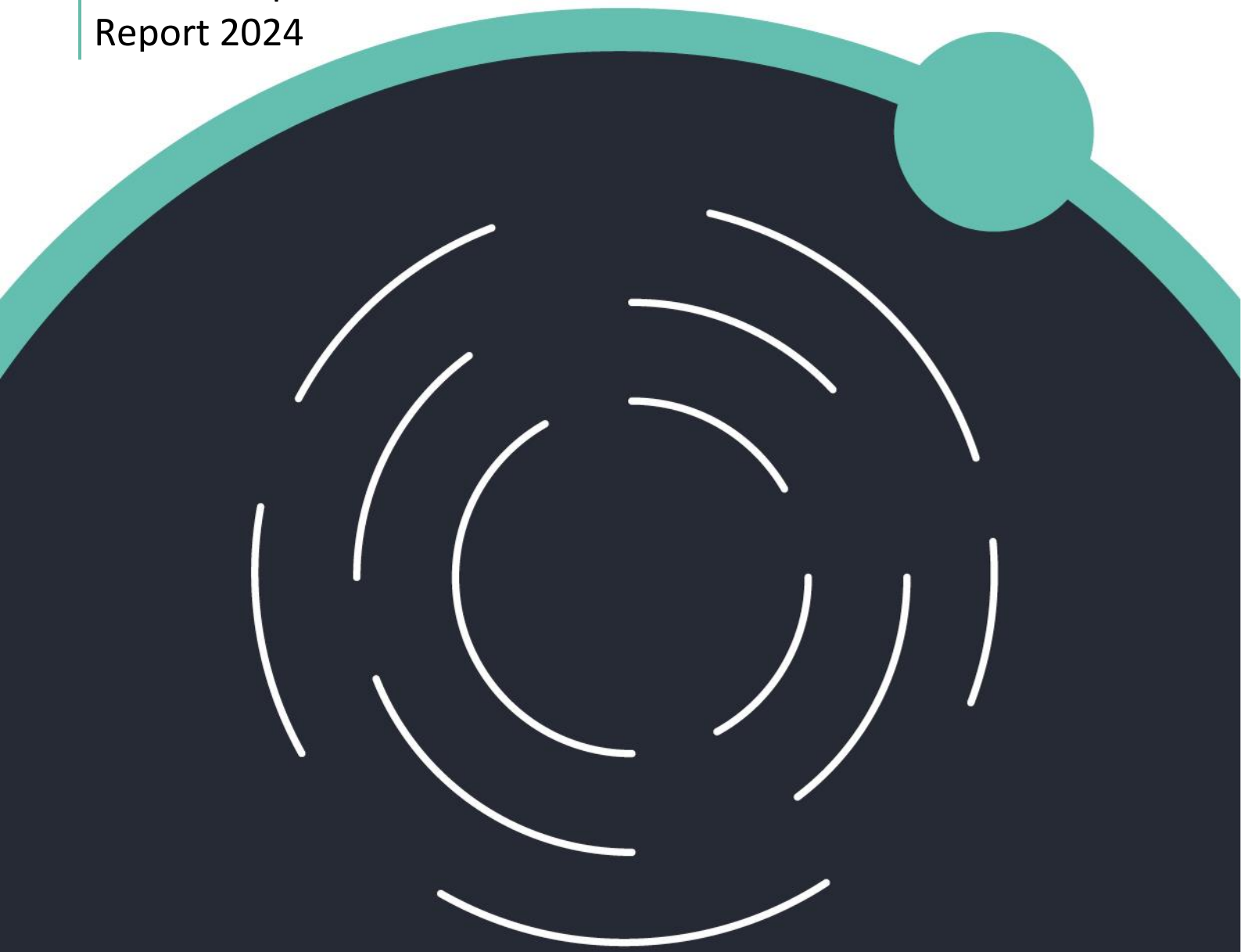
Le Brun House & Whitethorn House, Vergemount Mental Health Facility

Annual Inspection Report 2024



Promoting Quality, Safety and Human Rights in Mental Health

LE BRUN HOUSE & WHITETHORN HOUSE, VERGEMOUNT MENTAL HEALTH FACILITY

Clonskeagh Hospital, Clonskeagh, Dublin 6

Date of Publication:
4 December 2024

ID Number: AC0150

2024 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Psychiatry of later life
Mental health rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
9 February 2024

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Martina Behan, General Manager, CHO East Mental Health Services

Inspection Team:
Noeleen Byrne, Lead Inspector
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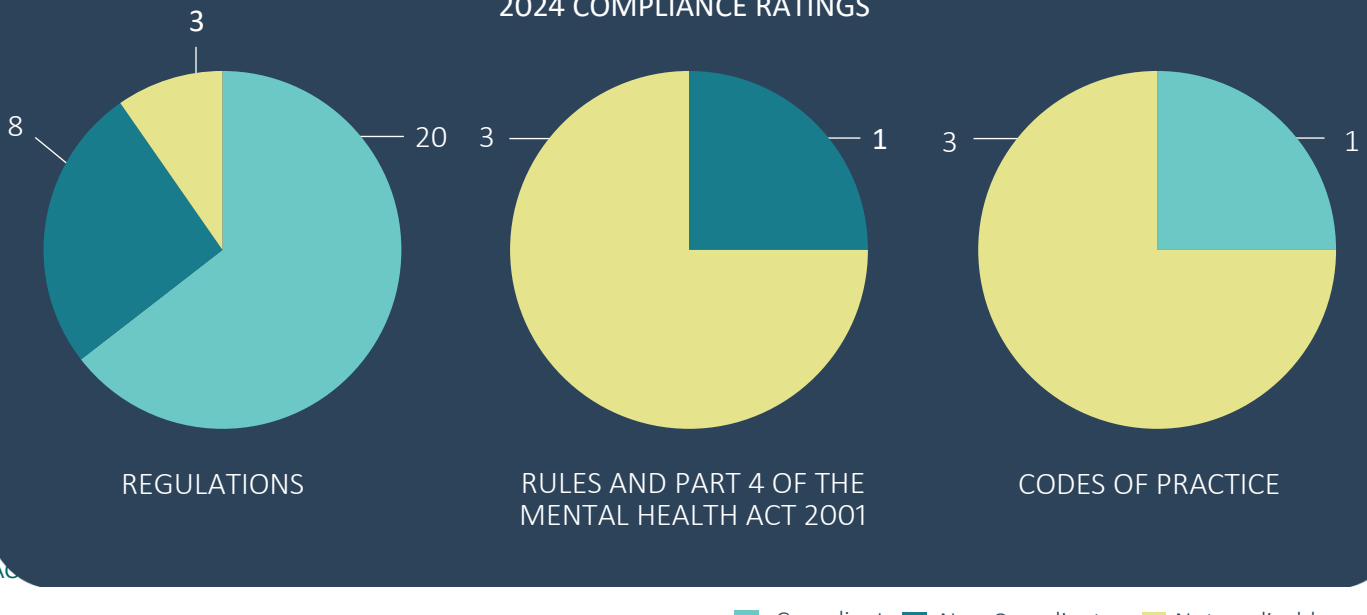
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
23 – 26 April 2024

Previous Inspection date:
21 – 24 February 2023

Inspection Type:
Unannounced Annual Inspection

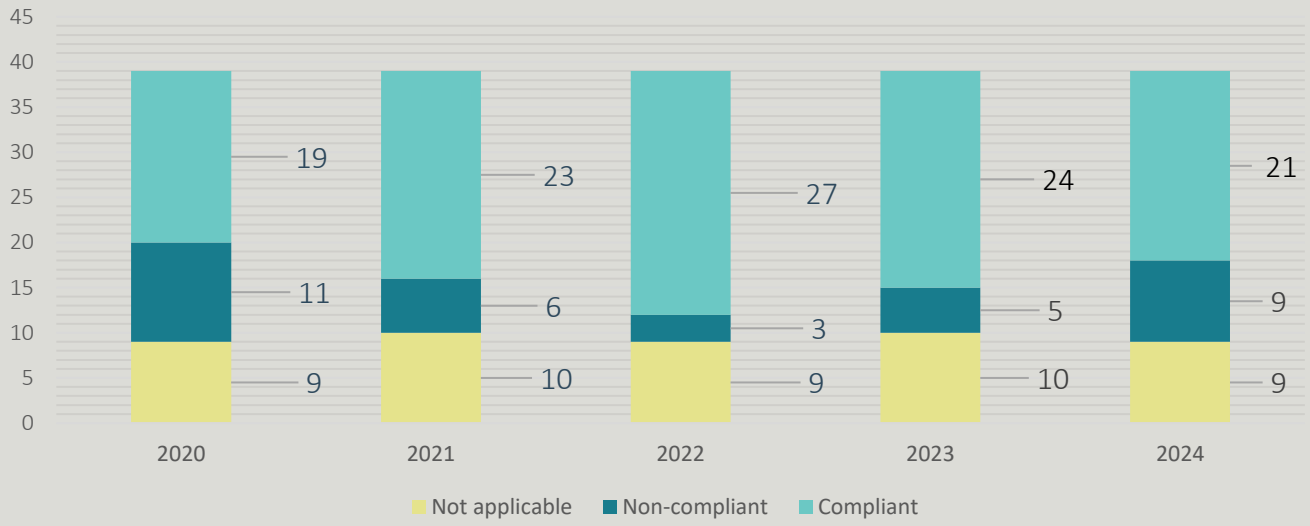
2024 COMPLIANCE RATINGS



RATINGS SUMMARY 2020 – 2024

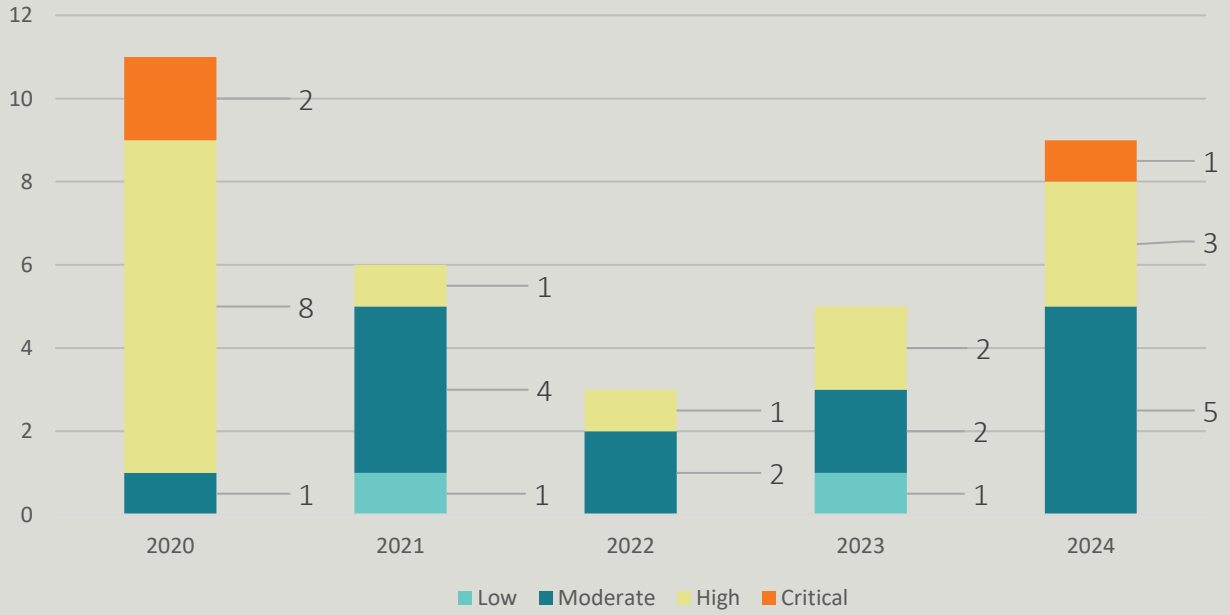
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2020 – 2024



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 2020 – 2024



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

Inspector of Mental Health Services Summary

The approved centre consisted of Whitethorn House, providing mental health rehabilitation under the Rehabilitation and Recovery team with 14 beds, and Le Brun House, provided a specialist mental health service for people over the age of 65 under the Psychiatry of Later Life (POLL) team with 15 beds.

At the time of the inspection a refurbishment programme was underway; however, the inspection team identified serious fire safety concerns. Including the critical finding for risk management, there were nine areas of non-compliance. Whitethorn House was not suitably equipped to deliver rehabilitation and recovery services as the premises did not have an assessment kitchen, a space for residents to prepare food or a therapeutic space for residents to meet clinicians privately. There were deficiencies in the governance structure: policies were out of date for 10 months and there were significant delays in providing documents to the inspection team that resulted in the inspection being extended.

Areas of good practice were observed and these included a specialist clinical practice development programme where each month a member of staff would speak on their area of expertise. Dementia friendly gardens were accessible to all. Residents of Whitethorn House were able to attend CORE, the rehabilitation and recovery college on the campus. Some of the areas of non-compliance had been identified for many years and we expect that the quality improvement process will see remediation without delay.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	63%	79%	90%	83%	70%

Conditions of 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

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice 10000337	*3/7/2024*	*Critical Non Compliance Regulation 32: Risk Management Procedures.*	*The MHC requested the Approved Centre to review the critical risks found on inspection, and to provide an itemised, costed, funded time bound plan for each. The Approved Centre submitted plans to address the non compliances with Regulation 32. The MHC continues to engage with the HSE on this matter and this enforcement action remains open.*

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

Dietitians carried out a “mealtimes matter” audit that looked at improving mealtime choices by adding extra fruit and vegetables with residents expressing their preferences. Results were shared with kitchen staff and improvements made.

A subgroup was set up to plan outings for residents.

In addition to the quality initiatives listed, the inspection team also reviewed quality aspects in relation to the following specific regulations:

- Regulation 11: Visits
  The approved centre maintained physical environment and facilities that were fit for purpose, welcoming and well decorated and designed. There was a lot of space in both gardens and around the units for visits. Visiting information was provided in accessible and understandable manner. Toys were available for children who visited.

- Regulation 14: Care of the Dying
  There were facilities for families to stay overnight with a tea station. The approved centre incorporated a holistic approach to care within a compassionate biopsychosocial philosophy. Arrangements were made to stream a recent funeral mass for residents to watch.

- Regulation 20: Provision of Information to Residents
  Information was provided in a manner accessible and understandable to all. Communications were provided in a variety of media: by telephone, television, electronic tablet, face-to-face and newsletter. Advocacy groups were promoted.

- Regulation 26: Staffing
  Three nurses and some members of the rehabilitation and recovery multi-disciplinary ream (MDT) attended recovery principles training to become facilitators and were to roll out training for all staff in the coming months. Staff regularly attended decider skills training and self-harm and suicide prevention training, and learned venepuncture techniques for collecting blood samples. Staff delivered modules on dementia training and assisted decision making.

- Regulation 31: Complaints Procedures
  New posters to explain the HSE complaints procedure “Your Service Your Say” were placed in both units. Monthly resident meetings were facilitated and residents were encouraged to voice any issues they had.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located within the grounds of Clonskeagh Hospital, near the south Dublin village of Ranelagh. The approved centre consisted of Whitethorn House, which provided mental health rehabilitation under the Rehabilitation and Recovery team, and Le Brun House, which provided a specialist mental health service for people over the age of 65 under the Psychiatry of Later Life (POLL) team.

The approved centre was well signposted within the hospital campus. Entry to Le Brun house was by swipe card and an access code; the internal entrance foyer door of Le Brun House was also locked by key. Access to Whitethorn house was via swipe card only.

The approved centre was a single storey building and there were separate courtyard style garden areas situated internally to both houses. At the time of the inspection, a refurbishment programme was underway in Le Brun House, which included enlarging small single bedrooms and upgrading bathrooms and the unit generally. There were also shared bedrooms designed as two-bed rooms. The new configuration did not accommodate the registered number of 15 beds in Le Brun House.

Whitethorn House was due for refurbishment and was not suitable as mental health rehabilitation unit as there were no facilities for residents to prepare meals, no occupational therapy assessment kitchen and no therapeutic or clinical space for medical and allied health professionals to meet residents. Each house also contained a sitting room, an activities room, a dining room and a hairdressing room.

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

Resident Profile	
Number of registered beds	***29***
Total number of residents	**20**
Number of detained patients	0
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	18
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Community Healthcare East incorporated Dublin South East (DSE) and East Wicklow services, and the Community Healthcare East Executive Management Team (EMT) was responsible for the overall management and governance. The approved centre was part of the DSE service, and, locally, was managed

by the DSE management team. Governance processes in DSE encompassed two core monthly meetings, the Operational Management Team meeting and the Quality and Patient Safety (QPS) committee. The QPS committee meeting for the DSE region convened on a monthly basis. Agenda items indicated active review and planning with regard to several areas which underpin service improvement and quality; these included a review of the operational risks as outlined on the risk register, incident reports and serious incidents arising, and quality improvement plans. If required, issues could be further escalated to the Executive Clinical Director QPS committee. When required, issues had been escalated to the relevant executive forum as required which included the EMT meeting and the Executive Clinical Director QPS Committee; both convened on a monthly basis. In the approved centre, governance structures included a monthly regulatory compliance meeting and a monthly business meeting. Governance structures were not robust: policies were out of date and delays in getting documents to the inspection team necessitated extending the inspection.

Residents of Le Brun House and Whitethorn House were under the care of the Psychiatry of Later Life (POLL) team and the Rehabilitation and Recovery team respectively. The POLL team included nursing and medical staff , a psychologist, a social worker and a physiotherapist. However, there was no occupational therapist (OT) at the time of the inspection. Carew House was located in St Vincents University Hospital was where the POLL team were based. An OT from Carew House came into Le Brun House to do assessments. The Rehabilitation and Recovery team had full multi-disciplinary representation of all disciplines.

A QPS advisor was available to the approved centre and persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed through the National Incident Management System (NIMS). Clinical incidents were reviewed by the multi-disciplinary team, and subsequently reviewed at the QPS Committee. Risk assessments had been completed for identified risks and included on the local risk register which was reviewed regularly and escalated where appropriate to the corporate risk register. However, not all risks had been identified and treated in a timely manner within the approved centre. During the inspection, the radiators in both houses were noted be very hot to touch. As the radiators were unguarded, the risk of burns was present. This was identified during last year's inspection and had not been addressed. The temperature was turned down on the second day of inspection. Automatic self-closers on fire doors were broken or dismantled, there were gaps in some fire doors and seals were worn or damaged. An architect/fire engineer had completed a report on Le Brun and Whitethorn and this report was to be forwarded to the inspection team. However, the final report was delayed and the HSE fire officer confirmed that once the report has been approved, a schedule of works would continue and progress to tender for the works to be carried out over a phased basis. There was no fire certificate for these material alterations.

Refurbishment of Le Brun House was underway at the time of inspection. The improvements included new windows and some doors. A number of bedrooms had been enlarged where the wall between two small single bedrooms was knocked to make one bigger functional bedroom. Bathrooms were upgraded. There was a need to amend the registration to reflect the reduced bed numbers. Whitethorn house was not suitable to operate as a rehabilitation and recovery unit. There was no occupational therapy kitchen for resident assessment, no area for residents to prepare food, no therapeutic space for residents to meet clinicians and therapists and the bedrooms were not appropriately sized. There was no agreed admission criteria.

Members of the executive management team confirmed that a review of registered bed numbers was required. Members of the EMT, including the registered proprietor nominee, along with the HSE Estates Project Manager and Maintenance Manager undertook a quarterly walkaround to meet with the team locally. The risk associated with the premises was identified in the approved centre's risk register and was escalated to the executive risk register. The issues were discussed within the various governance forums at both an executive and local level. Minor capital funding was also secured for the purchase of new furnishings for bedrooms, upgrading of bathrooms, and decorative repairs including painting and flooring of the approved centre. Upon completion of the bedroom enlargement, there was a plan to review the remaining small single bedrooms with a view to expanding these rooms also.

The approved centre was dedicated to improving service quality. A clinical audit programme was developed with an annual audit plan and these audits formed part of the quality improvement in the approved centre. Results of various audits were discussed at the monthly regulatory compliance meeting. The service also provided training and education for staff. A special clinical practice development programme was delivered for relevant staff working on Clonskeagh campus.

Resident engagement in governance and quality improvement processes was facilitated throughout the service. The area lead for mental health engagement attended the Community Healthcare East EMT meetings and the operational team meetings on a monthly basis and provided feedback to the management teams. Within the approved centre, monthly resident community meetings and the use of suggestion boxes encouraged residents to provide feedback to the clinical team. Information on the complaints process was displayed within the approved centre and complaint forms were available for residents if required.

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 2020 and 2024 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2020		2021		2022		2023		2024	
Regulation 15: Individual Care Plans	✗	High	✓		✓		✓		✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✗	Critical	✓		✓		✓		✗	Moderate
Regulation 19: General Health	✓		✗	Moderate	✓		✓		✗	Moderate
Regulation 21: Privacy	✗	High	✗	Moderate	✗	Moderate	✓		✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✗	Moderate	✗	High
Regulation 29: Operating Policies and Procedures	✓		✓		✓		✗	Low	✗	High
Regulation 32: Risk Management Procedures	✗	High	✗	Moderate	✓		✗	High	✗	Critical
Part 4 of the Rules Governing Mechanical Restraint		N/A		N/A		N/A		N/A	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, 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.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.

Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice 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 and family members 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.

No resident met with the inspection team formally. Residents engaged with the inspection team informally throughout the inspection. One relative of a resident returned a service user experience questionnaire and rated the service 9 out of 10 for overall experience of care and treatment provided. The resident was well looked after and all their needs were met. Staff were friendly and positive.

5.2 Advocacy

The approved centre had an advocacy service.

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

6.0 Feedback Meeting

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

- Acting Head of Service and Registered Proprietor Nominee
- Operations Manager
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Consultant Psychiatrist x 2
- Assistant Director of Nursing
- Principal Social Worker
- Area Lead for Mental Health Engagement
- Clinical Nurse Manager III
- Clinical Nurse Manager II

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. It was agreed that a final report from the Architect/Chartered Engineer (Fire), following his 2-day assessment of the premises, would be forwarded to the Mental Health Commission.

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

There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Appropriate resident identifiers were used before administering medications, undertaking medical investigations and providing other health care services. The approved centre used medical record number and date of birth as identifiers. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. The approved centre used appropriate identifiers and alerts for same or similar name residents.

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, as per the Food Pyramid. Residents had at least two choices for meals, and menus were on a two-week cycle. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre; there were two water coolers in each house.

Nutritional and dietary needs were assessed where necessary, with the use of an evidence-based nutrition assessment tool and addressed in residents' individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a privately acquired dietitian.

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 provided suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking and serving of food. Both houses had a kitchenette and food was made in the main kitchen on site and transported to the houses.

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

Food and fridge temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored with clearly identified actions if the temperature breached cold chain parameters.

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 a supply of emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices where needed. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The residents were supported to manage and maintain their own laundry, through the provision by the approved centre of an internal laundry service. There was a laundry facility in Whitethorn. Each resident's laundry was done by staff on an individual basis once a week or twice a week if needed.

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 policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2020.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The property checklist was kept separate to the resident's individual care plan and was available to the resident. Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. There were property storerooms, and other safes and furniture for the safekeeping of the residents' valuables, personal property and possessions, as necessary. All residents were adequately supported to manage their own property.

The access to and use of resident monies was overseen by either two staff members or the resident and two staff members. A process to record, secure and manage the personal property and possessions of the resident, including money, was in place.

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 a wide range of recreational activities appropriate to the resident group on weekdays and weekends. Residents in Whitethorn House had access to the CORE day centre on the grounds of the approved centre. The CORE activities timetable included arts and crafts, creative writing, community gardening, and a walking group. Whitethorn House residents also had access to self-directed activities such as art, television, and music. Staff facilitated Wordwheel games daily, outings and walks. A car was available to both Le Brun House and Whitethorn House. Le Brun House activities included music, art, walks, outings, television, an interactive table and baking.

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. There was a spiritual room and a Catholic priest came to the approved centre once a month. There was a Catholic mass every six months and residents could go to the chapel on the campus. Most residents listened to mass on the radio. There was no requirement for other ministers at the time of the inspection and arrangements could be made if the need was to arise.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2020.

Visiting times were appropriate and reasonable. Visits could be facilitated in resident bedrooms or in the spiritual room in Le Brun House and in the quiet room in Whitethorn House. These visiting spaces were where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visitors room was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in December 2023.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. The Clinical Director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others based on risk assessment. There was no restriction on communication for any resident at the time of inspection.

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 July 2020 and included all requirements related to:

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

No searches were undertaken in the approved centre since the last inspection and compliance for this regulation was on the basis of policy only.

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 procedures on care of the dying. The policy was last reviewed in July 2020. The sudden death of the resident was reviewed and it was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident's representatives, family, next of kin and friends.

All deaths of residents were notified to the Mental Health Commission as soon as is practicable and, in any event, no later than within 48 hours of the death occurring.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents with allocated sections for needs, goals, treatment, care, resources required and 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.

All ICPs inspected identified appropriate goals for the resident, the care and treatment required to meet goals, and the resources required to provide the identified care and treatment.

Two ICPs were not reviewed by the multi-disciplinary team (MDT) in consultation with the resident every six months. One individual care plan was not updated to reflect any changes to the goals, treatment, care, best practice and required resources.

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

1. **Two individual care plans were not reviewed by the multi-disciplinary team (MDT) in consultation with the resident at least every six months.**
2. **One individual care plan was not updated to reflect any changes to the goals, treatment, care, best practice and required resources.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating MODERATE

(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 therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans.

The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. There was no access to therapeutic space within Whitethorn House for rehabilitation and recovery assessment and interventions. There were no occupational therapy kitchen facilities available for the purpose of assessment and intervention of residents under the care of the rehabilitation and recovery team.

Where a resident required a therapeutic service or programme that was not provided internally, such as dietetics, speech and language therapy, or a private occupational therapy service, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that services provided were directed towards restoring and maintaining optimal levels of physical and psycho-social functioning of a resident.

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 policy and procedures in relation to transfers. The policy was last reviewed in December 2023.

The clinical file of one resident who had been transferred from the approved centre in an emergency situation was inspected. As it was an emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a resident transfer form and medical prescription and administration record (MPAR).

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which was last reviewed in July 2020. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with their individual care plans. Residents had access to a privately acquired dietitian and a speech and language therapist. There was a physiotherapist employed by the service for both wards. A chiropodist visited every three months.

Five clinical files were examined in relation to the provision of general health services during the inspection process. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs and within a six-month period.

The health assessments all documented a physical examination, family and personal history, weight, dental health and medication review. One of the five files did not document the resident's smoking status, weight, blood pressure, nutritional status or level of physical activity.

All residents on anti-psychotic medication received an annual assessment of their glucose regulation, blood lipids and an electrocardiogram heart function.

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

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all residents' general health needs were comprehensively assessed as one resident's six-monthly general health assessment did not record the resident's smoking status, blood pressure, nutritional status or level of physical activity, 19(1)(b).

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in November 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 residents' needs.

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Staff displayed professional, engaging and compassionate attributes in their interactions with residents. Residents were called by their preferred name based on their self-identification. Staff appearance and dress was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

Not all showers and toilets had locks on the inside of the door. In Whitethorn House, one shower room did not have a thumbturn lock on the inside of the door and was operated by key only. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls. All residents wore clothes that respected their privacy and dignity.

The approved centre was non-compliant with this regulation as the registered proprietor did not ensure that the resident's privacy was appropriately respected at all times: one of the shower rooms in Whitethorn House did not have an appropriate type of lock on the door which enabled independent resident use.

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

The approved centre was adequately lit. Appropriate signage and sensory aids were provided to support resident orientation needs. Private and communal areas were designed and furnished to remove excessive noise.

The environment of Whitethorn House was not developed with due regard to the specific needs of residents living in a facility registered to provide rehabilitation and recovery services. There was no kitchen facility suitable for resident use and there were no designated therapeutic spaces or rooms.

Sufficient outdoor and communal spaces were provided for residents to move about, but seven bedrooms were too small and cramped which restricted residents' space to move about. The approved centre had completed refurbishment work of five single bedrooms at the time of inspection which enlarged their size, and additional works were in progress at the time of the inspection to increase the size of any resident bedrooms which did not have enough space.

Hazards were not minimised at the time of the inspection, as not all radiators were guarded which represented a burn hazard. The majority of radiators in the approved centre were too hot to touch. In addition, not all fire doors were working properly at the time of the inspection due to the improper functioning of fire door closer mechanisms, the lack of installation of fire door closer mechanisms where required, worn fire door brush seals, damage to the exterior surface of two doors, and a significant gap between one set of fire door leaves.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination and repair of assistive equipment. Records were maintained. Despite this, the approved centre was not kept in a good state of repair externally or internally. A fire door leading into the day room was damaged with wood which was splintering in parts and was in need of repair. The top of a second fire door leading into the dining room was damaged. A number of additional fire doors were in poor condition. One of the external doors did not fit correctly within the door frame. A toilet seat was improperly fitted in one shower room.

Ligature points were not minimised to the lowest practicable level based on risk assessment, and these ligatures were classified as 'high risk' on the approved centre's ligature audit. The approved centre was not clean and hygienic. There was a strong malodour present in one of the shower rooms in Whitethorn House. Furnishings did not support resident independence and comfort. The privacy screen mechanisms in the single bedrooms observation windows was very stiff, rendering the screens difficult to open and close.

The approved centre had sufficient toilets and showers for all residents, including assisted toilets. Current national infection control guidelines were followed.

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

a) **The registered proprietor did not ensure that premises were maintained in good structural condition as one of the external doors did not fit correctly within the frame, 22(1)(a).**
b) **The registered proprietor did not ensure that the environment of Whitethorn House was developed with due regard to the specific needs of residents living in a facility registered to provide rehabilitation and recovery services. There was no kitchen facility suitable for resident use and there were no designated therapeutic spaces or rooms, 22(3).**
c) **The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents not all bedrooms were appropriately sized, 22(3).**
d) **The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents as a toilet seat was improperly fitted in one shower room, 22(3).**
e) **The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents as there was a strong malodour in one shower room, 22(3).**
f) **The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents and the privacy screen screens were difficult to open and close, 22(3).**

g) **The registered proprietor did not ensure that the approved centre was developed with due regard to the safety of residents as not all radiators were guarded and represented a burn hazard, 22(3).**
h) **The registered proprietor did not ensure that the approved centre environment was maintained with due regard to the safety of residents, staff and visitors as issues were identified which affected the correct functioning of some of the fire doors, 22(3).**
i) **Ligature points were not reduced to the lowest practicable level, 22(3).**

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

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, prescribing, storing and administration of medicine. The policy was last reviewed in July 2020, and included the following requirements:

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

All residents had a Medication Prescription and Administration Record (MPAR). Ten MPARs were examined on inspection. While the administration route was recorded for the medication in all ten MPARs, the approved centre did not have appropriate and suitable practices relating to the prescribing and administration of medicines to residents. The following deficits were found on inspection: the allergy or sensitivities to any medication, including if the resident had no allergies section was not complete on one MPAR; a record of all medications administered to the resident was not recorded on a number of dates in two MPARs; there was no stop date recorded for two medication; the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was not present in two individual residents' MPARs.

Direction to crush medication was only accepted from the resident's medical practitioner, the pharmacist was consulted about the type of preparation to be used, and the medical practitioner documented within the MPAR that that the medication was to be crushed. In one MPAR the medical practitioner did not document a reason why the medication was to be crushed.

All medication was ordered and stored appropriately. Entries in the MPARs were legible and included the signature of the medical practitioner 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 approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing and administration of medicines to residents for the following reasons:

a) **The allergy or sensitivities to any medication, including if the resident had no allergies section was not complete on one Medication, Prescription, and Administration Record, 23(1).**
b) **A record of all medications administered to the resident was not recorded on a number of dates in two Medication, Prescription, Administration Records, 23(1).**
c) **There was no stop date recorded for two medication; the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was not present in two individual residents' Medication, Prescription and Administration Records, 23(1).**
d) **The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was not present in two individual residents' Medication, Prescription and Administration Records, 23(1).**

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in August 2023.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in June 2020 and included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staffing were sufficient to meet resident needs.

Residents were admitted to Le Brun House by the Psychiatry of Later Life team (POLL). Team members included medical, nursing, social work, psychology and physiotherapy. There was no occupational therapist; however, occupational therapists from Carew House completed assessments. Cross cover was provided as necessary. Residents in Whitethorn House were under the care of the Rehabilitation and Recovery team. There was a full team including medical, nursing, psychology, occupational therapy and social work.

All healthcare staff had completed mandatory training in basic life support, safeguarding, fire safety, and the management of violence and aggression. All healthcare staff were trained in the Mental Health Act 2001. All mandated individuals were trained in Children First. 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. Not all staff had completed the mandatory training required by the Mental Health Commission. However, there was a mandatory training plan and when implemented, over the coming months, would ensure full compliance with mandatory training requirements.

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

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing	22	100%	21	95%	21	95%	22	100%	22	100%	21	95%
Medical	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Occupational Therapist	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker	3	75%	4	100%	4	100%	4	100%	4	100%	4	100%
Psychologist	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Physiotherapist	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in March 2024.

Resident records were kept in good order and were up to date with no loose pages present. All records were maintained in a manner to ensure security, completeness, accuracy and ease of retrieval.

Residents' records were developed and maintained in a logical sequence. Throughout the approved centre, records were appropriately secured from loss, destruction, tampering or unauthorised access. 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 had an electronic register of all residents admitted to the approved centre. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

NON-COMPLIANT

Risk Rating HIGH

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

Seven operating policies and procedures requiring a three-yearly review were not reviewed appropriately. Specifically, the six policies due for review in June 2023 and one policy due for review in August 2023 were:

- Regulation 8 (Residents' Personal Property and Possessions).
- Regulation 11 (Visits).
- Regulation 13 (Searches).
- Regulation 19 (Responding to Medical Emergencies).
- Regulation 23 (Ordering, Prescribing, Storing and Administration of Medicines).
- Regulation 26 (Staffing).
- Regulation 32 (Risk Management Procedures).

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all written operational policies and procedures were reviewed at least every three years, as seven policies were out of date.

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 April 2021 and included the process for managing complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible and available for dealing with all complaints, who was based in the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet and on noticeboards in the approved centre. 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, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

(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 2020 and outlined:

- 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 throughout the approved centre to ensure effective implementation of the risk management policy. The person with responsibility for risk was identified and known by all staff but the risk management procedures had not actively reduced identified risks to the lowest practicable level of risk, particularly with ligature and fire risks. Structural risks, including ligature points, were not removed or effectively mitigated.

Not all health and safety were identified, assessed, treated, reported and monitored, as the radiators were too hot and radiator covers had not been fitted to prevent burns. In addition, automatic fire door closures were broken or dismantled at the time of the inspection. Fire doors had gaps and seals were worn or damaged.

Clinical and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate. 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 mechanical restraint, and resident admission, transfer and discharge.

Multi-disciplinary teams (MDTs) 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 MDT at their regular meeting. A record was maintained of this review and of any 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) **Structural risks, including ligature points, were not removed or effectively mitigated, 32(1).**
b) **Not all health and safety risks were identified, assessed, treated, reported and monitored, as the radiators were too hot and radiator covers had not been fitted to prevent burns, 32(1).**
c) **Not all health and safety risks were identified, assessed, treated, reported and monitored, as automatic fire door closures were broken or dismantled. The fire doors had gaps and seals which were worn or damaged, 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 and indemnity scheme statement was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with no conditions of registration attached. The certificate was displayed prominently in the approved centre. Where changes had arisen in relation to the information detailed in the certificate of registration, this was communicated to the Mental Health Commission.

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 Mechanical Restraint

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Evidence of Implementation: The clinical files of three individuals who had been restrained for enduring risk by mechanical means was inspected. The use of mechanical restraint was assessed and used to address an identified clinical need and risk. Mechanical restraint was only used when less restrictive alternatives were not deemed suitable. Mechanical restraint was ordered by a registered medical practitioner under the supervision of a consultant psychiatrist responsible for the care and treatment of the person. The clinical files contained a contemporaneous record that specified that there was an enduring risk of harm to self or others, the type of mechanical restraint and the situation where mechanical restraint was being applied. The multi-disciplinary team developed a plan of care for each person restrained by mechanical means, and included information with detail on attempts to reduce or eliminate the use of restraint for the person.

In the three separate episodes of mechanical restraint the following deficits were found:

- Though a risk assessment of the safety and suitability of the mechanical restraint for the person was undertaken, the risk assessment did not specify the monitoring arrangements which must be implemented during the use of mechanical restraint and the frequency which are implemented during its use.
- The multi-disciplinary review and oversight committee did not produce a report following each of their meetings together.
- The registered proprietor did not notify the Mental Health Commission (MHC) about the use of mechanical restraint for enduring risk to self and others in the format specified by the MHC, and within the timeframes set by the MHC.

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

a) **The risk assessment did not specify the monitoring arrangements which must be implemented during the use of mechanical restraint and the frequency of same, 10.2(i).**
b) **The multi-disciplinary review and oversight committee did not produce a report following each of their meetings together, 10.6(vi).**
c) **The registered proprietor did not notify the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission, 10.8.**

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

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.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in May 2021, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in May 2021, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was 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, work situation, education, dietary requirements, current mental health state, risk assessment and all other relevant information. A key worker system was in place, and a full physical examination was carried out.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre to another healthcare facility was examined. The discharge plan included a follow up plan, reference to early warning signs of relapse and other risks and documented communications with the relevant healthcare provider. The discharge meeting was attended by residents, key worker, relevant members of the multi-disciplinary team, and family, carer or advocate, where appropriate and with the consent of the resident.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs. The discharge was coordinated by the key worker.

A comprehensive discharge summary was sent on the day of discharge to the relevant healthcare provider. The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. A family member, carer or advocate was involved in the discharge process, where appropriate.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10005707		**Two individual care plans were not reviewed by the multi-disciplinary team (MDT) in consultation with the resident at least every six months. One individual care plan was not updated to reflect any changes to the goals, treatment, care, best practice and required resources.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review of all ICPs post MHC inspection by a fully constituted multi-disciplinary team.	Documented outcomes of MDT review and input to the care plans as appropriate.	Achieved	31/05/2024	MDT members with oversight from the local compliance committee.
Preventative Action	Ongoing quarterly audits of ICPs. Tracking system in place discussed at weekly MDT meetings managed by each unit CNM II.	Monthly Audit - results and recommendations presented to compliance committee and QPS committee	Achievable and ongoing	20/12/2024	MDT members with oversight from the local compliance committee.

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10005709		**The registered proprietor did not ensure that services provided were directed towards restoring and maintaining optimal levels of physical and psycho-social functioning of a resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review and identification of available therapeutic space to progress continuing care goals directed toward restoring and maintaining optimal levels of physical and psycho-social functioning both: Within the approved centre: an activity room in each unit and same can be used for bookable space as required. Spiritual room in Le Brun available if required for 1:1 sessions. Outside the approved centre: Access to the wider Clonskeagh Hospital campus including access to ARCHES Recovery Education programme & Clonskeagh Organisation for	ICP goals, referrals to members of the MDT to progress specific goals,	Achievable and ongoing	20/12/2024	All members of the MDT

	Recovery & Empowerment (CORE) Service with access to bookable kitchen space as appropriate/required.				
Preventative Action	Works ongoing to refurbish room number 3 in Whitethorn House for 1:1 bookable space for therapeutic assessments and interventions in house. With the identification of rehabilitation needs residents are supported with onward care planning from Whitethorn House to progress rehabilitation goals access to appropriate environments to facilitate same i.e high support community residences with access to facilities to progress independent living skills such as internal kitchen, laundry and external civil amenities.	Completed refurbishment works Discharge data from Whitethorn House ICP needs & goals	Achievable Ongoing	20/12/2024	HSE Estates, ADON, CNMs, General Manager, Senior Manager Operations All members of the Rehabilitation & Recovery MDT

Regulation 19 General Health					
Reason ID : 10005710		**The proprietor did not ensure that all residents' general health needs were comprehensively assessed as one resident's six-monthly general health assessment did not record the resident's smoking status, blood pressure, nutritional status or level of physical activity, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All six-monthly general health assessments were immediately reviewed to ensure all parameters, including smoking status, blood pressure, nutritional status, and level of physical activity, were recorded.	Updated general health assessments	Achieved	31/05/2024	CNM2s of Whitethorn and Le Brun House, MDT, and Compliance committee
Preventative Action	A checklist template was created and implemented for use in every resident's general health assessment with tracking system in place and monitored by CNM2s.	Quarterly audits of completed checklists and training records.	Achievable Ongoing	20/12/2024	CNM 2s of Whitethorn and Le Brun House, and members of the Compliance committee

Regulation 21: Privacy					
Reason ID : 10005711		**The proprietor did not ensure that the resident's privacy was appropriately respected at all times: one of the shower rooms in Whitethorn House did not have an appropriate type of lock on the door which enabled independent resident use.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review and replacement of the shower room lock to ensure it allows independent use while maintaining privacy.	Documented completion of the lock replacement with verification by staff and residents.	Achieved	31/05/2024	CNM2 of Whitethorn House and the maintenance staff
Preventative Action	Bi-monthly inspections by nursing staff to check the integrity of privacy measures. Any issues arising will be addressed immediately with engagement with maintenance or other external providers as required.	Inspection reports and maintenance logs will be reviewed bi-monthly by the compliance committee.	Regular inspections ensure ongoing privacy, supported by timely maintenance when necessary. Ongoing reviews	20/12/2024	CNM2s of Whitethorn House, and the members of the Compliance committee

Regulation 22: Premises					
Reason ID : 10005712		**The registered proprietor did not ensure that premises were maintained in good structural condition as one of the external doors did not fit correctly within the frame, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The specific external door was reviewed by a contractor and refitted.	Completion of works	Achieved	31/05/2024	HSE Estates, ADON, CNMs, Registered Proprietor Nominee
Preventative Action	Continuous monitoring to ensure facilities are maintained to the highest standards. - The Maintenance and Decorative programme is formally reviewed on a quarterly basis and any maintenance works required are logged and tracked to completion. - There will be ongoing visual checks by staff in the approved centre and any issues can be flagged to the Person in Charge at any stage. - Continued staff awareness regarding the Maintenance and Decorative Programme Plan and	Quarterly walk around scheduled meetings with RPN and key stakeholders, Progress against Programme Logs Visual checks Bi monthly meetings with estates, the HOS and RPN Bi monthly meetings with the Chief Officer, HOS, and Estates to discuss any emerging issues	Achievable Ongoing	20/12/2024	HSE Estates, ADON, CNMs, Registered Proprietor Nominee, general Manager, Senior Manager Operations, Fire Officer, QPS Advisor

	process around reporting any concerns re. same. - There are bi monthly meetings with estates, the HOS and RPN. In addition to this, there are bi monthly meetings with the Chief Officer, HOS, and estates to discuss any emerging issues. Both of these processes ensure that there is sign off and follow up on non-compliances				
Reason ID : 10005713		**The registered proprietor did not ensure that the environment of Whitethorn House was developed with due regard to the specific needs of residents living in a facility registered to provide rehabilitation and recovery services. There was no kitchen facility suitable for resident use and there were no designated therapeutic spaces or rooms, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Change of registration details for Whitethorn House Unit to remove reference to the provision of rehabilitation and replaced with Continuing Mental Health Care/Long Stay.	Correspondence to MHC & change of registration.	Achieved	06/06/2024	RPN
Preventative Action	Works ongoing to refurbish room	Completed refurbishment works	Achievable and ongoing	28/03/2025	HSE Estates, ADON, CNMs, General Manager, Senior Manager

	number 3 in Whitethorn House for 1:1 bookable space for therapeutic assessments and interventions in house. With the identification of rehabilitation needs residents are supported with onward care planning from Whitethorn House to progress rehabilitation goals access to appropriate environments to facilitate same i.e high support community residences with access to facilities to progress independent living skills such as internal kitchen, laundry and external civil amenities.	Discharge data from Whitethorn House ICP needs & goals			Operations All members of the Rehabilitation & Recovery MDT
Reason ID : 10005714		**The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents not all bedrooms were appropriately sized, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Confirmation of identified bedrooms and updated floor plan for decommissioned	Bedroom floor plan & subsequent completion of construction works.	Achievable	20/12/2024	Registered Proprietor Nominee, HSE Estates, Senior Nursing Team, Clinical Director, MDT members.

	rooms: Meeting held with General Manager, Clinical Director, Nurse Management, HSE Estates, and HSE Fire Officer. Detailed floor plan for Le Brun and Whitethorn House developed identifying bedrooms for (Green dots) and Highlight decommissioned rooms (Red).				
Preventative Action	The purpose and utilisation of all rooms at the Approved Centre is monitored by the Compliance Committee, with bedrooms allocated appropriately to meet the residents needs. Quarterly walk around with Heads of discipline, RP, Nurse Management, HSE Estates, Fire Officer, QPS manager.	Ongoing review and monitoring by the Compliance Committee. Quarterly walk around with the Registered Proprietor Nominee, HSE Estates, General Manager, Senior Manager Operations, Maintenance, Fire Officer and Senior Nursing team	Achievable Ongoing	20/12/2024	Local MDT members, Heads of discipline, Registered Proprietor Nominee, HSE Estates, General Manager, Senior Manager Operations, Maintenance, Fire Officer and Senior Nursing team
Reason ID : 10005715		**The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents as a toilet seat was improperly fitted in one shower room, 22(3). The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents as there was a strong malodour in one shower room, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The toilet seat noted on inspection was immediately replaced The identified shower room was immediately deep cleaned.	New Toilet Seat fitted Shower Deep Clean	Achieved	31/05/2024	Maintenance & CNM3
Preventative Action	There is a detailed planned maintenance and decorative works schedule in place for 2024 /2025. Daily checks of the interior and exterior environment of the Approved Centre takes place.	Daily checks conducted	Achievable Ongoing	31/05/2024	CNM2
Reason ID : 10005717		**The registered proprietor did not ensure that the environment was developed with due regard to the specific needs of residents and the privacy screen screens were difficult to open and close, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review of all fitted bedroom privacy screens within single bedrooms by nursing and maintenance to ensure ease of use.	Independent use by residents.	Achieved	31/05/2024	CNM2s & Maintenance staff
Preventative Action	Daily checks of the interior and exterior environment of the Approved Centre takes place.	Daily checks conducted	Achievable Ongoing	31/05/2024	CNM2
Reason ID : 10005718		**The registered proprietor did not ensure that the approved centre was developed with due regard to the safety of residents as not all radiators were guarded and represented a burn hazard, 22(3).**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Installation of 43 radiator covers on all radiators with detailed drawing of same to identify typical and anti-ligature cover requirement.	Radiator covers in situ	Achieved	11/10/2024	Registered Proprietor Nominee, HSE Estates, Senior Nursing Team,
Preventative Action	Risk assessment is carried out on an ongoing basis, with MDT involvement. - The Approved Centre has a comprehensive local risk register as per Risk Management Policy. Maintenance staff conduct regular temperature checks and regulated the heating temperature in the building heating system (BMS) as required. The nurse in charge of the units on each shift checks the temperature of the radiators and reports to the maintenance department immediately.	Review as part of the Approved Centre Risk Register review Weekly monitor of risk assessment Review at Quarterly walk arounds with the Registered Proprietor Nominee, HSE Estates, Maintenance and Senior Nursing team and MDT members Regular maintenance temperature checks	Achievable and Realistic and ongoing	18/10/2024	Maintenance ADONs, CNM2s, QPS Advisor, Registered Proprietor, Staff Nurses
Reason ID : 10005719		**The registered proprietor did not ensure that the approved centre environment was maintained with due regard to the safety of residents, staff and visitors as issues were identified which affected the correct functioning of some of the fire doors, 22(3).**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Fire Safety Risk Assessment (FSRA) completed and remedial works addressed in line with the Revised Timebound plan and the FSRA Priority Works. These items have been prioritised and a contractor has been engaged to replace all of the damaged closers. Review of the Le Brun & Whitethorn local Fire Safety Standard Operating Procedures to increase fire safety compliance both during and beyond these fire safety improvement works	FSRA completion	Achieved	24/05/2024	Estates, Maintenance, Fire Officer, General Manager, Senior Manager Operations
Preventative Action	Monthly Fire training continues as per the Training Needs Assessment schedule for 2024, with the reintroduction of monthly fire evacuation drills co-occurring with fire training with Fire	Updated SOP Compliance monitored through staff signature bank Staff training records Staff attendance at fire drills Successful tender process and completion of fire	Achievable / ongoing	27/06/2025	Maintenance, Fire Officer, ADONs CNMs, General Manager, Senior Manager Operations, Members of the MDT HSE Estates, Maintenance, Fire Officer, ADONs CNMs, General Manager, Senior Manager Operations

	Protection Ireland. Staff continue to have monthly Fire drills on Whitethorn and Le Brun recorded on the fire safety register. Recurring training sessions. 2 No. Tenders were received in relation to the tender competition within the time limit for fire safety remedial works however after however a detailed review of the lowest tender received indicates that the mechanical and electrical costs tendered are excessively high and do not represent the scope of works tendered. The design team recommend that a new tender competition with updated tender documentation be progressed. The aim is to have the project retendered by	safety remedial works			

	15.12.2024 and the works complete by Q2 2025.				
Reason ID : 10005720		**Ligature points were not reduced to the lowest practicable level, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Anti-ligature works ongoing to reduce and remove the ligature points including: Upgrading of bedroom doors to include anti ligature ironmongery, Bedroom upgrades (conversion of smaller bedrooms into larger bedrooms and removing ligatures within each room). Refurbishment of all toilets to reduce the ligature risks. Upgrading of external windows. The ironmongery was replaced with anti-ligature alternatives.	The Ligature audit is a live document and is updated at least annually or as needed depending on changing circumstances.	Achievable Ongoing	27/06/2025	Registered Proprietor Nominee, HSE Estates, Senior Nursing Team,
Preventative Action	Continued annual application for anti-ligature funding to progress systematic and continuous process of ligature elimination in line with national and local	Reduction in high risk ligature rating as captured in the monthly ligature audit.	Achievable Ongoing	19/12/2025	Registered Proprietor Nominee, HSE Estates, Senior Nursing Team,

	policy and reflective of the population profile of the Approved Centre.				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10005721		**The allergy or sensitivities to any medication, including if the resident had no allergies section was not complete on one Medication, Prescription, and Administration Record, 23(1). A record of all medications administered to the resident was not recorded on a number of dates in two Medication, Prescription, Administration Records, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review and update of all MPARs to ensure the allergy section is completed for every resident and that all medication administrations are accurately recorded.	Weekly checks of MPARs will be conducted to ensure completion of all sections and adherence to documentation standards.	Achieved	31/05/2024	CNM2s, and MDT members of Local Compliance Committee
Preventative Action	Weekly checks conducted by nursing staff of all MPARs. Regular staff training and information sessions with regard to compliance with the policy on Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines) All staff have read, the policy of Ordering, prescribing, Storing and Administration of Medication. Hseland	MPARs updated and each unit communications diary. Training attendance logs will measure compliance.	Achievable Ongoing	19/12/2025	CNM2s, and MDT members of Local Compliance Committee

	training on medication management				
Reason ID : 10005723		**There was no stop date recorded for two medication; the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was not present in two individual residents' Medication, Prescription and Administration Records, 23(1). The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was not present in two individual residents' Medication, Prescription and Administration Records, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review of all identified MPARs and those identified with no MCRN brought the attention of the appropriate medical practitioner for immediate input.	Updated MPARs	Achieved	31/05/2024	CNM2s, and MDT members of Local Compliance Committee
Preventative Action	Review MPAR documentation system to ensure that all prescribed medications have stop dates recorded, and every MPAR includes the MCRN for all prescribing medical practitioners. Weekly checks all MPARs to confirm that stop dates and MCRNs are recorded accurately for each prescription.	Feedback sessions during MDT meetings to track compliance. Updated MPARs and MDT meeting discussions.	Achievable Ongoing	20/12/2024	CNM2s, and MDT members of Local Compliance Committee

Regulation 29: Operating Policies and Procedures					
Reason ID : 10005725		**The registered proprietor did not ensure that all written operational policies and procedures were reviewed at least every three years, as seven policies were out of date.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review and update of all seven out-of-date policies and procedures to ensure compliance with the regulation.	All seven policies are updated, signed off by relevant stakeholders, and circulated to staff	6 of 7 Policies ratified 15/09/2024, circulated and signed by all staff by 30/09/2024 Achieved	30/09/2024	Registered Proprietor, Responsible ADONs, and the members of compliance committee.
Preventative Action	Policy review tracking system with automatic reminders for review deadlines. Risk Management Policy reviewed by the EMT and awaiting ratification	The review schedule will be monitored through quarterly reports to the compliance committee. Ratified policy, signed off by relevant stakeholders, and circulated to staff	Achievable / ongoing	20/11/2024	Registered Proprietor, Responsible ADONs, and the members of compliance committee. Approved Centre Policy Review Group, HOD, Quality and Patient Safety Executive Committee.

Regulation 32: Risk Management Procedures					
Reason ID : 10005729		**Structural risks, including ligature points, were not removed or effectively mitigated, 32(1). Not all health and safety risks were identified, assessed, treated, reported and monitored, as the radiators were too hot and radiator covers had not been fitted to prevent burns, 32(1). Not all health and safety risks were identified, assessed, treated, reported and monitored, as automatic fire door closures were broken or dismantled. The fire doors had gaps and seals which were worn or damaged, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review of the local risk register and completion of a comprehensive risk assessment to address any identified structural risks, including ligature points, radiator covers, and fire doors. Repairs and mitigation measures for these risks are prioritized and completed.	Local risk register with accepted risk assessments and Dublin South East Risk register.	Achievable Risk assessment and prioritization completed July 2024, with all mitigation actions to be completed by December 2024.	20/12/2024	Registered Proprietor, Responsible ADONs, HSE Estates, Head of Maintenance and the members of compliance committee, General Manager.
Preventative Action	Establish a quarterly risk assessment schedule to be included as part of quarterly walkarounds with ongoing training for staff on risk identification and reporting processes.	Risk assessment logs and audits will track the identification and resolution of risks.	Achievable / ongoing	20/12/2024	Registered Proprietor, Responsible ADONs, HSE Estates, Head of Maintenance and the members of compliance committee.

Rules Governing the Use of Mechanical Means of Bodily Restraint					
Reason ID : 10005726		**The risk assessment did not specify the monitoring arrangements which must be implemented during the use of mechanical restraint and the frequency of same, 10.2(i). The multi-disciplinary review and oversight committee did not produce a report following each of their7 meetings together, 10.6(vi). The registered proprietor did not notify the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission, 10.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate update of the clinical risk assessment form to include detail of frequency of monitoring. Related to mechanical restraint to ensure that monitoring arrangements and frequency of checks are clearly specified. Multi-disciplinary oversight committee will meet and produce reports after each meeting. All notifications to the Mental Health Commission will be done promptly in the correct format.	A revised risk assessment template implemented, and reports will be produced after every oversight meeting.	Achieved	30/08/2024	ADONs, CNM2s, and the MDT members of the local compliance committee
Preventative Action	Develop and distribute the standard operating	Regular audits of the SOP adherence and review of all	Achievable	29/11/2024	ADONs, CNM2s, and the MDT members of the local compliance committee

	procedure (SOP) to all relevant staff members and train them on its implementation. Regular audits will ensure adherence to the SOP. Restrictive Practice Oversight Committee on Restrictive Practices in place, meet every quarter. The minutes of the meeting are available in Le Brun House. There is a list of dates available for calendar year in 2024. Restrictive Practice group meeting to review Terms of reference to include wide MDT representation & record taking following staff turnover.	restraint-related risk assessments and reports. Minutes of quarterly restrictive practice working group.			

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.

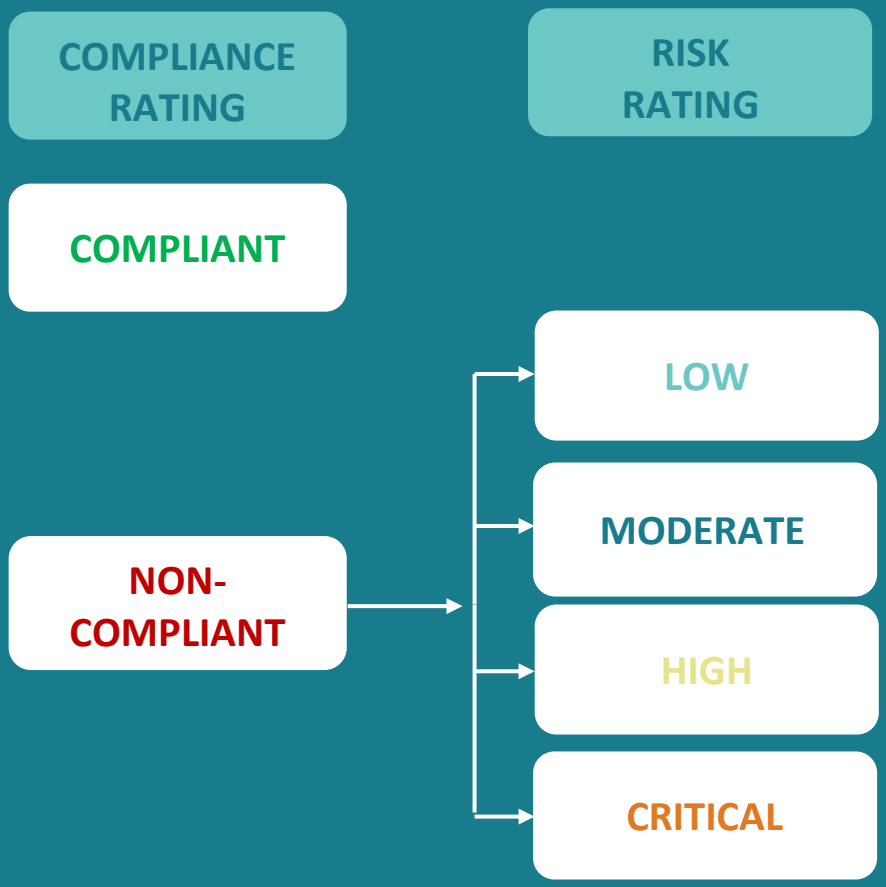
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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