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Bloomfield Hospital : Annual Inspection Report 2024

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Bloomfield Hospital



Annual Inspection
Report 2024

*Promoting Quality, Safety and
Human Rights in Mental Health*



mhc

coimisiún meabhair - shláinte
mental health commission

BLOOMFIELD HOSPITAL

Stocking Lane, Rathfarnham, Dublin 16,
D16C6T4

Date of Publication: 25th March 2025

ID Number: AC0131

2024 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:

Continuing Mental Health Care / Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Other: Neuropsychiatry

Most Recent Registration Date:

17 May 2022

Registered Proprietor:

Bloomfield Care Centre CLG

Conditions Attached:

Yes

Registered Proprietor Nominee:

Mr Joe Kelly, Chief Executive Officer

Inspection Team:

Siobhán Dinan, Lead Inspector
Carol Brennan-Forsyth
Fergal Duffy
Marianne Griffiths
Damien Lanigan

Inspection Date:

16 – 19 July 2024

Previous Inspection date:

28 February – 3 March 2023

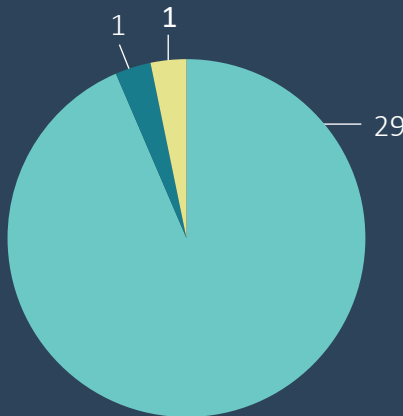
The Inspector of Mental Health Services:

Professor James V Lucey MCRN000646

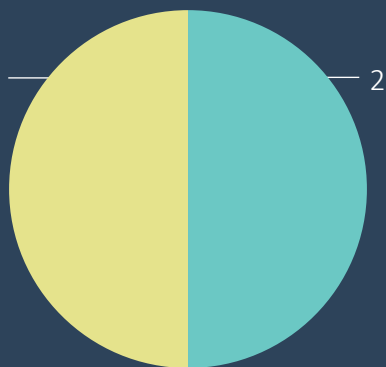
Inspection Type:

Unannounced Annual Inspection

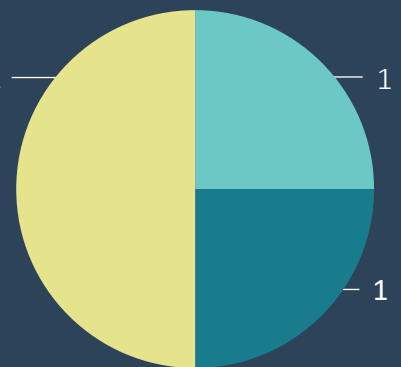
2024 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE
MENTAL HEALTH ACT 2001



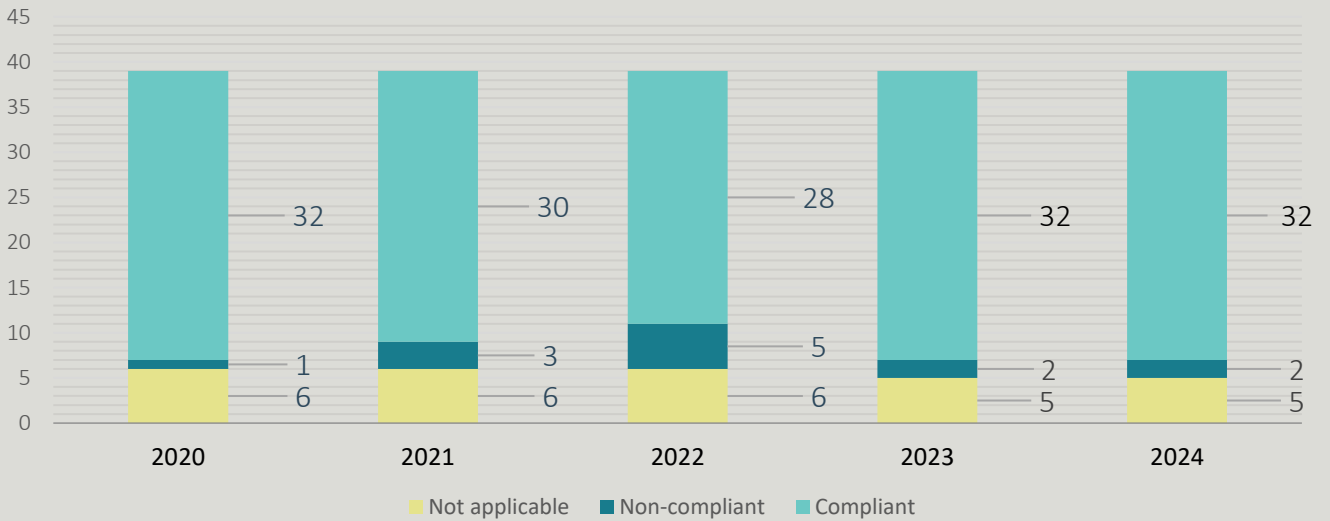
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2020 – 2024

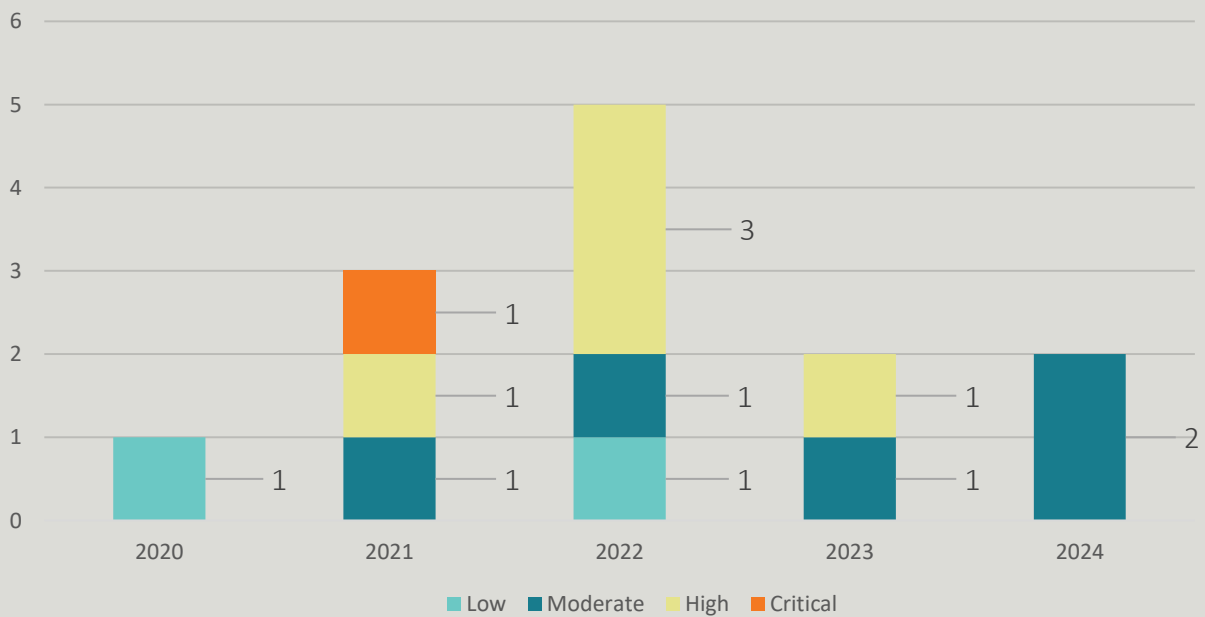
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Bloomfield Hospital is a 123 bed voluntary hospital located in Rathfarnham, South Dublin. It provides treatment for residents with a range of severe and enduring mental health issues and neuropsychiatric disorders. Since the last inspection the attached nursing home was taken over by Bloomfield and became a 22 bedded unit called Kilakee, which is specifically for residents with Huntington’s disease.

The inspection was well coordinated by staff and management in the approved centre. The unit itself is well maintained and was spotlessly clean throughout. It is evident throughout the unit that care and consideration is given to providing a warm and respectful environment to residents. The passion and drive from staff was evident; inspectors observed positive interaction between staff and residents.

In 2024, the inspection team found two areas of non-compliance, Regulation 15 Individual Care Plans and the Code of Practice on the Use of Physical Restraint. The previous year’s non-compliances of premises and staffing were found to be compliant this year, which is an improvement. Fire remedial works were progressing well and have been completed in all residential accommodation areas, and there have been works to reduce ligature points. Also, the approved centre has made impressive efforts in ensuring all relevant staff are trained in the mandatory areas.

The approved centre had an annual audit schedule that incorporated the standards and criteria of the National Quality Framework, and they had developed many new innovative quality initiatives over the year. At the time of inspection resident feedback was overall positive regarding the care and treatment they received in the approved centre, and they spoke warmly of staff.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	97%	91%	85%	94%	94%

Conditions of registration

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

Conditions	Findings
<p>Condition 1: <i>The approved centre must implement the Compliance Plan submitted to the Mental Health Commission by the service on 08 April 2022. The approved centre shall submit updates in a form and frequency specified by the Commission.</i></p>	<p>The approved centre was not in breach of Condition 1.</p>

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre provided a 'Brain Awareness Week' for residents. This event included a week long selection of activities such as a 'Remanence and Memories' art exhibit, Zumba, a sensory scavenger hunt, a sensory walk, meditation sessions and sound baths, brain stimulation activities, a film festival and a St Patrick's Day parade and festival.
2. The approved centre organised a 'Mental Health Day' for residents. This event included a sensory walk on the grounds for residents and staff, a hospital wide group craft tree, a group wall on positive mental health, a karaoke and DJ set and the day concluded with a movie.
3. The Specialist Rehabilitation Unit (SRU) Community Shop opened. This was an on-site shop run by residents of the SRU. Residents were involved in planning shopping lists, purchasing items, stock control, working in the shop on a rota basis, and training up other residents on the register.
4. Activity co-ordinator roles were centralised to a team of five staff to provide a more robust schedule of activities and promote increased participation of residents in off ward activities which also facilitated shared activities at weekends.
5. Implementation of medical emergency mock scenario training for staff.
6. Implementation of a Training Strategy to ensure all staff were upskilled in a timely and professional manner in line with Mental Health Commission requirements; monitoring and tracking completion stats; updates reported regularly to senior management, and an alert system was put in place.
7. Track and trend exit and retention data was retained to gain meaningful insights into employee engagement and attrition.
8. The approved centre fitted a full wall mural depicting a wildflower summer in the pantry of Donnybrook, providing a calmer dining experience.
9. The Bloomfield De-Prescribing Quality Improvement Program was underway at the approved centre. This was an active project for the continuous monitoring of the health of residents who were being treated with doses of antipsychotic medication above the recommended dosage.
10. Cultural and language exchange sessions were implemented. These sessions involved an introduction to other languages as well as the knowledge of habits and customs in other cultures.

In addition to the quality initiatives listed, the inspection team also reviewed quality aspects in relation to the following specific regulations which were informed by The National Quality Framework: Driving Excellence in Mental Health Services 2023.

- **Regulation 11: Visits**

- The approved centre maintained physical environments and facilities that were fit for purpose, welcoming, well-decorated and well-designed. There were multiple areas to facilitate visits on all units and the main dining room was also available to residents for visits.
- The approved centre provided information about visiting in a manner which was accessible and understandable to all. Visiting times were flexible.

- **Regulation 14: Care of the Dying**

- The approved centre incorporated holistic approaches to care within a compassionate bio-psycho-social philosophy.
- Palliative Care Education had been provided to clinical staff through information sessions by a Palliative Care Clinical Nurse Specialist as part of the approved centre liaising with Our Lady's Hospice in Harolds Cross.

- **Regulation 19: General Health**

- The approved centre had a health promotion nurse and promoted positive physical, mental health, and psychological wellbeing through general and targeted health promotion and preventive mechanisms.
- The approved centre collaborated with partner services across the continuum of care.
- The activity programme had groups directed at promoting physical, mental health, and psychological wellbeing such as art therapy, music therapy, pet therapy, cooking and cooking and nutritional groups, social skills groups, gardening groups, and exercise groups.

- **Regulation 20: Provision of Information to Residents**

- The approved centre promoted resident advocacy groups.
- The approved centre provided information in a manner which was accessible and understandable to all. Information was provided to residents and their families and/or carers in various different formats which included printed booklets, information boards, and online.

- **Regulation 21: Privacy**

- The approved centre provided culturally appropriate services to ethnic minorities and marginalised communities. A multi-faith room was available to residents and multi-faith chaplains were available to residents.
- The approved centre promoted the principles of equity, inclusion, and respect for diversity.

- The approved centre empowered residents to manage their own lives through stronger social relationships and sense of purpose.
 - The approved centre acknowledged the evolving understanding of human rights and maintained policies and practice in line with current requirements.
- **Regulation 26: Staffing**
 - The approved centre acknowledged that staff may suffer trauma through their work and took steps to ameliorate the risk and manage the effect.
 - The approved centre provided and ensured that staff had undertaken training in a variety of areas. For example, training in human rights, advocacy and the recovery ethos and in specific mental health therapies and mental health conditions.
 - The approved centre provided annual personal and professional development planning and facilitated opportunities for non-technical skills training.
 - The approved centre provided skilled staff to facilitate the generation of a holistic, multi-disciplinary, co-produced, individualised, and recovery-oriented care plans.
- **Regulation 29: Operating Policies and Procedures**
 - Policies, procedures, protocols, and guidelines were in place that related to the standards and criteria of the National Quality Framework.
 - The approved centre incorporated feedback from residents, families and carers into its policies, procedures, protocols, and guidelines.
 - The approved centre had policies and procedures in place for human resource management including retention of staff.
- **Regulation 31: Complaints Procedures**
 - The approved centre had a complaints process which was visible and easily accessible to families and carers in addition to residents. The approved centre had a process in place to gather feedback from families and residents.
 - The approved centre provided staff with training on the complaints management process.
 - The approved centre had a process in place to gather feedback from families and residents.
- **Regulation 32: Risk Management Procedures**
 - The approved centre had an audit and integrated quality and safety committee promoting a culture of governance with benchmarking across services. All risk registers were reviewed and updated by the department manager or risk owner.
 - The risk management processes were developed in order to facilitate organisational learning within the approved centre and shared the learning with other relevant services. Regular incident trend analysis reports were submitted to the Senior Management Team.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Bloomfield Hospital was a 123 bed, voluntary hospital located on Stocking Lane in Rathfarnham, south Dublin. It was originally founded in 1812 by the Quakers in Ireland. It provided treatment for residents with a range of severe and enduring mental health issues and neuropsychiatric disorders. The approved centre provided residential and outpatient specialist mental health assessment, treatment, and support services to adults throughout Ireland. It also provided a national facility for the care of residents with Huntington's disease. Bloomfield Hospital was an independent non-profit organisation.

The approved centre comprised of seven distinct units:

- Killakee was a 21-bed unit that provided care for residents with Huntington's Disease.
- Kylemore was a 15-bed unit that was the Specialist Rehabilitation Unit (SRU).
- Owendoher was a 26-bed unit that provided care for residents with enduring mental illness and challenging behaviour.
- Donnybrook was a 31-bed unit that provided care for psychiatry of later life.
- Laurel Hill was a 12-bed unit that provided care for residents with high dependency needs.
- Pearson was an 8-bed unit that provided care for residents with severe and enduring mental illness with higher levels of independence.
- Swanbrook beds had been decommissioned for fire remedial works.

The hospital had a modern dining facility for both staff and residents. The shared dining facility and attached kitchen were to begin fire remedial works. While these works were underway alternative dining options were to be put in place for residents and staff. There was a well-equipped occupational therapy room, library, hairdressing salon and beauty room, a resident run shop, and a visiting room. These were all situated off a link corridor known as 'Wicklow Way'. Whilst works were underway in the main dining area a small café was to open temporarily in the family visiting room. The approved centre had extensive grounds, which were accessible to residents and visitors. Residents also had access to a sensory garden, courtyards, and landscaped gardens.

The approved centre had three consultant psychiatrists, a general practitioner (GP), social workers, occupational therapists, a pharmacist, physiotherapists, psychologists, nursing staff, a speech and language therapist, and a dietitian. Admissions to the approved centre were pre-planned and by referral.

The approved centre had continued with a programme of extensive fire remedial works and while these works were underway beds had been decommissioned in Swanbrook unit. Fire remedial works in Donnybrook and Swanbrook and all other residential accommodation had been completed. Remaining fire remedial works included the Wicklow Way, kitchens, kitchen stores, service areas including laundry, the day activity centre ground and first floor, reception and the two-storey administration block.

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

Resident Profile	
<i>Number of registered beds</i>	123
Total number of residents	109
Number of detained patients	7
Number of wards of court	13
Number of children	0
Number of residents in the approved centre for more than 6 months	100
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the overall governance of a Board of Directors who meet monthly. The Chief Executive Officer (CEO), Chief Financial Officer (CFO) and Clinical Director attended the Board of Directors meeting each month, the remaining Senior Management Team (SMT) rotated attendance and attended once per quarter. The SMT at the time of inspection met weekly and comprised of the CEO, CFO, Clinical Director, Director of Nursing, Head of Human Resources, Head of Facilities and Technical Services, and Head of Quality, Risk & Compliance. Issues such as service development and strategy, recruitment, serious incidents, occupational health, and safety, safeguarding, quality improvement, facilities, finance, and risk management, and data protection, were discussed at these meetings.

Governance was strengthened by a Clinical Governance committee which was held monthly. The Clinical Governance committee meetings minutes evidenced agenda items such as quality improvement plans, sub-committee reports, quality and risk, compliance, adverse events, complaints and compliments, safeguarding, and items for escalation to SMT or the Board were discussed. The Clinical Governance committee comprised of the Senior Management Team (SMT), and had representation from physiotherapy, dietetics, speech & language therapy, social work, psychology, occupational therapy, human resources, infection control, nursing, and neuropsychiatry. The members completed an overview of the serious incidents reported within the approved centre and reviewed any issues identified as part of their risk management processes.

Subordinate committees included an infection, prevention and control committee, a living life to the full committee, a medical emergencies committee, an audit committee, a health and safety committee, a restraints committee, a food and nutrition committee, a prevention and management of aggression committee, a falls committee, and a drugs and therapeutics committee. All subordinate committees provided reports to the Clinical Governance committee.

The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded using an electronic standardised template and risk rated and uploaded to the National Incident Management System (NIMS) system. The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had departmental risk registers that

were maintained and overseen by Clinical Managers and the Head of Quality, Risk and Compliance, applicable risks had been escalated to the corporate risk register. Senior management formally reviewed the risk register every quarter and updated the register's content and control measures as necessary. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Training in risk management was provided to staff.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. The numbers and skill mix of staff were sufficient to meet the residents' needs. Health and Social care professionals, including occupational therapy, psychology, social work, physiotherapy, dietetics and speech and language therapy were accessible to all residents.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, and psychology. The inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. All disciplines had formal and informal clinical supervision arrangements in place where appropriate. Annual staff training plans were completed to identify and address training needs. Operational risks highlighted within these questionnaires included: recruitment and retention of staff, staff absences and maintaining adherence with mandatory training requirements. The identified risks were effectively mitigated by escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, weekly resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Peer Advocacy in Mental Health organisation contacted the approved centre regularly and spoke with residents; advocacy contact details were displayed within the approved centre. There were clear processes in place to follow up on any issues identified by service users.

The approved centre had an established culture of quality improvement. This was evident in the ongoing refurbishment of the approved centre. The progression and development of various quality initiatives in the approved centre was also a standing agenda item at the Clinical Governance committee meeting. A programme of audit was implemented by the multi-disciplinary team throughout the service. The Clinical Governance committee also provided a multi-disciplinary approach to policy development, review, approval and dissemination and all policies were up to date at the time of inspection.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) 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 Plan	✓	✓	✓	✓	X Moderate
Code of Practice on the Use of Physical Restraint	✓	✓	✓	✓	X Moderate

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

4.2 Areas that were not applicable on this inspection

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

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Eight residents spoke with the inspection team directly during the inspection. Residents expressed that they believed the care in the approved centre had been excellent, and that the atmosphere was pleasant and relaxed. Residents commented that staff were kind, respectful and approachable and encouraged independence. Residents expressed feeling safe in the approved centre, that it was nice to have a single room and felt that their privacy was respected. Residents commented that the food was very good and that they had a choice of meals each day. Residents stated that they met with their team to discuss their care plans regularly. Residents commented that the activities provided were good, there was enough to do during the day and that there was a nice balance of activities. Some residents informed the inspection team that their clothes were sent to laundry and not returned, and that staff were following up on this.

Two completed feedback questionnaires were received from residents. Both residents indicated they were orientated to the unit on admission and provided with information about their diagnosis and care and treatment in a way they could understand. Both residents indicated they knew who their multi-disciplinary team members were, understood what their care plan was, and were "always" involved in goal setting as part of the care planning process. Both respondents said they could talk to staff, give feedback to the team, and discuss worries or concerns with staff.

Both residents indicated there were enough leisure activities, group activities and talking therapies provided and were complimentary of the recreational and therapeutic programmes. Both residents indicated that they "always" felt safe in the approved centre. Both residents indicated they were happy with the manner in which staff spoke with them, that their dignity and privacy were respected, and they could communicate freely with family/friends/advocates.

There was a sense of overall satisfaction with the approved centre. On a scale of 1-10, with 1 being poor and 10 being excellent, all residents scored eight out of ten for overall care and treatment.

5.2 Advocacy

The approved centre had an advocacy service. The advocate visited the approved centre on a regular basis and offered face-to-face individual and group consultations to residents. 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:

- Head of Quality Risk & Compliance
- Head of Facilities & Technical Services
- Assistant Director of Nursing x 2
- Deputy CEO / Chief Financial Officer
- Head of Human Resources
- Senior Physiotherapist
- Senior Occupational Therapist
- Executive Assistant to CEO
- Nursing Consultant
- Clinical Nurse Manager 3 x 2
- Senior Clinical Psychologist
- Senior Neuropsychologist

Apologies:

- Clinical Director
- Chief Executive Officer (CEO)
- Director of nursing

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation

Regulation 2: Commencement and Regulation

Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers that were appropriate to the resident group profile and individual residents' needs when administering medication, undertaking medical investigations and providing other healthcare services.

An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for residents with the same or similar name.

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.

A source of safe, fresh drinking water was made available to residents at all times in easily accessible locations throughout the approved centre.

Nutritional and dietary needs were assessed with the use of an evidence-based nutrition assessment tool and addressed in the resident's individual care plan. The needs of residents identified as having special nutritional requirements were regularly reviewed by a 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 had suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, preparation, cooking and serving of food.

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.

Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

- (1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
- (2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate to the resident and considered the residents' preferences, dignity, bodily integrity and religious and cultural practices.

Residents changed out of night clothes during daytime hours unless specified otherwise in their individual care plan.

Residents were supported to manage and maintain their own laundry through the provision of internal and external laundry services.

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 written operational policies and procedures relating to residents' personal property and possessions. The policy was last reviewed in September 2022.

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

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

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

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 recreational activities appropriate to the resident group profile. Recreational activities were available both on weekdays and during the weekend and included a beauty club, karaoke, brain-stimulation games, a fitness club, walking, knitting, cooking and baking, arts and crafts, outings, book clubs, bingo, storytelling and relaxation groups. One-on-one activities were also provided depending on the resident's needs.

The recreational facilities provided by the approved centre were appropriately resourced.

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 multi-faith room with resources pertaining to different faiths. Religious preference was identified on admission and access to multi-faith ministers was provided. Mass and rosary was held on Sundays for Roman Catholics.

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 written operational policies and procedures relating to visits. The policy was last reviewed in February 2023.

Visiting times were appropriate and reasonable. Separate visitors areas were provided in each unit where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

The visiting room was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures on communication. The policy was last reviewed in May 2022.

Residents had access to means of sending or receiving messages or goods, except where the resident was otherwise risk assessed with due regard to their wellbeing, safety and health.

The clinical director, or a senior member of staff designated by the clinical director, only examined incoming and outgoing resident communication where there was reasonable cause to believe that the communication would result in harm to the resident or to others based on the risk assessment.

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 written operational policies and procedures on:

- The searching of a resident, their belongings and their environment.
- Carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
- The finding of illicit substances.

The policy was last reviewed in February 2024.

The clinical files of three residents who were searched were inspected. Risk was assessed prior to a search of a resident, their property or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches. The request for consent and the reply was documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. Where consent was not received, the process relating to searches without consent was implemented.

The resident search policy and procedure was communicated to all residents. Relevant staff were able to articulate the searching processes as set out in the policy. Residents were informed by those carrying out the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times while searches were being carried out.

The resident's dignity, privacy and gender were respected during searches and at least one of the staff members conducting the search was the same gender as the resident being searched. Residents were

given the opportunity to give feedback regarding their experience of the search in relation to their dignity and privacy.

A written record of every search of a resident and every property search was available, and included the reason for the search, the names of both staff members who undertook the search and details of who was in attendance for the search. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

- (1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.
- (2) The registered proprietor shall ensure that when a resident is dying:
 - (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
 - (b) in so far as practicable, his or her religious and cultural practices are respected;
 - (c) the resident's death is handled with dignity and propriety, and;
 - (d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.
- (3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
 - (a) in so far as practicable, his or her religious and cultural practices are respected;
 - (b) the resident's death is handled with dignity and propriety, and;
 - (c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.
- (4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.
- (5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

The approved centre had written operational policies and protocols for care of residents who are dying. The policy was last reviewed in February 2024.

The clinical file of one resident who had received end-of-life care in the approved centre was inspected.

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

The approved centre collaborated with partner services across the continuum of care to meet identified resident needs. The approved centre upheld the human rights of the resident and took account of their choice within a legal framework.

All deaths of residents, were notified to the Mental Health Commission as soon as was 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

Each resident had an individual care plan (ICP). Ten ICPs were inspected. The documents within the ICPs were identifiable and uninterrupted but not all ICPs were a composite set of documents distinct from the progress notes. One clinical file had a care plan review documented within the clinical notes and not in the ICP document.

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

Not all ICPs identified appropriate goals for the resident, the care and treatment required to meet the goals or the responsibilities for implementing the care and treatment. The ICP of one resident who had been injured and was at risk of falling did not address the injury or the risk, and as a result did not address the care needed for both.

ICPs were reviewed by the MDT in consultation with the resident, but not all ICPs were updated contemporaneously to reflect any changes to the goals, treatment, care, best practice and required resources. One ICP was not updated to indicate the resident had an injury and was a high-falls risk.

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

- a) One individual care plan did not identify appropriate goals for the resident.**
- b) One individual care plan did not comprehensively identify the care and treatment required to meet the identified goals.**
- c) One individual care plan was not updated following the residents' changing needs, goals and circumstances.**
- d) One resident's individual care plan was not a composite set of documents as the individual care plan reviews were amalgamated within the clinical progress notes.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided therapeutic services and programmes that were appropriate and met the assessed needs documented in residents' individual care plans. Occupational therapy (OT), social work and psychology staff provided therapeutic group programme input and one-on-one sessions for residents.

The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. OT activities included music therapy, art therapy, cooking and baking groups, pet therapy and a social skills group. Psychology provided individual and family work and collaborated with the speech and language therapist. Social work provided one-on-one session in family work, financial management and discharge planning. A physio service was provided onsite.

The approved centre arranged therapeutic services for residents when the services was not provided internally. External services were provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the transfer of residents. The policy was last reviewed in January 2024.

The clinical file of one resident who had been transferred from the approved centre to another facility was inspected. Full and complete written information on the resident was transferred with them, and included a letter of referral, a list of current medications and a resident transfer form. This information was sent in advance with the resident to a named individual.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

- (1) The registered proprietor shall ensure that:
- (a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
 - (b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
 - (c) each resident has access to national screening programmes where available and applicable to the resident.
- (2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

INSPECTION FINDINGS

The approved centre has written operational policies and procedures for responding to medical emergencies. The policy was last reviewed in February 2023.

The approved centre had an emergency trolley and staff always had access to an automated external defibrillator (AED).

Residents were provided with general health services, and received appropriate health care interventions in line with their individual care plans. Residents' general health needs were monitored and a six-monthly general health assessment were undertaken.

Five clinical files were examined in relation to the provision of general health services during the inspection process. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. The six-monthly health assessments documented a physical examination, family and personal history, weight, blood pressure, smoking status, dental health, nutritional status and a medication review. For residents on anti-psychotic medication, an annual assessment documented their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

Arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents had access to national screening programmes according to age and gender.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

- (a) details of the resident's multi-disciplinary team;
- (b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
- (c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;
- (d) details of relevant advocacy and voluntary agencies;
- (e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures for the provision of information to residents. The policy was last reviewed in May 2022.

Residents were provided with required information at admission, including the approved centre's information booklet that detailed the care and services provided. The booklet was available in a format that supported resident needs and clear and simple-to-read information was provided on housekeeping arrangements, personal property, mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies and residents' rights.

Residents were provided with the details of their multi-disciplinary team. Residents were provided with written and verbal information regarding their diagnosis, except where the resident's psychiatrist deemed the provision of such information as prejudicial to the resident's physical health, mental health, well-being or emotional condition.

Medication information sheets and verbal information were provided in a format appropriate to the resident's needs. The medication information sheets included information on indications for use of all medications administered to the resident, including possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Residents were called by their preferred name based on their self-identification. Staff appeared and dressed professionally and interacted with residents in a professional, engaging and compassionate manner. Staff showed discretion when discussing the resident's condition or treatment needs. Permission was sought before entering a resident's room.

All bathrooms, showers, toilets and single bedrooms had locks on the inside of the door, except where there was an identified risk to a resident. Locks had an override function.

Where residents shared a room, bed screening ensured that their privacy was not compromised. Observation panels on treatment room doors and bedroom doors had blinds, curtains or opaque glass. Rooms were not overlooked by public areas.

Noticeboards did not detail resident names or other identifiable information. Residents were facilitated to make private phone calls. All residents wore clothes that respected their privacy and dignity.

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

- (1) The registered proprietor shall ensure that:
 - (a) premises are clean and maintained in good structural and decorative condition;
 - (b) premises are adequately lit, heated and ventilated;
 - (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.
- (2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.
- (3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.
- (4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.
- (5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.
- (6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Residents in the approved centre had access to personal space: all resident rooms were adequately sized. Communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were sized and furnished to remove excessive noise. Lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs.

Residents had space to move about, including outdoor spaces. Hazards such as large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces were minimised in the approved centre. Ligation points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination and repair of assistive equipment. Records were maintained. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Water temperature in taps did not exceed 50°C. Current national infection control guidelines were followed.

There were sufficient toilets and showers for residents in the approved centre, with at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room. All resident

bedrooms were appropriately sized to address the residents' needs and furnished to support resident independence and comfort. Assisted devices and equipment were available to address resident needs.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had appropriate and suitable practices and written operational policies relating to:

- Ordering medicines.
- Prescribing medicines.
- Storing medicines.
- Administering medicines to residents.

The policy was last reviewed in April 2024.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident. The MPARs of ten residents were inspected. The MPARs recorded allergies and sensitivities to any medication, or recorded that the resident had no allergies. The MPARs detailed medication administration routes, a record of all medications administered to the resident and a clear date of discontinuation for each medication. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was recorded. Each entry was legible and signed by the prescribing medical practitioner.

Medication was reviewed and re-written at least six-monthly, or whenever there was a significant change in the resident's care or condition. This was documented in the clinical file. When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file.

A direction to crush medication was only accepted from the resident's medical practitioner. The medical practitioner documented why the medication was crushed and the pharmacist was consulted about the type of preparation used. The medical practitioner documented in the MPAR that the medication was crushed.

Medication was appropriately stored. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication was stored securely. Schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the health and safety of residents, staff and visitors. The policy was last reviewed in February 2024.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

- (a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
- (b) it shall be clearly labelled and be evident;
- (c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
- (d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
- (e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

The approved centre had clear written policy and protocols in relation to the use of CCTV for observing residents. The policy was last reviewed in January 2024.

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

The use of CCTV, or other monitoring systems, had been disclosed to the Mental Health Commission or the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe residents were incapable of recording or storing a resident's image on a tape, disc, hard drive or in any other form. CCTV cameras or other monitoring systems only transmitted images to a monitor that was viewed solely by the health professional responsible for the resident.

CCTV was not used to monitor a resident if they started to act in a way which compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

- (1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
- (2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
- (3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
- (4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
- (5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
- (6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

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

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. The approved centre had had three consultant psychiatrists, a general practitioner (GP), social workers, occupational therapists, a pharmacist, physiotherapists, psychologists, an assistant psychologist, nursing staff, health care assistants, activity co-ordinators and mental health support workers. An appropriately qualified staff member was on duty and in charge at all times.

All healthcare staff were trained in the Mental Health Act 2001. Not all healthcare staff had received up to date mandatory training in Basic Life Support, Fire Safety, the Management of Violence and Aggression or Safeguarding. However, at the time of inspection, the approved centre had a staff training co-ordinator and a mandatory training plan for the coming weeks that was provided to the inspection team and would, when implemented, ensure full compliance with mandatory training requirements. The approved centre also had a number of on-site trainers for the areas of mandatory training. 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.

See the table below for a breakdown of the numbers and percentages of staff trained in each area:

Staff Training Record

Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Nursing (79)	78	99%	77	97%	78	99%	79	100%	79	100%	79	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Physiotherapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Healthcare Assistants (74)	74	100%	73	99%	74	100%	74	100%	74	100%	72	94%
Other (13)	13	100%	13	100%	13	100%	13	100%	13	100%	13	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 written policies and procedures relating to the:

- Creation of records.
- Access to records.
- Retention of records.
- Destruction of records.

The policy was last reviewed in September 2022.

All residents' records were secure, up to date and in good order, and were constructed, maintained and used in accordance with national guidelines and legislative requirements. Resident records were physically stored together, where possible, and reflected the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and good order. There were no loose pages. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All applicable operating policies and procedures were reviewed within the required three-year time frame, having due regard to any recommendations made by the Inspector or the Commission.

Where regional or national policies were used, the approved centre had a written statement confirming this, which was reviewed at least every three years.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

- (1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.
- (2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.
- (3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.
- (4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.
- (5) The registered proprietor shall ensure that all complaints are investigated promptly.
- (6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.
- (7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.
- (8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.
- (9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the:

- Making of complaints.
- Handling of complaints.
- Investigating complaints from any person about any aspects of the service, care and treatment provided in or on behalf of the approved centre.

The policy was last reviewed in October 2023.

A nominated person was responsible for dealing with all complaints and was available to the approved centre. The approved centre's processes for managing complaints were well publicised and accessible to residents and their representatives. This included providing information about the complaints procedure to the resident and their representative at admission or soon thereafter.

The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family and next-of-kin were informed of all methods by which a complaint could be made. All complaints, 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 given to a resident were not adversely affected by any complaint made.

Minor complaints were documented. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, and subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. Complainants were

informed promptly of the outcome of the complaint investigation, details of the appeals process were made available to them and this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

- (1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.
- (2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
- (a) The identification and assessment of risks throughout the approved centre;
 - (b) The precautions in place to control the risks identified;
 - (c) The precautions in place to control the following specified risks:
 - (i) resident absent without leave,
 - (ii) suicide and self harm,
 - (iii) assault,
 - (iv) accidental injury to residents or staff;
 - (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
 - (e) Arrangements for responding to emergencies;
 - (f) Arrangements for the protection of children and vulnerable adults from abuse.
- (3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in February 2024, and outlined the roles and responsibilities for risk management, including:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The responsibilities of the multi-disciplinary team.
- The person responsible for the completion of six-monthly incident summary reports.
- A defined quality and safety oversight and review structure as part of the governance process for managing risk.

The policy also included:

- The process for identifying, assessing, treating, reporting and monitoring risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling specific 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.
- 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, including the roles and responsibilities of key staff, the sequence of required actions, the process for communication and escalating emergencies to management.

- The process for the protection of children and vulnerable adults within the care of the approved centre.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff.

Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks, health and safety risks and corporate risks were identified, assessed, treated, reported and monitored. Clinical risks, health and safety risks and corporate risks were documented in the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

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

Individual risk assessments were completed prior to and during physical and mechanical restraint. Individual risk assessments were also completed at admission, transfer and discharge, and in conjunction with medication requirements.

Multi-disciplinary teams (MDTs) were involved in the development, implementation and review of the individual risk management processes. Residents or their representatives were also involved in the 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. All clinical incidents were reviewed by the MDT and a record was maintained of this review and recommended actions.

The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission.

An emergency plan was in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered 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 one condition to registration attached. The certificate was displayed prominently.

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

COMPLIANT

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section "patient" includes –

- (a) a child in respect of whom an order under section 25 is in force, and
- (b) a voluntary patient.

INSPECTION FINDINGS

Evidence of Implementation: The clinical files of three persons who had been mechanically restrained for an enduring risk of harm to themselves or others were inspected.

Mechanical restraint was used to address an identified clinical need or risk. Mechanical restraint was only used when less restrictive alternatives were not deemed suitable and where a risk assessment of the safety and suitability of the mechanical restraint for the person was undertaken. The risk assessment specified the monitoring arrangements and frequency which were implemented during its use. A copy of the risk assessment, and a record of the monitoring of the person, was available.

The risk assessment was reviewed and updated regularly in line with the person's individual care plan (ICP). The multi-disciplinary team (MDT) developed a plan of care for each person restrained by mechanical means and included information on attempts to reduce or eliminate the use of restraint for the person.

Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of the consultant psychiatrist (CP) responsible for the care and treatment of the person or the duty CP. The clinical file contained a contemporaneous record that specified:

- That there was an enduring risk of harm to the person or to others.
- That less restrictive alternatives had not been successful.
- The type of mechanical restraint being used.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The multi-disciplinary review and oversight committee undertook a review of all persons at the approved centre who were the subject of Part 4 of these rules in the previous quarter to determine the appropriateness of the use of this restrictive practice. This review outlined the arrangements that are in place at the approved centre to reduce or, where possible, eliminate the use of mechanical restraint as it related to Part 4 of these Rules.

The committee met at least quarterly and determined if there was compliance with the rules on the use of mechanical restraint and with the approved centre's own policies and procedures relating to mechanical restraint, for each episode reviewed. The committee also:

- Identified and documented any areas for improvement.
- Identified the actions, the persons responsible, and the timeframes for completion of actions.
- Assured the registered proprietor nominee that each use of mechanical restraint accorded with the Mental Health Commission's rules.
- Produced a report following each meeting of the review and oversight committee.

An annual report on the use of mechanical restraint in the approved centre was published on the registered proprietor's website.

The registered proprietor notified the Mental Health Commission about the use of mechanical restraint for enduring risk of harm to self and others in the format and timeframes specified by the Mental Health Commission.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of seven patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment of the patients; six of whom were deemed not to have the capacity to consent and one of whom was deemed to have the capacity to consent.

A written record of consent for one patient detailed the following:

- The name of the medications prescribed.
- A confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of a discussion with the patients, including on the nature and purpose of the medications, the effects of medications such as the risk and benefits, and any views expressed by the patient.

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

A Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed for six patients. It documented the following:

- The names of the medications prescribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.
- Any views expressed by the patient.
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated January 2024. It addressed the following:

- The provision of information to the person which included information about the person's rights, presented in accessible language and format.
- Who could initiate and who may carry out physical restraint.
- The safety, safeguarding and risk management arrangements that should be followed during any episode of physical restraint.

Policies and procedures regarding staff training included:

- Who would receive training based on the identified needs of persons who are restrained and staff.
- The areas to be addressed within the training programme, which included training in:
 - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
 - Alternatives to physical restraint.
 - Trauma-informed care.
 - Cultural competence.
 - Human rights, including the legal principles of restrictive interventions.
 - Positive behaviour support including the identification of the social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.
 - The monitoring of the safety of the person during and after the physical restraint.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in physical restraint.

The approved centre had a reduction of physical restraint policy which was last reviewed in January 2024 and addressed the following:

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

Training and Education: There was a written record that all staff involved in physical restraint had read and understood the policy.

All staff who participated, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures and this training was in accordance with the policy outlined above.

A record of attendance at training was maintained.

Monitoring: An annual report was published on the registered proprietor's website.

A multi-disciplinary review and oversight committee met at least quarterly and:

- Determined if each episode of physical restraint reviewed complied with the code of practice on the use of physical restraint.
- Determined if each episode of physical restraint reviewed complied with the approved centre's own policies and procedures relating to physical restraint.
- Identified and documented any areas for improvement.
- Identified the actions, the persons responsible, and the timeframes for completion of any actions.
- Assured the registered proprietor nominee that each use of physical restraint was in accordance with the Mental Health Commission's code of practice.
- Produced a report following each meeting of the review and oversight committee which was available to the Mental Health Commission on request.

Evidence of Implementation: Three episodes of physical restraint were inspected. Orders for physical restraint were appropriately initiated and recorded. None of the orders inspected were renewed. The relevant section of the clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint as soon as was practicable and no later than three hours after the conclusion of the restraint, and the CPF was signed by the consultant psychiatrist (CP) or the duty CP within 24 hours.

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

In all three episodes of physical restraint inspected, there was no evidence in the clinical files to show that physical observations were conducted, including that vital clinical indicators such as the monitoring of pulse, respiration and complexion were conducted on any of the three people being restrained.

The person who led the physical restraint ended the restraint. The time, date and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended. The dignity of the person being restrained was respected at all times.

An in-person debrief with the person who was restrained followed two episodes of physical restraint. However, there was no record of such a debrief having taken place following one episode of physical restraint.

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

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

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

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

- a) In all three episodes of physical restraint inspected there was no evidence of the monitoring of physical observations of the three residents, 4.5(iii).**
- b) In one episode of physical restraint there was no evidence of an in-person debrief having taken place, 5.3.**

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 January 2024, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in January 2024, included all of the policy-related criteria for this code of practice.

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

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

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

Evidence of Implementation:

Admission: The clinical file of one 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 history, medical history, current and historic medications, social and housing circumstances, current mental health state, risk assessment, and all other relevant information. A full physical examination was carried out. A key worker system was in place, and a family member or carer was involved in the admission process with the resident's consent.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse or other risks and documented communications with the relevant healthcare

provider. The discharge meeting was attended by the resident, their key worker, relevant members of the resident's multi-disciplinary team (MDT) and a family member or representative, where appropriate.

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

The discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge and outstanding health or social issues. It provided follow-up arrangements, names and contact details of key people for follow-up and risk issues such as signs of relapse. Family members, carers and advocates were 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 : 10005996		One individual care plan did not identify appropriate goals for the resident. One individual care plan did not comprehensively identify the care and treatment required to meet the identified goals. One individual care plan was not updated following the residents' changing needs, goals and circumstances. One resident's individual care plan was not a composite set of documents as the individual care plan reviews were amalgamated within the clinical progress notes.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The single care plan identified in this non-compliance was immediately corrected and updated.	Care plan audits increased to quarterly	No barriers	19/07/2024	Clinical Director, Director of Nursing
Preventative Action	The ICP Audit has been updated and enhanced to identify more gaps should they be present in documentation. Results of these audits are reported to the Clinical Audit Committee for review of findings & arising quality improvements. The full MDT are involved in the audit process to ensure all members take accountability for the ICP. The Clinical	Quarterly clinical audit of ICPs, results to be reported to the Clinical Audit Committee for review. Findings to be addressed with corrective and preventative actions.	No barriers identified	31/03/2025	Clinical Director, Director of Nursing

	<p>Director is currently developing a ICP review checklist to ensure the MDT meet all the requirements when developing and reviewing the ICP. Lunch and Learn sessions are being organised to re-train and re-educate all clinical staff on ICP management.</p>				
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Code of Practice on the Use of Physical Restraint in Approved Centres

Reason ID : 10006000		In all three episodes of physical restraint inspected there no evidence of the monitoring of physical observations of the three residents, 4.5(iii). In one episode of physical restraint there was no evidence of an in-person debrief having taken place, 5.3.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Staff re-training and education in physical restraint requirements. Audit schedule reviewed and updated to maximise gap identification and learnings.	Audit of each episode of physical restraint. Monitoring and trending of TMVA training statistics to ensure staff remain compliant and up to date with the regulation.	No barriers identified	31/08/2024	Director of Nursing
Preventative Action	Physical Restraint booklet developed by ADONs which includes a checklist of every requirement for physical restraint compliance. This booklet will guide staff through all requirements ensuring no actions are missed. Increased scrutiny of training statistics, weekly review of training expiry dates. Development	Audit of each episode of physical restraint, monitoring and trending of training statistics.	No barriers identified	14/03/2025	Director of Nursing, Head of HR

	of new induction week for new starters to ensure new staff are fully trained in TMVA before their first working shift.				
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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.

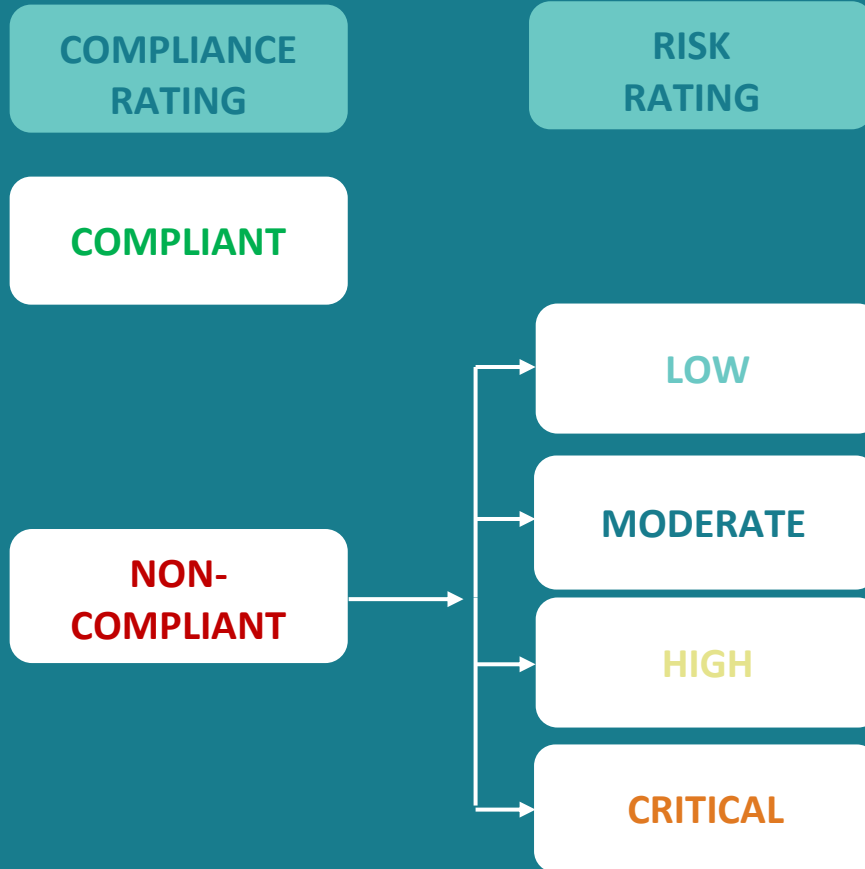
Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed 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.

