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Admission Unit and St Edna's Unit in St Loman's Hospital: Annual Inspection Report 2024

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Admission Unit & St Edna's Unit, St Loman's Hospital

Annual Inspection
Report 2024

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



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mental health commission

ADMISSION UNIT & ST EDNA'S UNIT, ST LOMAN'S HOSPITAL

Delvin Road, Mullingar, Co. Westmeath

Date of Publication:

3 June 2025

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2024 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:

Acute adult mental health care
Continuing mental health care / long stay
Psychiatry of later life
Community and Alcohol Drug Service

Most Recent Registration Date:

1 March 2023

Registered Proprietor:

HSE

Conditions Attached:

None

Registered Proprietor Nominee:

Ms Claire Donnelly, General Manager,
Mental Health Services

Inspection Team:

Carol Brennan-Forsyth, Lead Inspector
Martin McMenamain
Barbara McGeough
Shayne Wilson

Inspection Date:

15 – 18 October 2024

Previous Inspection date:

14 – 17 November 2023

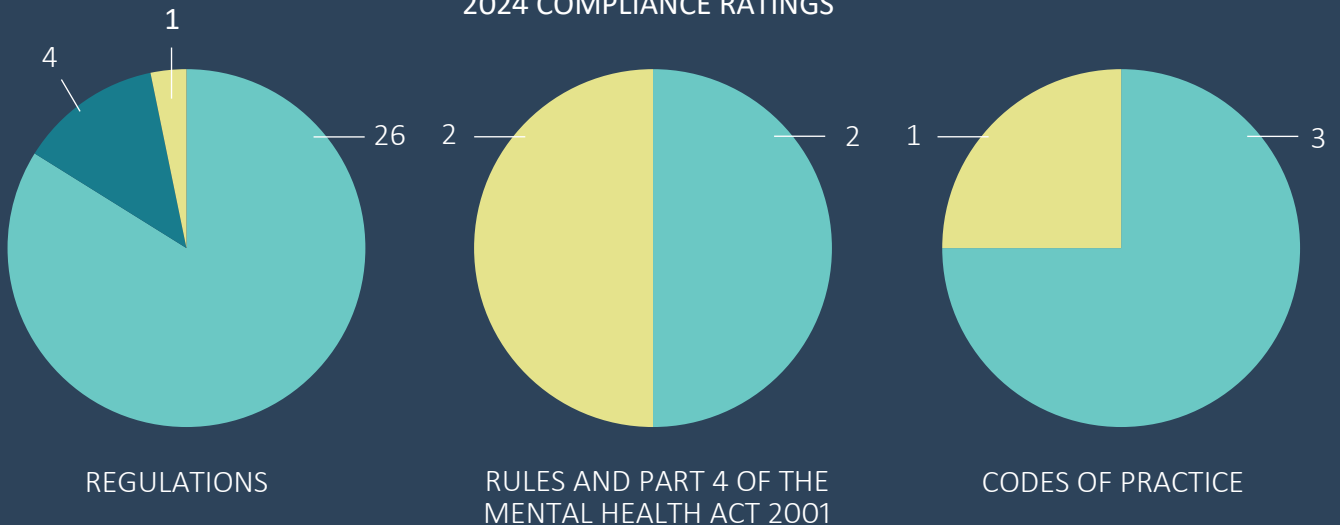
The Inspector of Mental Health Services:

Professor James V Lucey MCRN000646

Inspection Type:

Unannounced Annual Inspection

2024 COMPLIANCE RATINGS

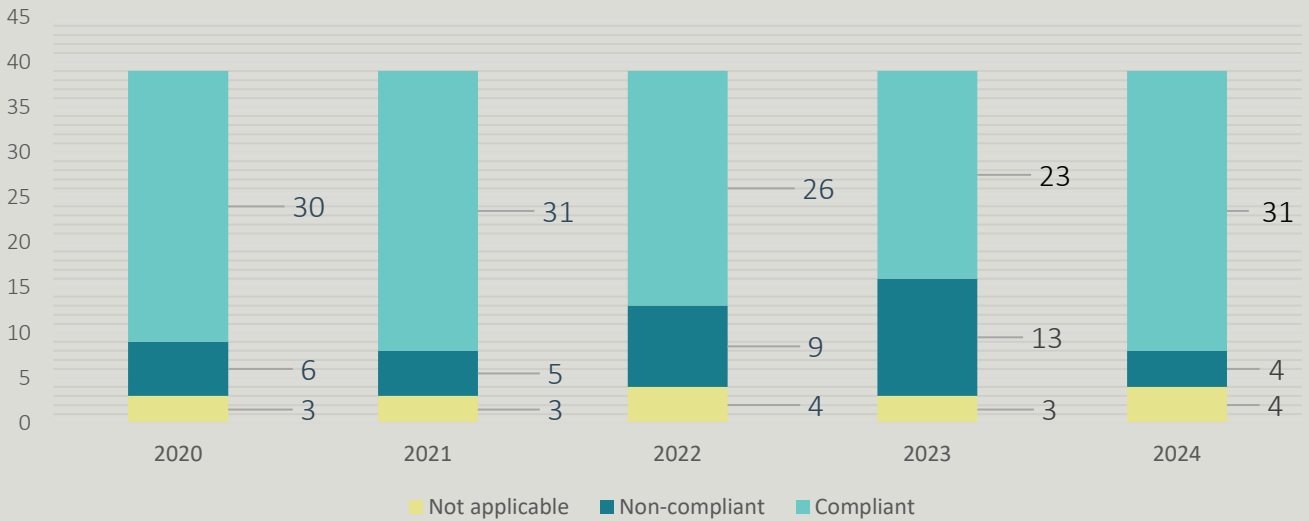


■ Compliant ■ Non-Compliant ■ Not applicable

RATINGS SUMMARY 2020 – 2024

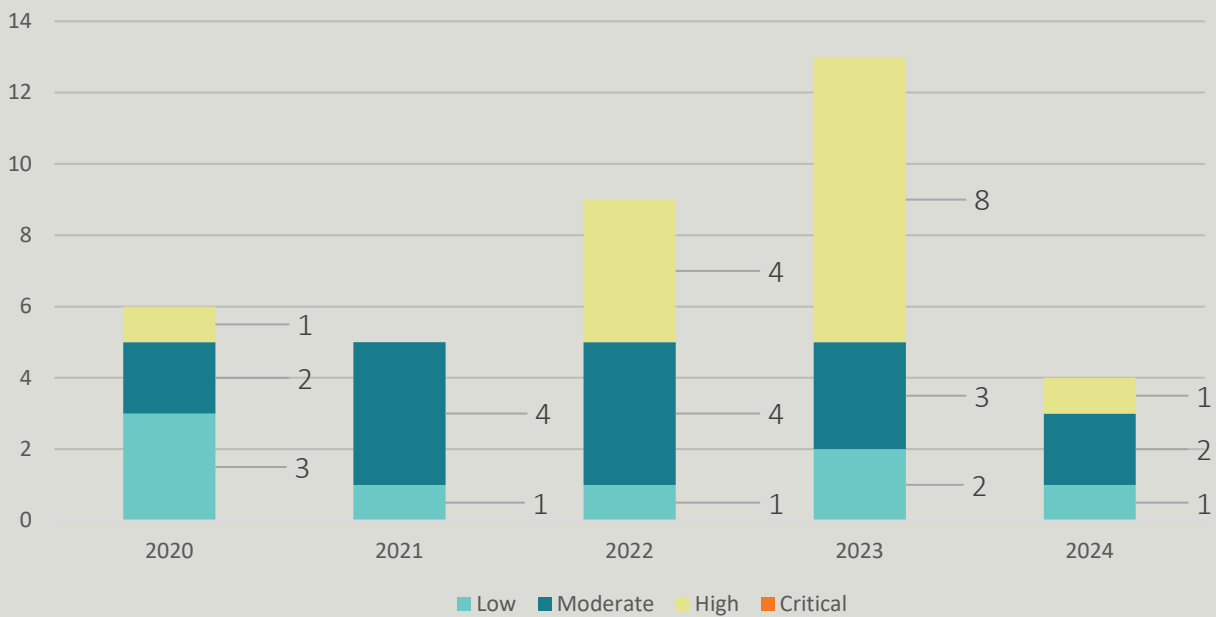
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

The inspection of the Admission Unit and St Edna’s Unit in St Loman’s Hospital was unannounced and occurred over a four-day period, from 15 to 18 October 2024. This summary reflects the findings at the time of the inspection.

Both the Admission Unit and St Edna’s Unit are located on the grounds of St Loman’s Hospital in Mullingar, Co. Westmeath. The approved centre is a two-storey building; the Admissions Ward and St. Edna’s Ward are located on the ground floor. The first floor of the approved centre contains offices and other non-clinical areas. The approved centre is registered to accommodate 44 residents. Eight community mental health teams, including four general adult teams and four specialist teams, have admission rights to the approved centre.

The inspection was well co-ordinated by staff and management. Staff involved in the inspection demonstrated an openness to assist with the inspection. The inspection team findings were generally very positive and there was evidence of a strong commitment to excellent quality practices. The inspection team found four areas of non-compliance: Regulation 8 (Residents’ Personal Property and Possessions), Regulation 22 (Premises), Regulation 26 (Staffing) and Regulation 32 (Risk Management Procedures). These were the only areas of non-compliance found during the inspection; this was a significant improvement from the 2023 inspection. Many new quality initiatives had been put in place since the last inspection to assist in delivering good quality care and treatment to the residents. Regular audits had been completed and there was a focus on continuous improvement. Feedback from the residents was generally positive regarding the care and treatment in the approved centre.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	83%	86%	74%	64%	89%

Conditions of registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- **Regulation 14: Care of the Dying**
Since the last inspection, staff in the approved centre had received training from the local palliative care team on the management of end-of-life care. An electric hospital bed specifically for end-of-life care had been purchased in addition to positioning chairs. The approved centre had established procedures for the provision of administering subcutaneous fluids when required which could prevent residents being transferred to the general hospital for end-of-life care.
- **Regulation 15: Individual Care Plan**
An individual care planning (ICP) group had been established since the last inspection to provide staff training to all disciplines and to review ICP documentation.
- **Regulation 20: Provision of Information to Residents**
Residents in the approved centre had access to six electronic tablets and a Talking Translator App to assist in communication where necessary.
- **New activity programmes were introduced and included a Siel Bleu 12-week exercise programme for older residents and art workshops. The resident's artwork was exhibited in a local library to celebrate World Mental Health Day.**
- **Parts of the approved centre were refurbished since last inspection and new furnishings were acquired. Examples of these improvements included the following:**
 1. The reception and assessment areas had been refurbished: works included painting, new flooring, new blinds and new furniture.
 2. Wood floors were revarnished and sections of floor coverings were replaced where required throughout the approved centre.
 3. Painting had commenced on the Admission Unit and St Edna's Unit, this work was ongoing.
 4. New chairs, sofas, coffee tables and soft furnishings had been acquired.
 5. Safety equipment in the seclusion area was upgraded.
 6. Works had commenced to install anti-ligature fittings in the approved centre, this work was ongoing.
 7. Painting and ground repairs had been completed in the internal court yards in both units.
- **A Quality Improvement Working group had been established to identify the vision, mission and purpose of St Edna's Ward. The working group engaged with residents, family members, staff and visiting clinicians. This project was ongoing at the time of inspection.**
- **A discharge working group had been established since the last inspection to review and improve the approved centre's discharge procedures.**

- A trial of a nurse-led pre-physical examination had commenced in St Edna's Ward. The purpose of this trial was to streamline the physical examination process and to ensure that each resident's physical health issues were identified, and a treatment plan put in place at the resident's six-monthly physical examination. A new electrocardiogram (ECG) machine and phlebotomy trolleys had been purchased to assist in the process.
- A Garda Liaison Group had been established to enhance communication between staff in the approved centre and local Garda authorities to ensure better outcomes for service users who come to their attention. The approved centre had provided education and training to members of local Garda authorities on mental health topics. Official meetings continue on a quarterly basis.
- A multi-disciplinary polydipsia working group had been established to review the policy procedure and requirement for polydipsia management for residents in the approved centre. This group had reviewed literature on polydipsia and was designing a plan to commence the reduction of polydipsia restrictions within St Edna's Ward. A risk benefit analysis had been undertaken as part of this project.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Located on the grounds of St. Loman's Hospital in Mullingar, Co. Westmeath, the approved centre is a two-storey building which comprises two separate wards: the Admissions Ward, and St. Edna's Ward. Both wards are on the ground floor. The first floor of the approved centre contains offices and other non-clinical areas. The approved centre is registered to accommodate 44 residents; there were 32 residents in the approved centre at the time of inspection. Eight community mental health teams, including four general adult teams and four specialist teams, have admission rights to the approved centre. The four general adult teams are assigned to the geographical areas covering North Mullingar, South Mullingar, Longford and Athlone. The four specialist teams provide a service for specified population cohorts and include the Psychiatry of Old Age team, the Rehabilitation and Recovery team, the Intellectual Disability team, and the Community Alcohol and Drugs Service.

St. Edna's Ward provides continuing care for male residents with enduring mental health issues. Sleeping accommodation consists of single en suite bedrooms. The Admissions Ward provides care to both male and female residents presenting with acute mental health issues. Sleeping accommodation consisted of single en suite bedrooms and three two-bed rooms.

Each ward also contained communal rooms such a recreational room, a sitting room, multi-purpose room, and a dining room. There are also non-communal rooms designated for specific purposes; these include interview rooms, laundry rooms, a seclusion suite, a sensory room (on St. Edna's ward only) and a kitchenette for resident use (on St Edna's ward only).

There are five outdoor areas in the approved centre, three of which are part of the Admission's Ward and two of which are part of St. Edna's ward.

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

Resident Profile	
<i>Number of registered beds</i>	44
Total number of residents	32
Number of detained patients	5
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre is part of the Midlands Integrated Health Area, which encompasses the governance of Longford/Westmeath and Laois/Offaly Mental Health Services. The approved centre is governed by the Longford/Westmeath Mental Health Services Catchment Management Team (CMT). The CMT met monthly, and these meetings were attended by managers of each healthcare discipline, the general manager, the business manager and the risk and patient safety advisor. Agenda items included themes relating to service planning, key performance measures, capital works, recruitment, regulatory compliance, risk management and finance. A Quality and Patient Safety committee also convened on a monthly basis. These meetings were attended by the heads of disciplines, the general and business managers, the Mental Health Act Administrator, the risk advisor and the clinical nurse managers. Minutes from these meetings were available to the inspection team. Local clinical governance meetings were conducted every month for the Admissions Ward and St. Edna's Ward. This forum reported into the CMT as appropriate. This meeting was attended by nursing management and various senior clinicians. Maintenance works, regulatory compliance, the local risk register, training, compliments and complaints, infection control, best practice and clinical and operational issues specific to the Admissions Ward and St. Edna's Ward were discussed at these meetings.

The approved centre had a local risk management policy and site-specific safety statement; these documents outlined risk and incident management processes. Incidents were reported and risk assessed through the National Incident Management System (NIMS). Significant incidents and trends were discussed at the approved centre's Local Clinical Governance meeting. All clinical and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate. Not all health and safety risks were identified. Fire doors in the sitting and recreation rooms in the Assessment Ward were wedged open during the inspection posing a safety risk to residents, this risk was not documented on the risk register. The safety statement was reviewed on an annual basis and the risk register was reviewed monthly at the approved centre Local Clinical Governance Group meeting. The main risks identified by the approved centre were the remaining ligature anchor points, a vacant pharmacist post, the unreliability and unsuitable design of staff personal alarms, the lack of a dedicated dietitian and the recruitment and retention of nursing staff. Risks were escalated to the wider service risk register as required; this register was reviewed at the CMT monthly meetings. Systems and processes were in place for the management of risks.

An organisational chart identified the leadership and management structures as well as the lines of authority and accountability within the approved centre. All heads of discipline had defined strategic aims in relation to the approved centre. All heads of discipline met with staff regularly or used a line management structure for reporting and engaging with staff. All disciplines had a system in place for supervision or peer review of staff members.

Not all staff had completed mandatory training in the required areas of fire safety and basic life support, this was monitored at the Local Clinical Governance meetings. There were other training opportunities provided for staff in the approved centre. Training topics included individual care planning, palliative care training, risk management, Irish National Warning System (INEWS) training to assist staff in making clinical judgements and decisions.

The mental health teams consisted of nursing, medical, occupational therapy, psychology and social work disciplines. The approved centre had regular recruitment drives to address the vacant nursing posts. Staff interviewed identified the nursing shortages as a national issue. Despite the use of overtime and agency staff, there were deficits in the day and night nursing staffing requirements for the approved centre. Two full time occupational therapy staff were based in the approved centre. Psychology and social work staff were based in the community and provided an in-reach service to the approved centre. Senior managers reported that the in-reach model was not an optimal model of care and had advocated for additional staff posts specifically for the approved centre.

Residents in the approved centre had virtual access to a private dietetics service based in Dublin. Staff reported that urgent and non-urgent residents were seen very quickly following receipt of a referral. There was a vacant pharmacy post for the mental health service. Attempts to recruit to the post were unsuccessful. Staff had access to a pharmacist for nine hours a week and at other times they had access to pharmacy advice by phone via the Midland Regional Hospital in Mullingar. Residents had access to a speech and language therapy (SLT) service via referral to community primary care teams.

Service user engagement was facilitated in different respects. A representative from the Peer Advocacy in Mental Health (formerly the Irish Advocacy Network) attended the approved centre regularly to meet with residents. The HSE's "Your Service Your Say" policy for gathering feedback about the service was in use in the approved centre for service users and visitors. Formal complaints were dealt with by a complaints officer and their contact details were prominently displayed. Monthly community meetings were facilitated by staff of the approved centre. This was a forum where residents made requests and suggestions. Some of the disciplines obtained specific feedback from residents on the therapeutic activities offered. It was reported that the Area Lead for Mental Health Engagement post was vacant 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 08: Residents' Property	✓		✓		✓		✓		X	Low
Regulation 22: Premises	X	Moderate	X	Moderate	X	Moderate	X	Moderate	X	Moderate
Regulation 26: Staffing	✓		✓		X	High	X	High	X	High
Regulation 32: Risk Management Procedures	X	High	X	Moderate	X	Moderate	X	High	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 had not admitted any children since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The inspection team spoke with seven residents. Residents were offered a Service User Questionnaire; none were returned to the inspection team.

Interviews with residents suggested that they liked being in the approved centre, two residents said the ward had improved a lot over the last few years.

One resident said the nurses were very good and another said there weren't enough nurses to bring them on outings; another said staff listened to them. Residents said they saw their doctors regularly. One resident said the cleaners were excellent.

Three residents said they felt safe in the approved centre, and another said their privacy was respected. Residents were very complimentary about their bedrooms.

There was very good feedback regarding the food, residents rated it from good to excellent. One resident said it was a long wait from dinner and supper to have a sandwich, with just cups of tea in between. This comment was reported to the CNM2 at the time of inspection. Residents have access to snacks at 3pm and 7pm.

The residents interviewed felt there were enough activities in the approved centre and they enjoyed art and music classes, outings to shopping centres and concerts, walks and farming.

Residents were asked what would improve their experience in the approved centre. One resident said they would prefer a mixed ward. One resident said they would like to go out more often. Another suggested that having a small shop in the approved centre for an hour a day to buy newspapers and small items would help them.

5.2 Advocacy

The approved centre had an advocacy service. The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

6.0 Feedback Meeting

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

- Registered Proprietor Nominee
- Clinical Director
- Acting Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Business Manager
- Principal Psychologist
- Occupational Therapy Manager
- Social Worker
- Mental Health Act Administrator
- Risk Manager/Quality & Patient Safety Advisor

Apologies:

- Principal Social Worker
- Operations Manager

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, appropriate to the resident group profile and individual residents' needs. The identifiers were checked before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. The approved centre had a process in place for the identification of residents with the same or similar names.

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. The approved centre was on a three-week menu cycle. Residents had at least two choices for meals. A source of safe, fresh drinking water was available at all times in easily accessible locations in 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

There was suitable and sufficient catering equipment in the approved centre and proper facilities for the refrigeration, storage, preparation, cooking and serving of food. Meals were cooked in the kitchen in the Regional Hospital in Mullingar and transported to the approved centre.

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

INSPECTION FINDINGS

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

Night clothes were not worn by residents during the day unless specified in their individual care plan. Each resident was supported to manage and maintain their own laundry through the provision of internal laundry services.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

NON-COMPLIANT

Risk Rating **LOW**

- (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 an operational policy and procedures relating to residents' personal property and possessions which was last reviewed in April 2023.

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

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP or in accordance with the approved centre's policy. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. There was a process to record, secure and manage the personal property and possessions of the resident, including money.

While there was a record of patient monies documented for each resident, the access to and use of resident monies was not overseen by two members of staff for every single transaction.

The approved centre was non-compliant with this regulation as the registered proprietor did not ensure that provision was made for the safekeeping of all personal property and possessions, as the access to monies was not overseen by two members of staff, 8.6.

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 appropriately resourced recreational activities appropriate to the resident group profile on weekdays and during the weekend. Activities included relaxation groups, art and gardening.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

- (1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.
- (2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.
- (3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.
- (4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.
- (5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.
- (6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2024. Visiting times were appropriate and reasonable. There was a visitors room available where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting room was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

After receiving a risk assessment, residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents had access to postal mail, internet including e-mail, and phone.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others based on risk assessment. Where restrictions had been applied to a resident's means of communication; this was supported by an individual 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 a written policy and procedures on the conducting of searches. The policy was last reviewed in September 2023, and included all requirements related to:

- The management and application of searches of a resident, their belongings and the environment in which they are accommodated.
- The consent requirements of a resident regarding searches.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

Three searches took place since the last inspection and the clinical files of each resident was examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property or the environment, as appropriate to the type of search being undertaken.

The resident's consent was sought prior to the search, and the request for consent and received consent were documented for each search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Each resident was informed by those implementing the search of what was happening during the search and why. A minimum of two clinical staff were in attendance at all times during the search, and due regard was shown to each of the resident's dignity, privacy and gender. At least one of the staff members conducting the search was the same gender as the resident being searched. A written record of the search

was available, which 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.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in June 2023. As no resident had died in the approved centre since the last inspection, the regulation was inspected against policy requirements only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and addressed the resident's goals, mental health care and treatment needs based on a multi-disciplinary team assessment of the person and where practicable, in consultation with them. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The ICPs were discussed, agreed where practicable and drawn up with the participation of the resident and their representative, family and next of kin, as appropriate. All ICPs inspected identified appropriate goals for the resident, the care and treatment required to meet goals, and the resources required to provide the identified care and treatment. The ICPs inspected were reviewed by the multi-disciplinary team (MDT) in consultation with the resident weekly, and were updated to reflect the resident's changing goals, treatment, care, best practices and resources.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Examples of therapeutic programmes included: social farming, art groups, gardening groups, 'Let's Get Active' exercise groups, recovery education groups and cognitive remediation therapy which is designed to improve cognitive functioning.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be 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 in relation to transfers. The policy was last reviewed in August 2023.

The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had a general health policy which was last reviewed in February 2023. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

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

The clinical files of five residents who were in the approved centre for more than six months at the time of the inspection were inspected. The six-monthly health assessment documented a physical examination, family and personal history, weight, blood pressure, smoking status, dental health, nutritional status, a medication review and weight.

The six-monthly health review also documented that there had been an annual assessment of the resident's glucose regulation, blood lipids, prolactin levels and an electrocardiogram (ECG).

Residents had access to national screening programmes which were available according to age and gender. These included: breast check, cervical screening, retina check (diabetics only) and bowel screening. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in April 2024.

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

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

The approved centre was clean, hygienic and free from offensive odours, and it had appropriate heating everywhere and all day-area rooms and bedrooms were ventilated. All private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support residents in finding their way around the building. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort. Residents had sufficient spaces to move about, including outdoor spaces.

Not all hazards were minimised in the approved centre. The sitting room and recreation room doors on admission ward were both labelled as fire doors, both were held open with a bin and a table posing a safety risk in the event of a fire. At the time of inspection these doors did not have a self-close mechanism. There were plans in place for the doors to be replaced and be linked to fire system as part of fire door replacement plan.

Ligature points were not minimised to the lowest practicable level, based on risk assessment.

While a programme of general and decorative maintenance, cleaning, decontamination and repair of assistive equipment was in place, the approved centre was not kept in good a state of repair on the inside. While some improvement works including painting and floor replacing had been completed since the last inspection, six rooms remained to be painted and refloored at the time of the inspection.

The overall approved centre environment was not maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, staff and visitors, as fire doors in the sitting room and Admission Ward were wedged open at the time of the inspection.

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

- a) The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, as ligature points were not minimised to the lowest practicable level, 22(3).
- b) Not all hazards were minimised as two fire doors were held open posing a safety issue in the event of a fire, 22(3).
- c) The registered proprietor did not ensure that a programme of routine maintenance was implemented as six bedrooms were in need of painting and reflooring, 22(1)(c).
- d) The registered proprietor did not ensure that the overall approved centre environment was maintained with due regard to the specific needs of residents and the safety of residents, staff and visitors, as fire doors were wedged open, 22(3).

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 a written policy and procedures in relation to ordering, prescribing, storing and administration of medicine. The policy was last reviewed in March 2023 and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident had none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

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

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified, and Schedule 2 and 3 controlled drugs were secured separately from other medications 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 a written health and safety policy and procedures in place. The policy was last reviewed in March 2023.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in March 2023.

There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. The approved centre's use of CCTV and any other monitoring system was disclosed to residents, residents' representatives, and the Mental Health Commission. Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed solely by the health professional with responsibility for the resident. CCTV was not used to monitor a resident in the event of their dignity being compromised, and all monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc, or hard drive.

The registered proprietor ensured that the existence and usage of closed circuit television or other monitoring device was disclosed to the resident and his or her representative.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating **HIGH**

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

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in relation to the recruitment, selection and Garda vetting requirements of staff. The policy was last reviewed in March 2023. An appropriately qualified staff member was on duty at all times, and this was documented.

Eight community mental health teams, including four general adult teams and four specialist teams, had admission rights to the approved centre. The four specialist teams provided a service for specified population cohorts and included the Psychiatry of Old Age team, the Rehabilitation and Recovery team, the Intellectual Disability team, and the Community Alcohol and Drugs Service. The mental health teams consisted of nursing, medical, occupational therapy, psychology and social work disciplines. However, the numbers of nursing staff were not always sufficient to meet resident needs. There were vacant nursing posts, and despite the use of overtime and agency staff, there were occasional deficits in the day and night staffing requirements for the approved centre.

Residents in the approved centre had virtual access to a private dietetics service based in Dublin and access by referral to a speech and language therapist in the community. There was a vacant pharmacy post in the approved centre, attempts to recruit to the post were unsuccessful. At the time of inspection staff had access to a pharmacist for three hours, three days a week and access to pharmacy advice by phone at other times via the Midland General Hospital in Mullingar.

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

Not all healthcare staff had received up-to-date mandatory training in fire safety and basic life support. The following table shows the number and percentages of staff trained in the different aspects of mandatory training:

Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
	Nursing (31)	29	91%	26	84%	30	96%	31	100%	28	90%	28
Medical (29)	22	76%	28	97%	28	97%	28	97%	28	97%	26	90%
Occupational Therapist (8)	8	100%	8	100%	8	100%	8	100%	8	100%	8	100%
Social Worker (8)	7	88%	8	100%	8	100%	8	100%	8	100%	8	100%
Psychologist (6)	6	100%	6	100%	6	100%	6	100%	6	100%	6	100%
Dietitian*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacist*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other MTA (7)	7	100%	6	86%	7	100%	N/A	N/A	7	100%	7	100%

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

- a) The registered proprietor did not ensure that the numbers of nursing staff were appropriate to the assessed needs of residents as staffing numbers were not always maintained at the required levels every day, 26(2).
- b) The registered proprietor did not ensure that all staff were trained to enable them to provide care and treatment in accordance with best contemporary practice as all staff were not trained in fire safety and basic life support, 26(4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in March 2023. Resident records were kept in good order and were up to date with no loose pages present. All records were maintained in a manner to ensure security, completeness, accuracy and ease of retrieval. Residents' records were developed and maintained in a logical sequence. Throughout the approved centre, records were appropriately secured from loss, destruction, tampering or unauthorised access. Documentation of food safety, health and safety and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an electronic register of all residents admitted to the approved centre. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

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 policies and procedures requiring a three-yearly review had been reviewed and updated as required.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in March 2023 and included the process for managing complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible and available for dealing with all complaints. Information was provided about the complaints procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints and larger formal complaints were documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating MODERATE

- (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 series of written operational policies and procedures in relation to risk management. The risk management policy was last reviewed in April 2022. The risk management policy addressed all requirements including:

- The process for identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

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

All clinical and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate. However, not all health and safety risks were identified. Fire doors in the sitting and recreation rooms in the Assessment Ward were wedged open posing a safety risk to residents, this risk was not documented on the risk register. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, at resident transfer and resident discharge, and prior to and during physical restraint, electro-convulsive therapy, and seclusion.

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

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

The approved centre was non-compliant with this regulation as not all health and safety risks were documented in the risk register. Two fire doors were wedged open posing a safety risk in the event of a fire.

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. The approved centre's insurance covered public liability, employers' liability, clinical indemnity and property. An indemnity scheme statement was available for inspection or on request by the Mental Health Commission.

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, which was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

(4) In this section "patient" includes –

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated April 2024.

The policy addressed the following:

- Who may initiate, and who may carry out, seclusion.
- The provision of information to the person being secluded, which included information about their rights, presented in accessible language and format.
- The safety, safeguarding and risk management arrangements that were to be followed during any episode of seclusion.

The approved centre had a policy on the reduction of seclusion which addressed:

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

Policy and procedures for training all staff involved in seclusion addressed:

- Who would receive training based on the identified needs of persons who are secluded and staff.
- The areas to be addressed within the training programme, including training in:
 - Alternatives to seclusion.
 - Trauma-informed care.
 - Cultural competence.
 - Human rights including the legal principles of restrictive intervention.
 - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).

- Positive behaviour support, including the identification of the social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in seclusion.

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

A record of attendance at training was maintained.

Monitoring: A multi-disciplinary review and oversight committee accountable to the registered proprietor nominee analysed in detail every episode of seclusion. The committee met at least quarterly and:

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

Evidence of Implementation: The approved centre had three seclusion rooms. Seclusion facilities were furnished, maintained and cleaned in such a way that ensured the person's inherent right to personal dignity and ensured that the person's privacy was respected. The construction of the seclusion room was designed to withstand high levels of violence. There were no ligature points or electrical fixtures and there was an anti-barricade door.

The clinical files of three persons who had been secluded were inspected. Orders for seclusion and renewal of seclusion orders were appropriately initiated, carried out, renewed and ended. The person being secluded was assessed and monitored, and their dignity and safety were respected. The person's representative was informed of the seclusion or not, in accordance with the person's wishes. The Mental Health Commission was informed of the start time and date, and the end time and date of each episode of seclusion.

An in-person debrief followed every episode of seclusion. This debrief was person-centred and gave the person the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved in their care and treatment. Where it was the person's wish not to engage in this debrief, that wish was respected.

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

of seclusion was appropriately recorded and all relevant information was placed in the person's clinical file.

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

Each episode of seclusion was reviewed by members of the MDT involved in the person's care and treatment and documented in the clinical file as soon as practicable and, in any event, no later than five working days after the episode of seclusion. The MDT review was documented, and recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person. The registered proprietor appointed a named senior manager who was responsible for the approved centre's reduction of seclusion.

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

A Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed for the patient who was unable to consent. 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 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 was reviewed annually and last reviewed in April 2024. It addressed the following:

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

The approved centre had a written policy on the reduction of physical restraint (Seclusion and Physical Restraint Reduction Policy). The policy included all the policy requirements for this code of practice.

Policies and procedures regarding staff training included the identification of who would receive training based on the identified needs of residents and staff, the identification of appropriately qualified individuals to give the training, the mandatory nature of training for those involved in physical restraint, and the areas to be addressed within the training programme.

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

Monitoring: The approved centre had established a multi-disciplinary review and oversight committee. They met at least quarterly and covered all of their responsibilities including the review of compliance with the code of practice on physical restraint, and compliance with the approved centre's own policies and procedures, specific to each episode reviewed. They produced a report following each meeting of the review and oversight committee. The annual report on the approved centre's use of physical restraint was published on their website.

Evidence of Implementation: Three episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there were no other less restrictive methods available to manage the person's presentation. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical files. A physical examination of the resident had been completed no later than two hours after the start of each episode of restraint.

The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the CP within 24 hours.

The residents were informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical files as soon as was practicable.

Where it was the resident's wish in accordance with their individual care plan (ICP), their representative was informed of the restraint as soon as was practicable. Where the resident's representative was not informed, a record explaining why this did not occur was placed in the clinical file. The Mental Health Commission was notified of the start and end time and date of each episode of physical restraint in the correct format and within three days of each episode.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the resident's ICP pertaining to that resident's specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy. The residents were continuously assessed throughout the uses of restraint to ensure their safety.

Ending of Physical Restraint: The physical restraint in each instance was ended by the person who had initiated the restraint. The time, date and reason for ending the physical restraint was recorded in the clinical file on the date that each episode ended. The residents were given the opportunity, where appropriate, to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. This occurred within two working days of each episode of physical restraint, unless it was the preference of the resident who was restrained to have the debrief outside of this timeframe. Appropriate emotional support was provided to the person following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

Recording of the Use of Physical Restraint: The episodes of restraint were recorded in the clinical files. The episodes of restraint were clearly recorded in the clinical practice forms. There was a copy of the clinical practice form in the clinical file and it was available to the Mental Health Commission on request.

Clinical Governance: The episodes of physical restraint were reviewed by members of the multi-disciplinary team within five working days from the date of each episode. The review included the following:

- 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.
- Consideration of the outcomes of the person-centred debrief, where available.

- An assessment of the factors in the physical environment that may have contributed to the use of restraint.

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

The approved centre was compliant with this code of practice.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of electro-convulsive therapy (ECT) for voluntary patients. The policy was last reviewed in March 2024. It contained protocols that were developed in line with best international practice, including

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: There was a dedicated ECT suite located in Mullingar General Hospital, and not based in the approved centre, and therefore the ECT suite was not inspected. ECT machines were regularly maintained and a record of maintenance was kept. There was confirmation of servicing of machines.

The clinical file of one voluntary resident who had received ECT was examined. The consultant psychiatrist (CP) assessed the resident's capacity to consent to receiving treatment, and this was documented in the resident's clinical file. The resident was deemed able to consent to receiving ECT. Capacity to consent ensured that the resident could understand the nature of ECT (including risks, benefits and alternatives), understand why ECT was proposed, and the broad consequences of not receiving ECT, and make a free choice to receive or refuse ECT. Consent was obtained in writing for each ECT treatment session, including anaesthesia. All consent was obtained by the CP or a registered medical practitioner (RMP) under supervision of the CP prior to each ECT treatment session and recorded in the clinical file.

A programme of ECT was prescribed by the responsible CP and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the resident and next of kin, and a current mental state examination. Cognitive assessments, in line with best international practice, were completed and recorded before and after each ECT session.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file. The ECT register was completed on

conclusion of the ECT programme. All pre-ECT assessments, including capacity to consent, pre-anaesthetic assessments, anaesthetic risk, and mental state were detailed and placed in the clinical file. All post-ECT assessments, including clinical status and patient progress, were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT were recorded.

The approved centre was compliant with this code of practice.

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

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

Discharge: The discharge policy, which was last reviewed in July 2024, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary covered all aspects of a comprehensive summary in this case, and the discharge summary was sent to the relevant healthcare provider within three days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 08 Residents' Personal Property and Possessions					
Reason ID : 10006221		The registered proprietor did not ensure that provision was made for the safekeeping of all personal property and possessions, as the access to monies was not overseen by two members of staff, 8(6).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Immediately on the day of the inspection, all monies were counted and double signed by 2 staff and all balances were noted to be correct.	All balances were noted to be correct.	Yes. Completed on 16.10.24	16/10/2024	CNM2, ADON
Preventative Action	The introduction of a new signing sheet for the management of resident's monies was introduced to include 3 distinct areas for signing, 2 for staff members and an area for the resident to sign.	Audit to ensure that 2 staff signatures are present on each entry.	Yes	10/11/2024	CNM2, CNM3, ADON, Clerical.

Regulation 22: Premises

Reason ID : 10006222 **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, as ligature points were not minimised to the lowest practicable level, 22(3).**

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Ligature audit to be conducted and specific actions to be agreed from the audit. A. Plan to replace soap, hand towel, and toilet roll with anti-ligature back boards removing up to 219 potential ligature points. B. Door replacement plan replacing 32 doors with ligature reduced version, regarding handles, door closures, vistamatic panels. Removing up to 13 ligature points. C. List of small anti ligature works to be discussed and managed by local maintenance department Removing 8 ligature points. D. En suites bathroom doors to be reviewed and alternative plan to be devised for each en suite door.	YES - the audit will show a reducing number of ligatures.	A) Yes - Budget dependent. 1 trial safe room completed - By end q2 2025. B) Yes - Budget agreed design team and contractor agreed - by end q3 2025. C) Yes - by end of q2 2025 D) Yes - Product availability and budget dependent - by end of 2025.	31/12/2025	A) ADON, Maintenance Manager, General Manager, Estates Manager, CNM3

	Potential removal of up to 41 ligature points.				
Preventative Action	Ligature audit to be conducted yearly and results to be circulated Ligature reduction works to be discussed at ACG monthly and overall number of ligatures and progress to be discussed	yes	Yes - should show a reduced number of ligatures. Timebound is ongoing.	31/12/2025	CNM3
Reason ID : 10006223		Not all hazards were minimised as two fire doors were held open posing a safety issue in the event of a fire, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A) Fire risk discussed with fire officer for HSE. Risk analysis determined that the risk of fire was less than the risks if the doors were permitted to swing freely, Risk was also reduced due to the room use (dayroom) and the doors were not the final point of the fire compartment. Staff are aware of the issue and understand that the area is the vulnerable point in the fire plan. B) Upgrading of the fire panel to allow of	A) Yes – Fire drill with increased frequency ensuring that managers monitor staff awareness of the doors and the vulnerability in the fire plan. B) Yes.	Yes. A) Ongoing until corrective action is complete. B) Completed 01.03.2025	30/09/2025	A) ADON B) ADON, Maintenance Manager C) ADON, Maintenance Manager

	additional requirements and electronic door closures in doors when the fire panel is activated.				
Preventative Action	Continued audit of fire doors by external service provider and audit to be discussed at ACG as a standing item on the agenda.	yes. Continued audit of fire doors by external service provider and audit to be discussed at ACG as a standing item on the agenda.	yes - Timebound is ongoing.	28/04/2026	Maintenance Manager
Reason ID : 10006224		The registered proprietor did not ensure that a programme of routine maintenance was implemented as six bedrooms were in need of painting and reflooring, 22(1)(c).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Tender for painter conducted and painter appointed Business case for painting of 6 bedrooms completed and contractor available. Business care for the replacement of 6 bedroom floors and contractor available.	By end of Q3.	Yes	30/09/2025	ADON, Maintenance Manager, General Manager.
Preventative Action	Monthly walkabout to assess each bedroom for painting and flooring, The Domestic services supervisor should ensure MTA staff document issues on the weekly bedroom	yes. Monthly walkabout to assess each bedroom for painting and flooring. The Domestic services supervisor should ensure MTA staff document issues on the weekly bedroom	yes. Ongoing - monthly	30/04/2026	Domestic Services supervisor, CNM2, CNM3, ADON, Operations Manager.

	record and that these issues are raised with the ADON and at ACG.	record and that these issues are raised with the ADON and at ACG.			
Reason ID : 10006225		The registered proprietor did not ensure that the overall approved centre environment was maintained with due regard to the specific needs of residents and the safety of residents, staff and visitors, as fire doors were wedged open, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A) Fire risk discussed with fire officer for HSE. Risk analysis determined that the risk of fire was less than the risks if the doors were permitted to swing freely, Risk was also reduced due to the room use (dayroom) and the doors were not the final point of the fire compartment. Staff are aware of the issue and understand that the area is the vulnerable point in the fire plan. B) Upgrading of the fire panel to allow of additional requirements and electronic door closures in doors when the fire panel is activated.	Yes – Fire drill with increased frequency ensuring that managers monitor staff awareness of the doors and the vulnerability in the fire plan.	Yes. A) Ongoing until Corrective action is complete. B) Completed 01.03.2025	30/04/2026	A) ADON B) ADON, Maintenance Manager
Preventative Action	Continued audit of fire doors by external service provider and	yes. Continued audit of fire doors by external service	Yes - ongoing.	24/04/2025	Maintenance Manager

	audit to be discussed at ACG as a standing item on the agenda.	provider and audit to be discussed at ACG as a standing item on the agenda.			
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Regulation 26: Staffing

Reason ID : 10006226		The registered proprietor did not ensure that the numbers of nursing staff were appropriate to the assessed needs of residents as staffing numbers were not always maintained at the required levels every day, 26(2).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Nursing management have adopted a proactive approach when managing staffing related issues. All rosters are reviewed in advance and depending on the need identified we utilise overtime, agency and redeployment. These measures are employed to ensure that we have appropriate staffing levels in place to ensure the safety of service users. The planned deployment of resources can enhance the service user experience and ensure a therapeutic environment.	Monthly audits by the Nurse Allocation Officer will allow for analysis that the current approach is meeting the service need.	Yes	01/04/2026	Area DoN
Preventative Action	Nurse management in conjunction with Midlands HR have advertised for Staff Nurses recently including our 2025 Graduates, this	A review of our workforce needs following the current recruitment campaign will allow us plan accordingly.	Yes	01/04/2026	Area DoN

	campaign should result in an increase of staff members available to meet the needs of the service. We have also launched Nursing Grand Rounds in 2024 as a retention strategy while we have committed to taking more undergraduate students in 2025 to meet workforce demands in the future.				
Reason ID : 10006227		The registered proprietor did not ensure that all staff were trained to enable them to provide care and treatment in accordance with best contemporary practice as all staff were not trained in fire safety and basic life support, 26(4).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The HSE was awaiting a national tender for fire training - which was completed in early 2025. An analysis of fire training was conducted with nursing and a decision to provide training each autumn for new nurses to include intern student nurses. All Heads of Discipline are responsible for releasing staff for fire	Yes - An analysis of fire training was conducted with nursing and a decision to provide training each autumn for new nurses to include intern student nurses. Training a standing item on the agenda of Catchment Management Team meetings	A) Yes - Completed sessions of fire training 31.01.2025 B) Yes - Planned Session 22.08.2025	28/08/2025	Nursing Allocations Officer, CNM2, Heads of Discipline.

	training. Training rates attached.				
Preventative Action	Monthly training meeting to discuss compliance rates with all mandatory training for nursing. Training a standing item on the agenda of Catchment Management Team meetings. Training plan available (see attached)	yes - Monthly training meeting to discuss compliance rates with all mandatory training. Training a standing item on the agenda of Catchment Management Team meetings	Yes - ongoing.	28/04/2026	ADON, CNM3, Nursing Allocations Officer, CNM2. Heads of Discipline.

Regulation 32: Risk Management Procedures

Reason ID : 10006228

Not all health and safety risks were documented in the risk register. Two fire doors were wedged open posing a safety risk in the event of a fire.

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A) Fire risk discussed with fire officer for HSE. Risk analysis determined that the risk of fire was less than the risks if the doors were permitted to swing freely, Risk was also reduced due to the room use (dayroom) and the doors were not the final point of the fire compartment. Staff are aware of the issue and understand that the area is the vulnerable point in the fire plan. B) Upgrading of the fire panel to allow of additional requirements and electronic door closures in doors when the fire panel is activated.	Yes - Fire drill with increased frequency ensuring that managers monitor staff awareness of the doors and the vulnerability in the fire plan.	A) Yes – Ongoing until corrective action is complete B) Yes - completed 01.03.2025	28/04/2026	ADON, Maintenance Manager
Preventative Action	Continued audit of fire doors by external service provider and audit to be discussed	Continued audit of fire doors by external service provider and audit to be discussed	Yes - ongoing	30/04/2026	Maintenance Manager

	at ACG as a standing item on the agenda.	at ACG as a standing item on the agenda.			
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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.

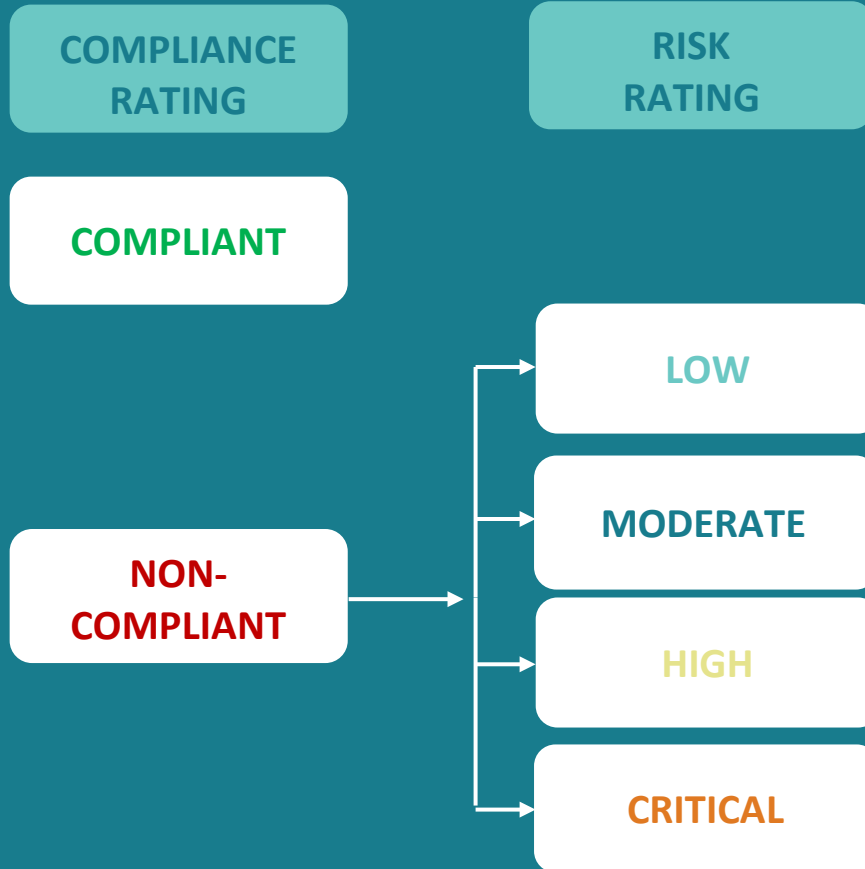
Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed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

