undertaken for the cross doors and there was a phased plan to install new flooring and fire doors.

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. An individual risk assessment was not continually reviewed on the use of mechanical restraint on one person.

Multi-disciplinary teams were involved in the development, implementation and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

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

a) **The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk as the service had admitted patients and residents over the registered bed numbers on 15 occasions, 32 (1).**
b) **Health and safety risks were not adequately treated and monitored by the approved centre. Fire doors were observed wedged open or leaves not closed which compromised fire safety. Fire doors throughout the unit were damaged. Not all health and safety risks relating to fire safety were documented within the unit risk register, 32 (1).**
c) **Individual risk assessments were not reviewed during the use mechanical restraint, 32 (1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration prominently displayed in the reception area.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

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

The policy addressed the following:

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

The approved centre had a policy on the reduction of seclusion, which was last reviewed in September 2023 and addressed:

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

The policy for training all staff involved in seclusion addressed:

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

of restrictive intervention; the prevention and therapeutic management of violence and aggression; positive behaviour support including the identification of social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in seclusion.

Training and Education: There was a written record indicating that staff involved in seclusion had read and understood the policy. All staff who participated, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

Monitoring: A multidisciplinary review and oversight committee accountable to the registered proprietor nominee had been established to analyse every episode of seclusion. The committee met at least quarterly and determine if each episode of seclusion reviewed complied with the rules governing the use of seclusion, as well as with the approved centre's own policies and procedures for seclusion.

The committee also identified and documented areas for improvement, and the actions, persons responsible and timeframes for completion of the actions.

The committee assured 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 and was available to the Mental Health Commission upon request.

Evidence of Implementation: A new seclusion suite was completed in the approved centre in April 2023. Seclusion facilities were furnished, maintained and cleaned in such a way that respected the patient's dignity and privacy. The seclusion room was constructed to withstand high levels of violence with the potential to damage the physical environment. There were no ligature points or electrical fixtures. There was an anti-barricade door. Staff could clearly observe the patient within the seclusion room. The room had externally controlled heating and air conditioning, as well as limited furnishings that included a pillow, mattress, and covering, all of which met current health and safety requirements. The room was large enough to support the patient and a team of staff.

The patient had sight of a clock displaying the time, day and date. As far as possible, the seclusion room was far away from communal sitting rooms and sleeping accommodation, without being isolated. The seclusion room had a window with a clear view of the outdoor environment, but the room was not visible to unauthorised persons from outside. The patient had access to sanitary facilities and items. All furniture and fittings in the seclusion room were such as not to endanger the safety of the patient. Seclusion facilities were not used as bedrooms and bedrooms were not used as seclusion facilities.

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

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

The patient was medically examined by a RMP as soon as practicable. This included an assessment and record of any physical, psychological or emotional trauma caused to the person as a result of the seclusion. The RMP contact the patient's consultant psychiatrist (CP) or the duty CP to inform them of the episode of seclusion. The CP ordered the discontinuation or continuation of the use 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 advised the duration of the order. The RMP recorded this information on the seclusion register. Seclusion order was not made for a period of time longer than four hours from the commencement of the seclusion episode. The order of the CP confirmed that there are no other less restrictive ways available to manage the person's presentation. The CP medically examined the patient and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The examination was recorded in the clinical file.

The patient was informed of the reasons for, likely duration of and circumstances which led to the discontinuation of seclusion, and a record was recorded in the patient's clinical file as soon as was practical.

As soon as practicable, and where it was the patient's wish in accordance with their ICP, their representative was informed of the seclusion and a record of this communication was entered in the clinical file. If this communication did not occur, a record explaining why not was entered in the clinical file. The patient's representative was not communicated with where the patient's wished not, except to fulfil legal and professional requirements. This was recorded in the clinical file.

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

Seclusion was only used when all other options had proven unsuccessful and following risk assessment. The patient wore their own clothing in seclusion, respecting their right to dignity, bodily integrity and privacy. Bodily searches were only undertaken in exceptional circumstances following a risk assessment, and the outcome was recorded in the clinical file. Bodily searches were undertaken in the presence of more than one staff member, and respected the patient's dignity, bodily integrity and privacy. The patient's gender, cultural sensitivity and preferences were respected.

A RN directly observed the patient for the first hour following the initiation of seclusion. After the first hour, the RN continuously observed the patient and remained within sight and sound of the seclusion room. A written record was made by the RN every 15 minutes which recorded the patient's level of distress, their behaviour, their level of awareness, their level physical health and especially their breathing, pallor and cyanosis and whether elimination, hygiene, hydration and nutrition needs were met.

Following risk assessment, a nursing review of the patient took place every two hours. A minimum of two staff members, one of whom was a RN not directly involved in the decision to seclude, entered the

seclusion room and assessed the patient to determine whether to end the episode of seclusion. This assessment and decision were recorded. A medical examination was carried out by a RMP every four hours. The decision to end or continue seclusion was recorded.

At the start of each episode of seclusion, a seclusion care plan was developed by a RN for the patient. The seclusion care plan included personal details, known mental and physical clinical needs, how de-escalation strategies would continue to be used, the patient's preferences in relation to seclusion and what any previous debrief with the patient had recorded, signs that the patient's behaviour was no longer an unmanageable risk towards themselves or others, how potential risks may be managed, specific support plans for the patient and details of how their mental health needs would be met while in seclusion, meeting of food and fluid needs, meeting of personal hygiene and dressing needs; meeting of elimination needs while maintaining the patient's privacy and dignity, medication reviews, the monitoring of physical observations and a strategy for ending seclusion with criteria.

The seclusion order was renewed by an order made by a RMP under the supervision of the CP or the duty CP following a medical examination, for a period not exceeding four hours and a maximum of five renewals (24 hours) of continuous seclusion. Where the seclusion order was renewed beyond 24 hours, the CP or the duty CP undertook a medical examination, and this was recorded in the clinical file.

Seclusion was ended by a RMP following discussion with the patient and relevant nursing staff; or by the most senior RN in the unit, in consultation with the patient and a RMP. The CP or duty CP was notified of the ending of seclusion, as was the patient. The time, date and reason for ending seclusion were recorded in the clinical file on the date seclusion was ended.

An in-person debrief followed one episode of seclusion. The patients in the other two episodes inspected refused a debrief, and this decision was respected and recorded in the clinical file.

The debrief undertaken was structured, person-centred and gave the patient the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved in their care and treatment. The debrief occurred within two working days of the episode and included a discussion regarding alternative de-escalation strategies and the patient' preferences in the event where a restrictive intervention would be needed in the future.

In all cases, the patient was given the option of having their representative or a nominated support person attend the debrief with them, and, if this person did not attend, a record of why not was recorded in the clinical file.

A record was kept of the offer of the debriefing, whether it was accepted and what the outcome was. The patient's individual care plan was updated to reflect the outcome of the debrief and, in particular, their preferences in relation to restrictive interventions going forward. For the patient who participated in a debrief, a record of all attendees at the debrief was placed in the clinical file. Where a patient's representative was informed of the seclusion, they were also informed of its ending as soon as practicable. A record of this communication was entered in the clinical file. If this communication did not occur, a record explaining why not was entered in the clinical file.

Appropriate emotional support was provided to the patient in the direct aftermath of the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion.

Clinical Governance

Seclusion was not used to ameliorate staffing or operational difficulties, as a punitive action, with mechanical restraint, solely to protect property or as a substitute for less restrictive interventions. Each episode of seclusion was reviewed by members of the MDT involved in the patient's care and treatment and documented in the clinical file as soon as practicable. The review included the following:

- The identification of the trigger or antecedent events which contributed to the seclusion episode.
- A review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support.
- The identification of alternative de-escalation strategies to be used in future.
- The duration of the seclusion episode and whether this was for the shortest possible duration.
- Considerations of the outcomes of the person-centred debrief, if available.
- An assessment of the factors in the physical environmental that may have contributed to the use of seclusion.

The MDT review was documented, and recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the patient.

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

The approved centre was compliant with this rule.

Section 69: The Use of Mechanical Restraint

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

Evidence of Implementation: The clinical file of one patient who had been mechanically restrained for an episode of enduring risk was inspected. The mechanical means of restraint were only used to address an identified clinical need and risk as a fall prevention. Mechanical restraint was only used when less restrictive alternatives were not deemed suitable.

A risk assessment of the safety and suitability of the restraint was undertaken but the assessment did not specify the monitoring arrangements of the mechanical restraint to be implemented during its use. The risk assessment was not reviewed and updated regularly in line with the patient's individual care plan.

The patient's multi-disciplinary team (MDT) developed a plan of care for the patient but this plan did not include information on attempts to reduce or eliminate the use of restraint.

Mechanical restraint was ordered by a registered medical practitioner under the supervision of the responsible consultant psychiatrist. The clinical file contained a contemporaneous record that specified that there was an enduring risk of harm to self or others, that less restrictive alternatives had not been successful, the type of mechanical restraint used, the situation where mechanical restraint was being applied and the duration of the restraint. However, the file did not record the duration of the order nor the review date for the use of mechanical restraint.

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

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

a) **The risk assessment of the safety and suitability of the mechanical restraint was undertaken but did not specify the monitoring arrangements to be implemented during its use, 10.2 (i).**
b) **The risk assessment was not reviewed or updated regularly in line with the patient's individual care plan, 10.2 (ii).**
c) **The multi-disciplinary team developed a plan of care for the patient restrained by mechanical means but did not include information on attempts to reduce or eliminate the use of the restraint, 10.3 (iii).**
d) **The clinical file contained a contemporaneous record but did not specify the duration of the order or a review date, 10.5 (vi)(vii).**

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of three residents who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined.

The responsible consultant psychiatrist had undertaken a capacity assessment of all three residents and they were deemed to have the capacity to consent to treatment. There was a written record of this consent, as well as the name of the medications prescribed and confirmation of the assessment of the resident's ability to understand the nature, purpose and likely effects of the medications.

Details of the discussion with the resident were recorded, which addressed:

- The nature and purpose of the medications.

- The effects of the medications, including risks and benefits and any views expressed by the resident.
- Any supports provided to the resident 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

COMPLIANT

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

INSPECTION FINDINGS

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

- The provision of information to the resident, including information about their 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 to be followed during any episode of physical restraint.

The approved centre had a policy for the reduction of the use of physical restraint which 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, the 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.

Policies and procedures regarding staff training addressed:

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

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

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

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. Physical restraint was initiated by a registered nurse in accordance with the approved centre's policy. The order confirmed that there were no other less restrictive ways available to manage the resident's presentation, and the consultant psychiatrist (CP) or the duty CP was notified as soon as was practicable. The registered medical practitioner completed a medical examination of the resident no later than two hours after the start of an episode of physical restraint. The order for physical restraint lasted a maximum of 10 minutes and was not extended by a renewal order.

The episode of physical restraint and the time that the medical examination took place were clearly recorded in clinical file. The relevant section of the clinical practice form was completed by the person who initiated and ordered the use of physical restraint as soon as was practicable, and was signed by the CP or the duty CP within 24 hours.

The resident was informed of the reasons for, and the circumstances which would lead to the discontinuation of, physical restraint, except where such information was prejudicial to their mental health, well-being or emotional condition. A record of this should be recorded in their clinical file as soon as is practicable.

As it was the resident's wish in all three cases that their representative not be informed of their restraint, this wish was respected and no such communication occurred outside what was necessary to fulfil legal and professional requirements. This was recorded in their clinical file. The Mental Health Commission was appropriately notified of the start time and date and the end time and date of each episode of physical restraint.

Staff involved in the use of physical restraint took into account all relevant entries in the resident's individual care plan (ICP) pertaining to their specific needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episode of physical restraint and all staff involved had undertaken appropriate training in accordance with the approved centre's policy.

The resident was continuously assessed throughout the use of the restraint to ensure their safety. All three residents were restrained in an upright position and there was documented evidence that their head

and neck were protected and supported, their airway and breathing were not compromised, vital clinical indicators were observed, communication was maintained with the resident and their physical and psychological health were monitored for as long as clinically necessary after using physical restraint.

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

An in-person debrief followed every episode of physical restraint. This debrief occurred within two working days of the episode. It was person-centred and gave the resident the opportunity to discuss the physical restraint with members of their multi-disciplinary team as part of a structured debrief process.

The debrief discussed alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future, and the resident's preferences in the event where such interventions were needed. The resident had the option of having their representative or nominated support person attend the debrief with them. If the resident chose not to have their representative present, a reason why was recorded in the clinical file. The resident's ICP was updated to reflect the outcome of the debrief and, in particular, their preferences in relation to restrictive interventions going forward. A record of all attendees at the debrief was recorded in the resident's clinical file. Appropriate emotional support was provided to the resident following the episode of physical restraint, and support offered to other persons who may have witnessed it.

The episode of physical restraint was recorded in the resident's clinical file and in the clinical practice form in accordance with Provision 3.7. A copy of the clinical practice form was placed in the clinical file and was available to the Mental Health Commission on request.

The episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) within five working days from the date of the restraint. The review included:

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

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

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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 a policy in relation to admission, transfer and discharge. This policy was last reviewed in July 2023.

Admission: The admission policy included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy 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 policy.

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. There was documented communication with the relevant healthcare provider and a follow up plan. A discharge meeting was attended by the resident, key worker and relevant members of the resident's multi-disciplinary team. The discharge letter did not make reference to early warning signs of relapse or risks.

The discharge assessment included psychiatric and psychological needs, current mental state examination, a comprehensive risk assessment and risk management plan, social and housing needs and informational needs. The discharge was coordinated by the key worker.

A discharge summary was issued and included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements and the names and contact details of key people for follow-up. It did not include details of risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was non-compliant with this code of practice because one resident's discharge letter did not include early warning signs of relapse or risks, 38.4.

Appendix 1: Corrective and Preventative Action Plan

Regulation 11: Visits					
Reason ID : 10005254		The registered proprietor did not ensure that the privacy of a resident during visits was respected, in so far as was practicable, as there was a CCTV camera in the visiting room which monitored the visitors room and the monitor could be viewed by clinical staff, 11(4).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A new visiting area was developed in the approved centre.	Completed	Completed, no barriers to implementation	08/05/2024	ADON, CNM3, Tech Services
Preventative Action	All visitors are accommodated in the new visiting area.	Completed	Completed	08/05/2024	ADON, CNM3, CNM2

Regulation 21: Privacy					
Reason ID : 10005275		**The registered proprietor did not ensure that the residents' privacy and dignity was appropriately respected at all times as observation panels on bedroom doors on the high dependency unit did not provide privacy as they were not fitted with blinds, curtains or opaque glass.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Doors fitted with strips of opaque screening. At time of inspection, review of screening undertaken, screening upgraded to ensure privacy	Audit/analysis	Completed	08/05/2024	Tech Services ADON/CNM3
Preventative Action	Process commenced for the replacement of doors across the APU. All new doors with be fitted with integrated blinds that residents can manage.	Audit/analysis	Achievable	31/07/2024	Tech Services ADON/CNM3

Regulation 22: Premises					
Reason ID : 10005255		**The registered proprietor did not ensure that the environment was maintained with due regard to the safety of residents as ligature points were not minimised to the lowest practical level based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature risk reduction works are continuing with the aim of reducing ligature points. Installation of Sovie anti-ligature beds since inspection	Bi-annual audit Observations Policy Quality Improvement plan	Achievable	30/06/2024	Nurse Management/Techs Services/Estates
Preventative Action	Monthly Walkaround Bi-annual Ligature Audit. Tony Crumpton Environmental Safety Sales Director for the Anti-ligature shop is scheduled to assess the rooms/common areas for ligatures/anchors and provide a detailed report which will augment the Manchester audit tools results	Bi-annual ligature audit Observations Policy Quality Improvement plan	Achievable	30/06/2024	Nurse Management/Techs Services/Estates
Reason ID : 10005256		**The registered proprietor did not ensure the approved centre's physical structure and overall environment were maintained with due regard to the specific needs and safety of the residents and patients, as hazards were not minimised, 22(3). The registered proprietor did not ensure the approved centre was clean as dust, cobwebs, dirty windows, stained toilets, dirty bathroom**			

		mirrors and dirty ceiling vents were visible in the approved centre, 22(1)(a).The registered proprietor did not ensure the approved centre was kept in good decorative condition as bedroom doors and floors, corridor ceilings and floors, overhead lights, garden vents and bathrooms walls and doors were damaged; corridor skirting boards and walls were scuffed; and ceiling tiles and corridor walls were stained, 22(1)(a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ongoing works to replace all flooring in bedrooms. Decorative and maintenance plan in place. Funding for Quarterly painting allocated Quarterly window washing by external company Process commenced for the replacement of fire doors across the APU. Phase 1 completed. Domestic supervisor/staff were notified of non-compliances at the time of inspection, same addressed Stained ceiling tiles removed and replaced	Monthly walkabout/analysis of the unit Bi annual Environmental Audit	Achievable	31/07/2024	Domestic services Tech Services ADON/CNM3 Estates
Preventative Action	A cleaning schedule is in place and maintenance programme is in place. Monthly	Monthly walkabout/analysis of the unit Bi annual Environmental Audit	Achievable	31/07/2024	Tech Services ADON/CNM3 Estates

	meetings with Tech Services, Business Managers, Clinical Director and Nurse Management Smart plan/ Quality Improvement Plan in place to ensure the continuing quality improvement of the APU. Monthly walkabout of unit Bi annual Environmental audit ADON/CNM3 sourcing different anti ligature sanitary ware to eliminate staining				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10005284		**On one occasion, one resident's Medication Prescription Administration Record was missing an administration record, 23(1). On two occasions, one resident's Medication Prescription Administration Record did not clearly show whether as-required medication was administered, 19(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff now informed that any signing indicates administration. All staff advised to undertake HSELand Training on medication management. Memo to be issued to all staff.	Audit	Realistic	31/07/2024	Clinical Director ADON /CNM3 CNM2 Nursing Staff
Preventative Action	CNM2 to oversee completion of MPARS Regular audits to be conducted.	Quarterly Audit Nursing metrics	Realistic	31/07/2024	Clinical Director ADON /CNM3 CNM2 Nursing Staff
Reason ID : 10005286		**There was no evidence of a consultation with the pharmacist regarding alternative preparations or routes of administration for one resident on crushed medications, 19 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Pharmacist was consulted regarding alternative preparations or routes of administration for the resident on crushed medications. Memo to all staff	Clinical Director ADON/CNM3	Achievable	31/07/2024	Clinical Director ADON/CNM3 Nursing

	highlighting need for pharmacy input in the event that crushed medications are prescribed				
Preventative Action	Direction to crush medication is only accepted from the resident's medical practitioner. There is a documented reason why the medication is to be crushed. The pharmacist will be consulted about the type of preparation to be used. The medical practitioner will document within the MPAR that the medication is to be crushed	Clinical Director ADON/CNM3	Achievable	31/07/2024	Clinical Director ADON/CNM3 Nursing

Regulation 26: Staffing					
Reason ID : 10005289		**Not all staff had completed mandatory training in basic life support, fire safety, and the prevention and management of violence and aggression, 26 (4). Not all staff had completed mandatory training in the Mental Health Act 2001, 26 (5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training is available to all staff. A schedule of training dates is circulated to all HODs to ensure compliance with mandatory training	Monthly returns submitted to registered proprietor. Training matrix updated as training completed	Achievable	31/07/2024	Heads of Disciplines Area DON Clinical Director ADON/CNM3 APU Ennis
Preventative Action	Training matrix in place. All HOD to monitor compliance with mandatory training for their respective disciplines	Monthly returns submitted to registered proprietor.	Achievable	31/07/2024	Heads of Disciplines Area DON Clinical Director ADON/CNM3 APU Ennis

Regulation 32: Risk Management Procedures					
Reason ID : 10005276		**The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk as the service had admitted patients and residents over the registered bed numbers on 15 occasions, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There have been no episodes of overcapacity since the time of inspection.	Audit	Realistic	08/05/2024	Clinical Director Consultant Group
Preventative Action	Daily bed management meetings/regular review of residents. Process in place to manage beds when nearing full capacity	Audit	Achievable	31/07/2024	Clinical Director Consultant Group ADON/CNM3
Reason ID : 10005277		**Health and safety risks were not adequately treated and monitored by the approved centre. Fire doors were observed wedged open or leaves not closed which compromised fire safety. Fire doors throughout the unit were damaged. Not all health and safety risks relating to fire safety were documented within the unit risk register, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Risk register updated at time of inspection to highlight all health and safety risks relating to fire safety. All wedges removed to ensure functionality of doors Standing agenda in resident community meetings	Daily environmental observation Completion of fire register daily	Achievable	31/07/2024	ADON/ CNM3 CNM2 Tech Services Estates

Preventative Action	Process commenced for the replacement of doors across the APU. Standing agenda item on resident meetings Standing agenda item on APU management meetings	Daily environmental observation Completion of fire register daily	Achievable	31/07/2024	ADON/ CNM3 CNM2 Tech Services Estates
Reason ID : 10005278		**Individual risk assessments were not reviewed during the use mechanical restraint, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident was reviewed by the treating Cons Psychiatrist and the episode of mechanical restraint was ended. Alternative falls management interventions were put in place.	Complete	Realistic	08/05/2024	Clinical Director Consultant ADON/CNM3
Preventative Action	In the event that mechanical restraint is required, a risk assessment of the safety and suitability of the mechanical restraint will be undertaken and will specify the monitoring arrangements to be implemented during	All episodes of mechanical restraint will be reviewed by the APU Oversight Committee Annual review of the policy on the Use of Mechanical Means of Bodily Restraint	Achievable	31/07/2024	Clinical Director Consultant ADON/CNM3

	its use. The risk assessment will be reviewed or updated regularly in line with the resident's individual care plan as per the Rules Governing the Use of Mechanical Means of Bodily Restraint (2022). The use of mechanical restraint will always be a last resort after all other interventions have been tried.				

Rules Governing the Use of Mechanical Means of Bodily Restraint					
Reason ID : 10005293		**The risk assessment of the safety and suitability of the mechanical restraint was undertaken but did not specify the monitoring arrangements to be implemented during its use, 10.2 (i). The risk assessment was not reviewed or updated regularly in line with the patient's individual care plan, 10.2 (ii). The multi-disciplinary team developed a plan of care for the patient restrained by mechanical means but did not include information on attempts to reduce or eliminate the use of the restraint, 10.3 (iii). The clinical file contained a contemporaneous record but did not specify the duration of the order or a review date, 10.5 (vi)(vii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There was 1 resident prescribed mechanical restraint to mitigate enduring risk of falls from lying position in bed. The treating Consultant Psychiatrist reviewed this resident and other falls management interventions were put in place. The episode of Mechanical restraint was ended immediately	Complete	Realistic	08/05/2024	Clinical Director Consultant ADON/CNM3
Preventative Action	In the event that mechanical restraint is required, a risk assessment of the safety and suitability of the mechanical restraint will be	All episodes of mechanical restraint will be reviewed by the APU Oversight Committee Annual review of the policy on the Use of	Achievable	31/07/2024	Clinical Director Consultant ADON/CNM3

	undertaken and will specify the monitoring arrangements to be implemented during its use. The risk assessment will be reviewed or updated regularly in line with the patient's individual care plan as per the Rules Governing the Use of Mechanical Means of Bodily Restraint (2022). The use of mechanical restraint will always be a last resort.	Mechanical Means of Bodily Restraint			

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10005253		**One resident's discharge letter did not include early warning signs of relapse or risks, 38.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A comprehensive discharge summary template has been formulated to include all aspects pertaining to the Code of Practice. The non-compliance was rectified by the treating team	Audit	Achievable	08/05/2024	Clinical Director
Preventative Action	A comprehensive discharge summary template has been formulated to include all aspects pertaining to the Code of Practice. Email to all Consultants, NCHDS re completion of discharge summary	Audit	Achievable	31/07/2024	Clinical Director

Appendix 2: Background to the inspection process

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

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

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

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

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

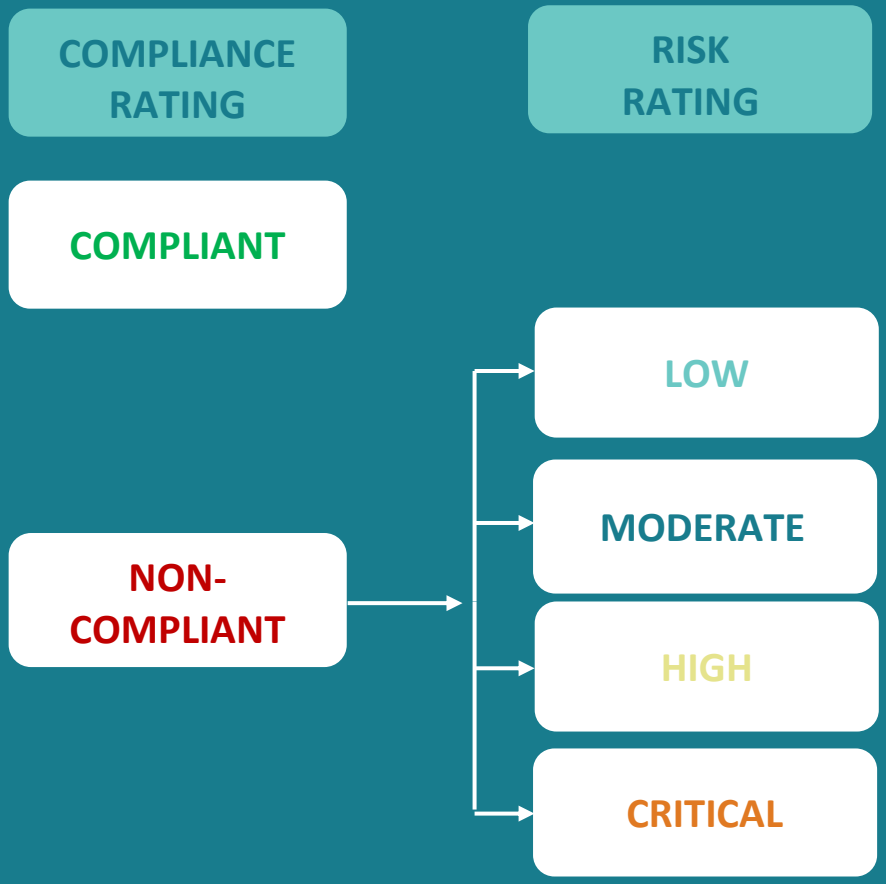
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

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



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

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

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

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