Mental Health Commission publishes seven inspection reports

Common themes of concern around premises, risk management, staffing and individual care planning

Friday, 21 June 2024: The Mental Health Commission (MHC) has this morning published seven inspection reports for approved inpatient mental health centres that, combined, show three critical risk non-compliances in two centres, and 34 high-risk non-compliances across all seven centres in areas such as premises, risk management, staffing, and individual care planning.

The reports released today focus on St Vincent's Hospital, Fairview, Co. Dublin (74% overall compliance, down from 76% in 2022); the Department of Psychiatry at Midlands Regional Hospital in Portlaoise (92% overall compliance, up from 86% in 2022); Drogheda Department of Psychiatry (60% overall compliance, down from 71% in 2022); the Department of Psychiatry at University Hospital Waterford (76% overall compliance, down from 94% in 2022); the Acute Psychiatric Unit at Ennis General Hospital (77% overall compliance, down from 86% in 2022); the Lakeview Unit at Naas General Hospital (83% overall compliance, down from 86% in 2022); and St John of God Hospital in Dublin (70% overall compliance, down from 91% in 2022).

Selected good practices and quality initiatives observed during the inspections included the completion by staff in one centre of a 'Making Sense of Hearing Voices Workshop' to encourage a more positive response and understanding of voice-hearing and related experiences. In another centre, 'Professional Management of Complex Behaviours' training had commenced; while age-appropriate activities such as chair exercises, reminiscence therapy and music was introduced in another for psychiatry of later life residents. In one centre, a smoking cessation officer had been introduced to support residents who wished to quit smoking.

However, there were common themes of concern across many of the centres, including failings in regulations for premises, risk management, staffing and individual care planning.

"We found that all seven centres inspected had high-risk non-compliances with the regulation on premises," said the Director of Regulation for the Mental Health Commission, Gary Kiernan. "The reasons for non-compliance were primarily about premises which were not clean and well maintained, and premises which did not prioritise the safety of residents.

"Failure to comply with legal minimum standards of cleanliness, maintenance and safety is unacceptable," Mr Kiernan added. "Five of the seven inspection reports published today are for centres where the registered proprietor is the HSE. Unless we see the implementation of a comprehensive capital investment programme in our public mental health services, these premises issues are likely to reoccur and that may result in the MHC having to resort to formal enforcement actions."

Non-compliances observed during the inspections included:

- two critical risk non-compliance with the regulations on staffing, and with therapeutic services and programmes; along with four high-risk non-compliances with the regulations on individual care planning; general health; premises; and privacy at **St Vincent's Hospital**
- one critical risk non-compliance with the regulations on individual care planning; along with six high-risk non-compliances with the regulations on therapeutic services and programmes; premises; staffing; maintenance of records; register of residents; and risk management procedures at **Drogheda DOP**
- nine high-risk non-compliances with the regulations on individual care planning; general health; premises; maintenance of records; risk management procedures; the rules governing the use of seclusion; the code of practice on the use of physical restraint; the code of practice for the admission of children; and the code of practice for admission, discharge and transfer at **St John of God Hospital**
- six high-risk non-compliances with the regulations on individual care planning; premises; the ordering, prescribing, storing and administration of medicines; staffing; the rules governing the use of seclusion; and the code of practice on the use of physical restraint at **Lakeview**
- five high-risk non-compliances with the regulations on privacy; premises; medication management; risk management procedures; and with the rule governing the use of mechanical restraint at the **APU at Ennis General Hospital**
- three high risk non-compliances with the regulations on general health; premises; and risk management procedures at the **DOP, University Hospital Waterford**
- one high-risk non-compliance with the regulation on premises at **DOP, Portlaoise**

The MHC requires corrective and preventive action plans (CAPAs) from all services where non-compliances are identified, each of which must address each non-compliance specifically. The MHC monitors the implementation of these CAPAs on an ongoing basis and requests further information and action as necessary. Enforcement action is taken when the MHC is concerned that the care and treatment provided in an approved centre may be a risk to the safety, health and wellbeing of residents, or where there has been a failure by the provider to address an ongoing area of non-compliance.

All critical risk issues are considered by the MHC's Regulatory Management Team (RMT) as a matter of course. Enforcement actions commonly arise from inspection findings, quality and safety notifications, and compliance monitoring. Enforcement actions available to the MHC range from the aforementioned CAPAs (at the lower end of enforcement) to removing an approved centre from the register and/or pursuing prosecution (at the higher end).

Links to Inspection Reports

- St Vincent's Hospital
- Department of Psychiatry at Midlands Regional Hospital
- Drogheda Department of Psychiatry
- Department of Psychiatry at University Hospital Waterford
- Acute Psychiatric Unit at Ennis General Hospital
- Lakeview Unit at Naas General Hospital
- St John of God Hospital

Ends

Notes to the Editor:

About the Mental Health Commission:
The Mental Health Commission (MHC) is an independent statutory body. The primary functions of the MHC are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001. The MHC also has statutory responsibility for the Decision Support Service (DSS) under the Assisted Decision-Making (Capacity) Act 2015.