Willow Grove Adolescent Unit, St. Patrick's University Hospital

ID Number: AC0080

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Willow Grove Adolescent Unit
St. Patrick's University Hospital
James's Street
Dublin 8

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
30 April 2016

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan

Registered Proprietor Nominee:
Mr Paul Gilligan

Inspection Team:
Sandra McGrath, Lead Inspector
Dr Enda Dooley, MCRN004155
Orla O'Neill
Barbara Morrissey

Inspection Date:
25 – 27 April 2017

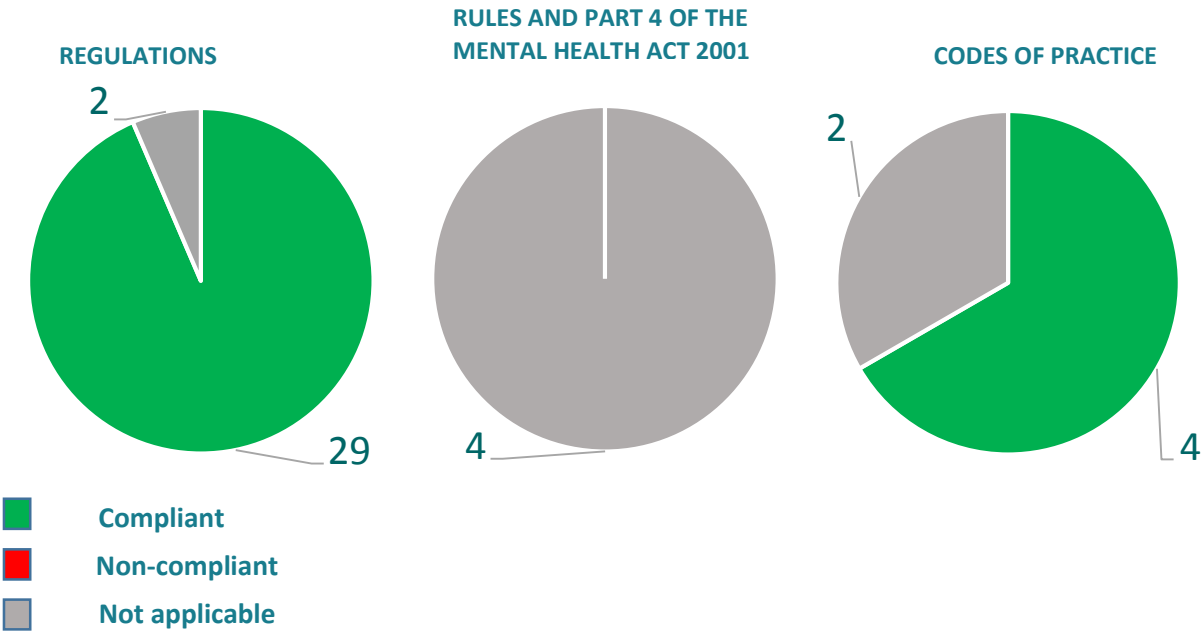
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
20 – 22 September 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
31 August 2017

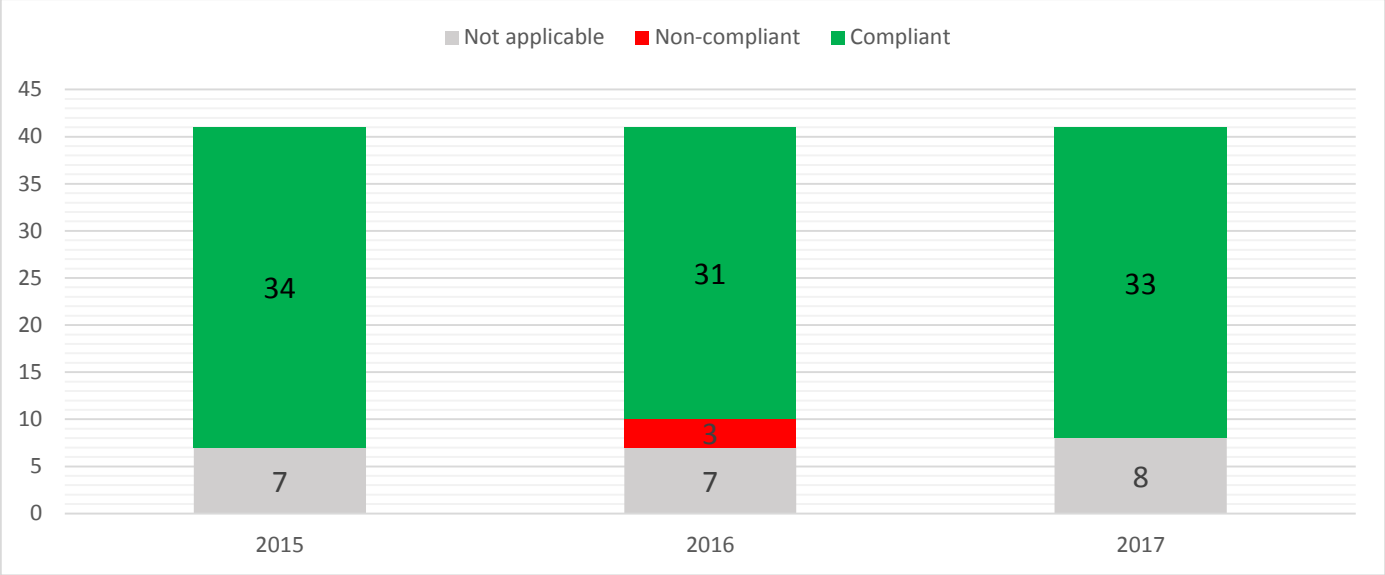
COMPLIANCE RATINGS 2017



RATINGS SUMMARY 2015 – 2017

Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017



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 2015 – 2017

Willow Grove had no areas of non-compliance in 2015 and in 2017 and, therefore, no associated risk ratings for those years.

Contents

1.0 Introduction 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.

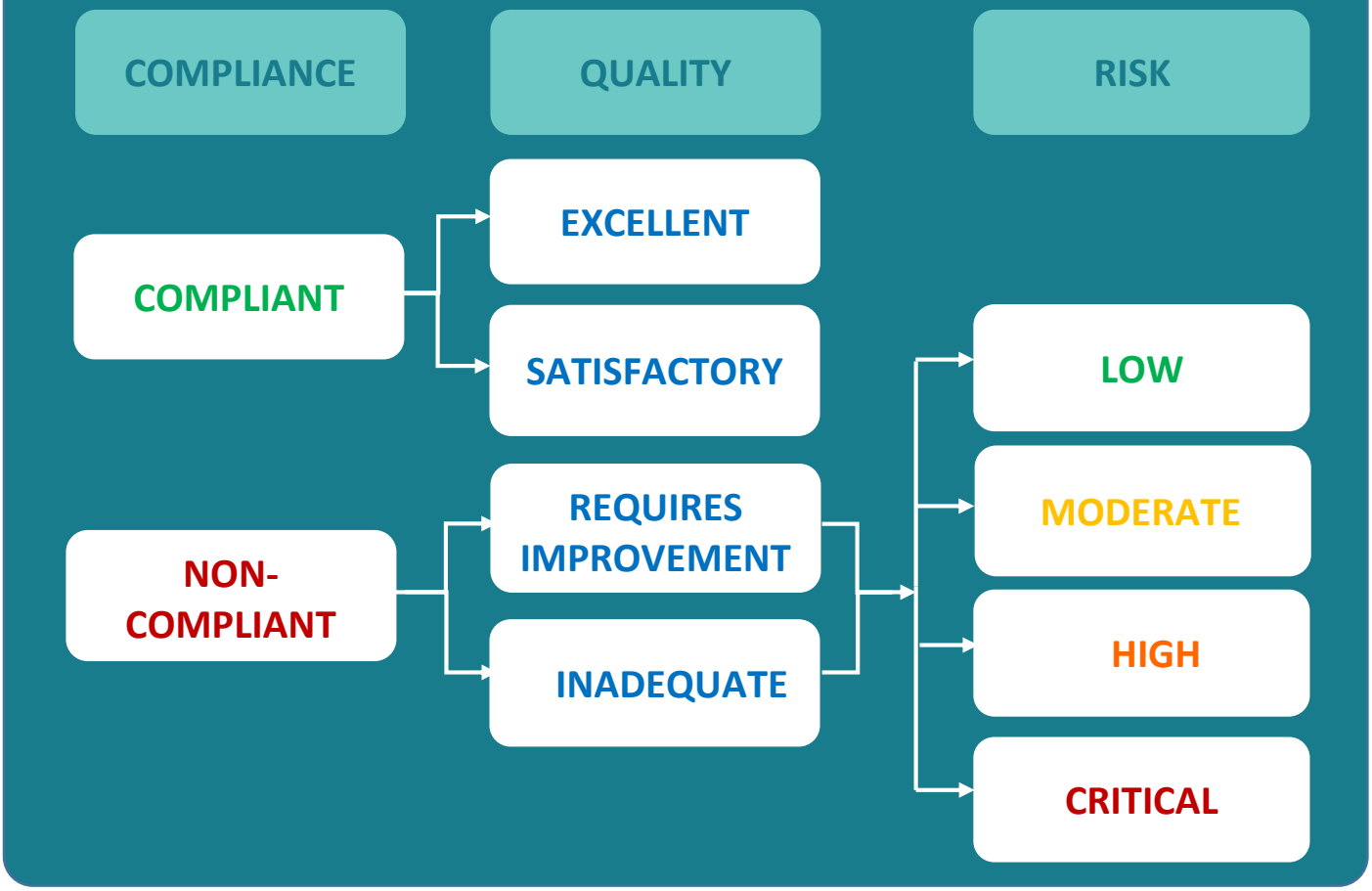
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

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, risk ratings and quality assessments, 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, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected. COMPLIANCE RATINGS are given for all areas inspected. QUALITY RATINGS are given for all regulations, except for 28, 33 and 34. 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, realistic, achievable 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.

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated *Judgement Support Framework*, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

Safety in the approved centre

There was a written policy in place in relation to the health and safety of residents, staff, and visitors. There was also an associated corporate safety statement in place. The Datix system had been fully implemented service-wide to improve the process of incident reporting and to allow for analysis and improvement in relation to safety and risk management. The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Clinical risks were identified, assessed, treated, monitored, and recorded in the risk register. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks and health and safety risks were identified, assessed, treated, reported, and monitored by the approved centre.

A minimum of two resident identifiers appropriate to the resident group profile were used. There were excellent food safety processes in place. Ligature points were minimised and monitored, and individual residents were risk-assessed on an ongoing basis. Ordering, prescribing, storage, and administration of medication was excellent.

The numbers and skill mix of staffing were sufficient to meet resident needs. Staff were trained in accordance with the assessed needs of the resident group profile and of individual residents. All staff had received up-to-date training in fire safety, Basic Life Support, management of violence and aggression, and the Mental Health Act 2001.

AREAS REFERRED TO
Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.

Appropriate care and treatment of residents

Willow Grove is newly involved in the Quality Network for In-patient Child and Adolescent Mental Health Care (QNIC), which sets service standards for child and adolescent in-patient mental health care. Each resident had a multi-disciplinary individual care plan (ICP). All residents had access to their ICPs and were kept informed of any changes. The method by which these changes were communicated was highlighted by residents as they felt unclear at times about their ICPs. The therapeutic services and programmes provided by Willow Grove Adolescent Unit were evidence-based and reflective of good practice guidelines. They were appropriate and met the needs of the residents, as documented in the residents' ICPs. Child residents were assessed in terms of their individual educational requirements. Where appropriate to the needs and age of the child, the education provided by the approved centre was reflective of the required curriculum. Residents received appropriate general health care interventions in line with their ICPs. The approved centre's menus had regular input from and had been reviewed and approved by a dietician to ensure nutritional adequacy in accordance with the residents' dietary needs. All residents' records were secure, up to date, and in good order. The approved centre was compliant with the Codes of Practice relating to Physical Restraint; Admission, Transfer, and Discharge; and Admission of Children to Approved Centres.

AREAS REFERRED TO
Regulations 5, 14, 15, 16, 17, 18, 19, 23, 25, 27, Part 4 of the Mental Health Act 2001, Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Rule Governing the Use of ECT, Code of Practice on Physical Restraint, Code of Practice on the Admission of Children, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, Code of Practice on Admission, Transfer and Discharge, service user experience, and interviews with staff.

Respect for residents' privacy and dignity

There was evidence that there was respect for residents' privacy and dignity throughout. Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs, and they had an adequate supply of individualised clothing. Residents had locked drawers in their bedrooms with fob access and personal lockers. Patient services had secure facilities for cash. Searches were implemented with due regard to the residents' dignity, privacy, and gender. There were clear signs in prominent positions to convey where CCTV cameras were located throughout the approved centre, and residents were monitored solely for the purposes of ensuring their health, safety, and welfare. Monitors were located in the nurses' station and cameras were incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other format.

AREAS REFERRED TO
Regulations 7, 8, 13, 14, 21, 25, Rule Governing the Use of Seclusion, Code of Practice on Physical Restraint, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Responsiveness to residents' needs

The unit itself was bright and well maintained. All bedrooms were single and had en suite toilet and shower facilities. The gym had been upgraded with new equipment and two staff had been trained to support young people in using the gym. There was an advocate specifically for the young people residing in Willow Grove who provided a weekly information meeting. Residents were provided with menus offering a variety of wholesome and nutritious food choices, and hot meals were served daily. Meals were attractively presented. Willow Grove provided access and facilities for recreational activities appropriate to the resident group profile, during the weekdays and at weekends. Residents had opportunities to share their views and contribute ideas to recreational activities development. Residents' rights to practice religion were facilitated within Willow Grove Adolescent Unit insofar as was practicable. Appropriate and reasonable visiting times were publicly displayed throughout Willow Grove, and were detailed in information documentation. Residents could use mail, fax, e-mail, telephone, and the Internet if they wished. Information was supplied about the approved centre, housekeeping arrangements, medication, and diagnosis.

Willow Grove Adolescent Unit was adequately lit, heated, and ventilated. It was clean and hygienic. Sufficient spaces were provided for residents to move about, including outdoor spaces. The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively.

AREAS REFERRED TO
Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Governance of the approved centre

The chief executive officer (CEO) of St. Patrick's Mental Health Services (SPMHS) was the registered proprietor for Willow Grove. There were clear, documented governance structures in place, as indicated in the organisational chart and in minutes of executive team and clinical governance team meetings. The CEO, clinical director, programme manager, director of services, director of nursing, and heads of department for all allied health care professionals were based in St. Patrick's University Hospital, next door. Policy clearly outlined lines of responsibility as appropriate to individual roles, and all staff spoken to were aware of reporting structures specific to Willow Grove.

An appropriately qualified staff member was on duty at all times, and this was documented. All policies were specific to the approved centre, and operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. There was open and regular communication between departments and active participation on executive teams. All disciplines involved in Willow Grove had perspectives represented at senior level, enabling ongoing and appropriate responses to issues that arose. While staff received ongoing formal line management

supervision from their heads of department, clinical supervision for some allied health care professionals was accessed externally. Each person interviewed communicated the same vision for Willow Grove. Reporting structures were clear and fully implemented.

AREAS REFERRED TO
Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The gym had been upgraded with new equipment and two staff had been trained to support young people in using the gym.

2. The service continually reviewed processes to ensure that young people gave ongoing input and feedback on services provided in Willow Grove.

3. The Datix system had been fully implemented service-wide to improve the process of incident reporting and to allow for analysis and improvement in relation to safety and risk management.

4. Willow Grove was newly involved in the Quality Network for In-patient Child and Adolescent Mental Health Care (QNIC), which sets service standards for child and adolescent in-patient mental health care. The staff in Willow Grove engaged in a peer review process in line with QNIC standards, allowing for objective feedback and increasing opportunities to improve service delivery.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Willow Grove Adolescent Unit (WGAU) was located on the grounds of St. Patrick's University Hospital, Dublin, and was part of St. Patrick's Mental Health Services. It was on the ground floor of a three-storey building. Willow Grove had its own entrance and its own staffing, and day-to-day operations were independent of those of the main hospital. The unit had been open for seven years and provided treatment to young people with mental illness between the ages of 12 and 17, from all over the Republic of Ireland. The hospital was accessible by trains from Houston Station, trams, buses, and car.

Willow Grove was a 14-bed unit with 14 young people resident at the time of inspection, ten females and four males. All admissions to WGAU were planned and the criteria for admission were specific. There were adequate facilities and adequate staffing to support the treatment and recovery of young people receiving care and treatment in Willow Grove. All allied health care professionals working in the unit had training and experience specific to child and adolescent mental health.

The unit itself was bright and well maintained. All bedrooms were single and had en suite toilet and shower facilities. There were communal areas with recreational activities for young people to engage in. Residents had access to a fully equipped gym. There was an outdoor garden area and another outdoor area where tennis or football could be played. Young people attended school on-site as appropriate to their needs and their fitness to engage.

All staff involved in the inspection process were clear about, and demonstrated commitment to, their role in Willow Grove.

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

Resident Profile	
Number of registered beds	**14**
Total number of residents	**14**
Number of detained patients	0
Number of Wards of Court	0
Number of children	**14**
Number of residents in the approved centre for more than 6 months	0

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

4.4 Governance

The chief executive officer (CEO) of St. Patrick's Mental Health Services (SPMHS) was the registered proprietor for Willow Grove. There were clear, documented governance structures in place, as indicated in the organisational chart and in minutes of executive team and clinical governance team meetings. The CEO, clinical director, programme manager, director of services, director of nursing, and heads of department for all allied health care professionals were based in St. Patrick's University Hospital. Policy clearly outlined lines of responsibility as appropriate to individual roles, and all staff spoken to were aware of reporting structures specific to Willow Grove. There was documentation throughout the service indicating evidence-based and best contemporary practice appropriate to child and adolescent mental health care.

The Datix system had been launched throughout SPMHS to ensure risk and incident reporting was escalated appropriately. As part of SPMHS, Willow Grove operated under the same governance structures. As a specialised Child and Adolescent Mental Health Services unit, it was noted that there was heavy reliance on the expertise of staff within the unit. There was limited expertise within SPMHS, outside of staffing directly allocated to Willow Grove. There was potential for gaps when these staff moved into other roles, even within SPMHS. Management provided opportunity and supported staff to access further education. A number of allied health care professionals were dual trained. There were both benefits and challenges to this.

Strict admission criteria ensured that Willow Grove operated within capacity, only offering in-patient care to young people whose needs could be met within the environment of Willow Grove and by the therapeutic programmes and services available. This was reflected in the quality and consistency of service that could be provided.

5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 20 – 22 September 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

Regulation/Rule/Act/Code	2017 Inspection Findings
Regulation 27: Maintenance of Records	Compliant
Regulation 31: Complaints Procedures	Compliant
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Compliant

5.2 Non-compliant areas on this inspection

There were no areas of non-compliance identified during this inspection.

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 15: Individual Care Plan
Regulation 16: Therapeutic Services and Programmes
Regulation 17: Children's Education
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 22: Premises
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 25: Use of Closed Circuit Television

Regulation 26: Staffing
Regulation 27: Maintenance of Records
Regulation 29: Operating Policies and Procedures
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

6.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engaged 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.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.

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.

Seven young people met with two inspectors for one hour. A further three questionnaires were completed and returned.

Young people reported an overall positive experience of Willow Grove. A theme regarding communication emerged as young people felt unclear at times about aspects of their care. Examples of this were their individual care plans, as well as leave arrangements and discharge plans. Young people felt that, while they were involved in decision making and planning, they got very short notice of changes.

Ten out of the 14 residents at the time of inspection were from outside of Dublin. In meeting with inspectors, residents commented that they found visiting times difficult when they did not have family/friends coming to see them. They found being away from their families and friends challenging and would like something to do during these times. Some residents reported finding the 30-minute checks policy within Willow Grove intrusive, despite understanding the rationale for this policy. Some residents felt they could not access outside spaces as often as they would like as, due to supervision levels among a child/adolescent population, staff must be present at all times. There were planned outings, which they enjoyed, but staff were not always able to respond immediately to requests to go out into the gardens. The seven young people who met with inspectors reported feeling safe in the approved centre. They felt that staff cared and that it was "more than just a job" to them. The group held their teacher in high esteem. They liked the food during the week more than at the weekend.

There was an advocate employed within St. Patricks Mental Health Services specifically for the young people residing in Willow Grove. The advocate met with the group of residents fortnightly, with additional access as required. Residents were taught to self-advocate and were provided with additional supports from the advocate as required.

7.0 Interviews with Heads of Discipline

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following individuals:

- Chief Executive Officer
- Medical Director
- Programme Manager
- Occupational Therapy Manager
- Consultant Child Psychiatrist
- Director of Psychology
- Head of Social Work
- Assistant Director of Nursing (in place of the Director of Nursing who was on leave)
- Advocate

Having heads of discipline and senior management on-site proved beneficial to Willow Grove. There was open and regular communication between departments and active participation on executive teams. All disciplines involved in Willow Grove had their perspectives represented at senior level, enabling ongoing and appropriate responses to issues that arose. While staff received ongoing formal line management supervision from their heads of department, clinical supervision for some allied health care professionals was accessed externally. Each person interviewed communicated the same vision for Willow Grove. Reporting structures were clear and fully implemented.

8.0 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:

- Chief Executive Officer
- Medical Director
- Director of Services
- Programme Manager
- Consultant Child Psychiatrist
- Occupational Therapy Manager
- Head of Social Work
- Director of Psychology
- Clinic Nurse Manager 3
- Clinic Nurse Manager 2
- Assistant Director of Nursing
- Head of Pharmacy
- Clinical Governance Department representative
- Nurse Practice Development Coordinator

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. There were no corrections or clarifications made by representatives of the service in attendance.

9.0 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

Quality Rating **Excellent**

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

Processes: The approved centre had a policy dated March 2017 on the identification of residents. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on the identification of residents. Relevant staff interviewed were able to articulate the processes for identifying residents within Willow Grove Adolescent Unit.

Monitoring: An annual audit was undertaken to ensure there were appropriate resident identifiers on clinical files. A documented analysis had been completed to identify opportunities for improving resident identification processes.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile were used. The identifiers were detailed within the residents' clinical files and checked before staff administered medications, carried out medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

Willow Grove Adolescent Unit used the name and photograph of each resident as identifiers, and all residents and their families/guardians had given consent to have their photograph taken. The identifiers used were person-specific and did not include room number or physical location. The identifiers were appropriate to the residents' needs and communication abilities. There was an alert stamp in place for residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a policy on food and nutrition, dated June 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on food and nutrition. Relevant staff interviewed – the catering manager and the clinical nurse manager – articulated the processes relating to food and nutrition, as set out in the policy.

Monitoring: A regular review of menu plans was conducted on the basis of service user comment and criticism. The review ensured that residents were provided with wholesome and nutritious food suitable to their needs. A documented analysis was completed to enhance the food and nutrition processes.

Evidence of Implementation: The approved centre's menus had regular input from and had been reviewed and approved by a dietitian to ensure nutritional adequacy in accordance with the residents' dietary needs. Residents were provided with menus offering a variety of wholesome and nutritious food choices, and hot meals were served daily. Meals were attractively presented. Both hot and cold drinks were offered regularly. Residents had adequate supplies of safe and fresh drinking water in easily accessible locations throughout the approved centre.

The needs of residents identified as having special nutritional requirements were reviewed weekly by a dietitian and more frequently when specifically indicated. An evidence-based nutritional assessment tool, the St. Andrew's Nutrition Screening Instrument (SANSI), was used for residents with special dietary needs. Nutritional and dietary needs were assessed, where necessary, and addressed and documented in the residents' individual care plans.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a policy in place on food safety, dated July 2015. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy. The catering manager articulated the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). The training was documented.

Monitoring: Food temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored in the kitchen of each unit. Food safety audits were periodically undertaken, and a documented analysis was completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was appropriate and sufficient catering equipment, crockery, and cutlery to suit the individual needs of residents in Willow Grove Adolescent Unit. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

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

Processes: The approved centre had a written policy, dated March 2017, in relation to residents' clothing. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on residents' clothing. Relevant staff interviewed were able to articulate the processes on residents' clothing, as set out in the policy.

Monitoring: The availability of a supply of emergency clothing was monitored regularly. A record of residents wearing nightclothes during the day was kept, monitored, and documented in the midnight numbers sheet, where relevant.

Evidence of Implementation: No resident was wearing night clothing during daytime hours over the course of the inspection. Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs, and they had an adequate supply of their own individualised clothing.

Residents were provided with emergency personal clothing that was appropriate to them and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. An impressive stock of emergency clothing was kept in the laundry room of the hospital. The emergency clothing included suitable day clothes for young people as well as nightclothes and underwear.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy dated March 2016 relating to residents' personal property and possessions. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on residents' personal property and possessions. Relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were maintained, audited, and monitored in the approved centre. A documented analysis was completed to identify opportunities to improve the processes for managing residents' personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions, as necessary. Residents had locked drawers in their bedrooms with fob access and personal lockers. Patient services had secure facilities for cash.

Willow Grove Adolescent Unit maintained a signed property checklist detailing each resident's personal property and possessions. The property checklist was kept separately from the resident's individual care plan (ICP). Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

Processes: The approved centre had a written policy dated September 2015 in relation to the provision of recreational activities. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on recreational activities. Relevant staff interviewed could articulate the recreational activities processes, as described in the policy.

Monitoring: There was a record of the occurrence of planned recreational activities, including a record of resident uptake and attendance. A documented analysis had been completed to identify opportunities to improve the processes relating to recreational activity.

Evidence of Implementation: Willow Grove Adolescent Unit provided access to recreational activities appropriate to the resident group profile, during the weekdays and at the weekend. Residents had opportunities to share their views and contribute ideas to recreational activities development. Information on recreational activities was in an accessible format via a timetable. In addition, the Willow Grove information booklets for children and their parents were in user-friendly style and provided an account of the recreational activities and facilities provided.

The activities available in the approved centre included gym, gardening, pottery classes, relaxation session in a quiet sensory room, football, basketball, music playing and appreciation, TV, DVDs, game consoles, community outings (e.g. G Quest), zoo facilitated educational and hands-on visits, Dublin Society for the Prevention of Cruelty to Animals visits and educational sessions, table tennis, leisure cookery, and cinema. Communal spaces were available throughout the approved centre, which were suitable for recreational activities. The main communal area had a generous array of games, magazines, books, and soft toys. There were two computers with screened Internet access located in the main unit's lobby area. These could be used by residents at selected times. There was a goldfish tank. Furniture comprised sofas and bean bags, all of which were brightly coloured and age appropriate.

Attendance at recreational activities was documented in each resident's clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a policy dated September 2015 on the facilitation of religious practices. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on religion. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy to support residents' religious practices had been reviewed to ensure that it reflected the identified needs of the residents. This was documented.

Evidence of Implementation: Residents' rights to practice religion were facilitated within Willow Grove Adolescent Unit insofar as was practicable, with facilities available to support their religious practices. There was a multi-faith oratory within the main hospital campus. Residents had access to multi-faith chaplains. Residents were facilitated to observe or abstain from religious practice in accordance with their own free will.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

(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

Processes: Willow Grove Adolescent Unit had a written operational policy, dated September 2015, and protocols in place in relation to visits. The policy and protocols included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on visits. Relevant staff interviewed were able to articulate the processes for visits, as described in the policy.

Monitoring: Restrictions on residents' rights to receive visitors were audited, monitored, and reviewed on an ongoing basis. A documented analysis of the processes relating to visits had been completed.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed throughout Willow Grove Adolescent Unit and were detailed in information documentation.

A separate visitors' room and visiting areas were provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. All visits were risk-rated and supervised by staff.

Children could visit, if accompanied by an adult and supervised at all times. The visiting rooms, spaces, and facilities available in Willow Grove Adolescent Unit were suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

(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 six, up-to-date written operational policies in relation to communication. The policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policies on communication. Relevant staff were able to articulate the processes for communication, as outlined in the policies.

Monitoring: Residents' communication needs and restrictions on communication such as social media were monitored on an ongoing basis and recorded in their clinical files. Analysis had been undertaken to identify opportunities to improve the communication process.

Evidence of Implementation: Residents could use mail, fax, e-mail, telephone, and the Internet if they desired. Only relevant senior staff examined incoming and outgoing resident communication if there was cause to believe the resident or others may be harmed. Both the child and their parent/guardian signed a consent form in relation to computer usage and mobile telephone use in Willow Grove Adolescent Unit.

Fourteen clinical files were inspected in relation to the requirements of this regulation on communication. Willow Grove Adolescent Unit completed individual resident risk assessments, when necessary, in relation to any risks associated with residents' external communications. These were documented in each resident's individual care plan and in risk assessment documentation. The admission assessment included a section on the resident's communication abilities and identified a child's usage of communication media such as Instagram, Facebook, and Snapchat. The clinical files inspected provided a clear account of each child's communication needs: expressive and social skills and their experience and use of social media, especially coping skills in interaction and in relation to any episodes of cyberbullying.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

(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

Processes: There was a written policy, dated March 2017, available in relation to the searching of a resident, his or her belongings, and the environment in which he or she was accommodated. The policy included all of the requirements of the *Judgement Support Framework,* including the following:

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

Training and Education: There was documented evidence that relevant staff had read and understood the policy on searches. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained by the clinical governance department using the Datix incident reporting system. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis was completed to identify opportunities for improvement of the search processes.

Evidence of Implementation: The search policy and procedures were communicated to all residents. Willow Grove Adolescent Unit conducted two environmental searches daily and general written consent from residents and their parents/guardians was sought for this.

There had been one search of a resident's personal property (for a dangerous item) since the last inspection. Risk had been assessed prior to the search, and resident consent was sought and documented. The resident was informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when the search was being conducted.

Searches were implemented with due regard to the resident's dignity, privacy and gender; at least one of the staff members who was conducting the search was the same gender as the resident being searched. A written record of every search of a resident, every property search, and all environmental searches was available (i.e. a record of 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. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 14: Care of the Dying

NOT APPLICABLE

(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

Willow Grove was a Child and Adolescent Mental Health Services unit, where no residents were in receipt of end of life care. This regulation was not applicable.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Excellent**

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

Processes: There was a policy on individual care plans (ICPs) dated March 2017. The policy covered all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all clinical staff had read and understood the policy on individual care planning. All clinical staff interviewed could articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members were trained in individual care planning.

Monitoring: Individual care plans were audited on a quarterly basis to assess compliance with the regulation: 159 clinical files and ICPs were examined, 10 per consultant psychiatrist. Results informed Willow Grove's clinical audit report. Analysis was completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: Each resident had an ICP, 14 of which were inspected. All ICPs were a composite set of documentation detailing goals, treatment, care, and resources required. Reviews were included. The documentation was stored within each resident's clinical file, was identifiable, uninterrupted, and not amalgamated with progress notes.

Each resident had been assessed at admission by the admitting clinician and an ICP was established. The ICPs were then developed by the MDT following a comprehensive assessment, as soon as was possible but within seven days of admission. Evidence-based assessments were used.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs identified appropriate goals, care and treatment, and interventions and specified the resources required to provide the care and treatment identified. The MDTs reviewed ICPs at least weekly. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances, and goals; this was documented.

All residents had access to their ICPs and were kept informed of any changes. The method by which these changes were communicated was highlighted by residents who met with the inspectors because they felt unclear at times about their ICPs. This will be reviewed by the service. Each resident was offered a copy

of their ICP, including any reviews, and this was documented. All ICPs of child residents included their educational requirements.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written policy in relation to therapeutic services and programmes, dated March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all clinical staff had read and understood the policy on therapeutic services and programmes. All clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as described in the policy.

Monitoring: There was evidence of ongoing monitoring of the range of therapeutic services and programmes provided to ensure that they met the assessed needs of residents. The Health of the Nation Outcome Scales for Children and Adolescents were implemented for assessing all residents. A documented analysis was completed to improve the processes relating to therapeutic services and programmes.

Evidence of Implementation: Willow Grove Adolescent Unit provided care and treatment for young persons with mood disorders, anxiety disorders, psychosis, and eating disorders. Fourteen clinical files were inspected. The therapeutic services and programmes provided were evidence-based and reflective of good practice guidelines. They were appropriate to and met the needs of the residents, as documented in their individual care plans (ICPs).

All therapeutic programmes and services in the approved centre were provided by staff trained in accordance with their care delivery roles, and these programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Adequate resources and facilities were available. There was a range of group and individual rooms available for therapeutic interventions and a gym.

A list of therapeutic services and programmes provided within the approved centre was available to residents via a weekly schedule of activities posted up within the unit. A personal copy of the timetable was provided to each resident where required.

Therapeutic services and programmes were provided in a separate dedicated room or in the occupational therapy department. Willow Grove Adolescent Unit had recreational and communal seating areas, a quiet multi-sensory room, a kitchen used for cooking and arts and crafts, a group room, a gym, a garden, and a minibus to transport residents to community-based activities.

Where a resident required a therapeutic service or programme that was not provided internally, such as physiotherapy, Willow Grove Adolescent Unit arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within each resident's clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

INSPECTION FINDINGS

Processes: There was a written policy dated March 2017 in relation to the provision of education to child residents in the approved centre. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Individual providers of educational services on behalf of the approved centre were qualified in line with their role and responsibilities. Relevant staff were appropriately trained in the legislation relating to working with children and their educational needs.

Monitoring: A daily record was kept of the child residents' attendance at internal and external educational services. All 14 children were currently involved in education and all had an educational plan and assessment documented within their clinical file.

Evidence of Implementation: Child residents were assessed in terms of their individual educational requirements, with consideration of their needs and age on admission. Where appropriate to the needs and age of the child, the education provided by the approved centre was reflective of the required curriculum. Attendance by child residents at the educational services of Willow Grove Adolescent Unit was documented, including reasons for non-attendance.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy dated March 2017 in relation to the transfer of residents. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on transfers. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as outlined in the policy.

Monitoring: Operational factors meant that all residents transferred from St. Patrick's Mental Health Services had to be discharged for their period of absence from the service.

Evidence of Implementation: The clinical file of one resident who had been transferred to another facility for treatment was inspected. All relevant information was sent to the receiving facility. The registered medical practitioner had made the decision to transfer, the decision to transfer was agreed with the receiving facility, and an assessment, including a risk assessment, was completed. The resident's family was informed and consent was obtained from them. A copy of the referral letter was retained in the resident's clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had written operational policies and procedures for responding to medical emergencies, dated June 2016, and in relation to general health, dated September 2015. The policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all clinical staff had read the policies on the provision of general health services and for responding to medical emergencies. All clinical staff interviewed were able to articulate the processes for the provision of general health services and for responding to medical emergencies, as outlined in the policies.

Monitoring: Resident take-up of national screening programmes was not applicable to Willow Grove Adolescent Unit as the young residents did not come within the remit of current national screening programmes. There was no current resident in Willow Grove Adolescent Unit for longer than six months, which meant it was too early to have a systematic review to ensure six-monthly reviews of general health needs occurred. A documented analysis was completed to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had an emergency trolley, and staff had access at all times to an Automated External Defibrillator – both were used to respond to medical emergencies. There had been no medical emergency in the approved centre since the last inspection.

Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, but not less than every six months. Physical assessment results and related lab results were documented. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

(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

Processes: There were four, up-to-date written operational policies and procedures available in relation to the provision of information to residents. The policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all staff had read the policies on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents, as outlined in the policies.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure the information was appropriate and accurate, particularly where information changed, such as information on medication and housekeeping practices. A documented analysis was completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: Residents were provided with an information handbook at admission. It contained all necessary information on housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents' rights. In addition, the information booklet contained details of residents' multi-disciplinary teams.

The designated advocate held a once-weekly information and discussion group for residents. Diagnosis-specific information about medications, including potential side-effects, was provided to each resident. Medication information sheets, as well as verbal information, was provided in a format that was appropriate to the residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.

Residents were provided with written and verbal information regarding their diagnosis unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had up-to-date policies in relation to privacy. The policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all staff had read and understood the policies relating to resident privacy. All staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policies.

Monitoring: An annual review was undertaken to check that the policies were being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. This was documented. Analysis was completed to identify opportunities to improve the processes relating to residents' privacy and dignity.

Evidence of Implementation: Staff were observed to be respectful of residents. Young people interacted comfortably with staff. Staff were dressed neatly, and their clothing blended in with the dress code of Willow Grove Adolescent Unit. Residents were dressed appropriately to ensure their privacy and dignity.

All residents had their own single rooms. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

Most rooms were not overlooked by public areas, and windows had curtains but not opaque glass. It was, therefore, possible to see into bedrooms that overlooked an internal garden area, which was also the pathway to the school. Young people were reminded to pull their curtains if getting changed or for further privacy, but it was possible to see into all bedrooms along that path.

Residents were facilitated to make private phone calls and were given mobile phones on admission. Residents could use their bedrooms to make private calls.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.

Regulation 22: Premises

COMPLIANT

Quality Rating **Excellent**

(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

Processes: Willow Grove had four up-to-date written policies in relation to premises. The policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the premises policies. Relevant staff interviewed were able to articulate the processes relating to the maintenance of the premises as mapped out in the policies.

Monitoring: There was documented evidence that a hygiene audit had been completed. A ligature audit was completed and documented. There was documented analysis that identified opportunities for improving the premises.

Evidence of Implementation: Accommodation for each resident in Willow Grove Adolescent Unit assured their comfort and privacy and met their assessed needs. Each resident had a single en suite bedroom. All bedrooms were appropriately sized to match residents' needs. There was a sufficient number of toilets and showers for residents. The approved centre provided appropriately sized communal rooms. Willow Grove Adolescent Unit also had a group room and a visitors' room.

Willow Grove Adolescent Unit was adequately lit, heated, and ventilated. It was clean, hygienic, and free from offensive odours. There was suitable and sufficient heating with a minimum temperature of 18 °C (65°F) in bedroom areas and 21°C (70°F) in day areas and in bedrooms where residents sat during the day. Heating could be safely controlled in each residents' bedroom, in compliance with health and safety guidance and building regulations.

The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including outdoor spaces.

Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised and monitored, and individual residents were risk-assessed on an ongoing basis.

Willow Grove Adolescent Unit was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained.

Remote or isolated areas of Willow Grove Adolescent Unit were monitored, and CCTV was in place.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy dated March 2017 on the ordering, prescribing, storing, and administration of medicines. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all nursing, medical, and pharmacy staff had read and understood the policy. Staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical, and pharmacy staff were trained in reporting medication incidents or near misses, and documented evidence of training was provided.

Monitoring: Quarterly audits had been conducted on residents' Medication Prescription and Administration Records (MPARs). Incident reports were recorded for medication errors and near misses. Analysis was completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, and 12 MPARs were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: resident identifiers, medications administered, route of medication, dose of medication, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases. A record was kept when medication was refused by or withheld from a resident.

All medication was administered by a registered nurse or registered medical professional. Controlled drugs were checked by two staff members prior to administration. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications.

Medication arriving from the pharmacist was verified against the order by a nurse to ensure it was correct and was accompanied by appropriate directions for use. Medication dispensed or supplied to the resident was stored securely in a locked unit or fridge, where appropriate. The medication trolley remained locked at all times and secured in a locked room.

Medication was appropriately stored, and medication storage areas were clean and tidy. Refrigerators used for medication were used only for this purpose and a log was maintained of the temperature. An

inventory of medications was kept by the pharmacist, and unused or expired medication was returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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

Processes: There was a written policy in place dated January 2017 in relation to the health and safety of residents, staff, and visitors. There was also an associated corporate safety statement in place. The policy and safety statement included requirements of the *Judgement Support Framework,* with the exception of staff training requirements in relation to health and safety.

Training and Education: There was documented evidence that all staff had read and understood the health and safety policy and safety statement. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy and safety statement.

Monitoring: The health and safety policies were monitored pursuant to Regulation 29: Operational Policies and Procedures.

Evidence of Implementation: This regulation was only assessed against the approved centre's written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Excellent**

(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

Processes: There were policies and procedures in Willow Grove on the use of CCTV. The CCTV policy was dated September 2015. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that relevant staff had read and understood the policy on CCTV. Relevant staff interviewed were able to articulate the processes relating to the use of CCTV, as set out in the policy.

Monitoring: The quality of CCTV images was checked regularly to ensure the system was operating appropriately, and this was documented. An audit and analysis had been completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions, indicating where CCTV cameras were located throughout the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The Mental Health Commission had been informed about the approved centre's use of CCTV. Monitors were located in the nurses' station. Cameras were incapable of recording or storing a resident's image on a tape, disc, or hard drive, or in any other format. CCTV cameras used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 26: Staffing

COMPLIANT

Quality Rating **Excellent**

(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

Processes: Willow Grove Adolescent Unit had a number of staffing policies, which were all reviewed within the required three-year time frame. Combined, the policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all relevant staff had read and understood the staffing policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

Monitoring: The implementation and effectiveness of the staff training plan was reviewed and documented on an annual basis. The numbers and skill mix of staff were reviewed against the levels recorded in the approved centre's registration, which resulted in a 100% match. Analysis was completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place. An appropriately qualified staff member was on duty at all times, and this was documented. All staff were Garda vetted, and the numbers and skill mix of staffing were sufficient to meet resident needs.

Willow Grove was a Child and Adolescent Mental Health Services unit. Staff were trained in accordance with the assessed needs of the resident group profile and of individual residents, and this was detailed in the staff training plan. All staff had received up-to-date training in fire safety, Basic Life Support, management of violence and aggression (e.g. Therapeutic Crisis Intervention/Professional Management of Aggression and Violence), and the Mental Health Act 2001. All staff training was documented.

The Mental Health Act 2001 and Mental Health Commission (MHC) rules and codes and all other MHC documentation and guidance were made available to staff throughout the approved centre.

The following is a table of clinical staff assigned to the approved centre.

Ward or Unit	*Staff Grade*	*Day*	*Night*
Willow Grove	ADON	1	On call
	CNM3	1	0
	CNM2	1	0
	CNM1	1	0
	RPN	6 morning 5 evening	3
	Consultant Psychiatrists	1 WTE 2 X 0.5 WTE (current 0.5 vacancy in the process of being filled)	On call (registrar)
	Occupational Therapists	1	
	Psychologists	1	
	Cognitive Behavioural Therapist	1	
	Advanced Nurse Practitioner	1	
	Social Worker	1	

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Assistant Director Of Nursing (ADON)

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy dated June 2016 in relation to the maintenance of records. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all clinical staff and other relevant staff had read and understood the policy relating to the maintenance of records. All clinical staff and other relevant staff interviewed articulated the processes for the creation of, access to, retention of, and destruction of records, as described in the policy. All clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. Analysis was completed to identify opportunities to improve the maintenance of records process.

Evidence of Implementation: All residents' records were secure, up to date, in good order, and constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and the national guidelines and legislative requirements. Resident records were reflective of the residents' current status and the care and treatment being provided. Records were maintained through the use of an identifier that was unique to the resident.

Resident records were developed and maintained in a logical sequence. The records were maintained appropriately, in good order, and with no loose pages. Entries were factual, consistent, and accurate and each recorded the date and time using the 24-hour clock. Hand-written records were legible and written in black ink. Records were appropriately secured throughout the approved centre from loss or destruction, tampering, and unauthorised access or use. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

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

Willow Grove Adolescent Unit had an up-to-date register of residents. It was available to the Mental Health Commission on inspection. The register included all of the information specified 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

Quality Rating **Excellent**

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

Processes: The approved centre had two up-to-date written policies in relation to the development, management, and review of operating policies and procedures. The policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was documented evidence that all relevant staff had read and understood the policies on developing and reviewing operating policies. Relevant staff were trained on approved operational policies and procedures. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policies.

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis of operating policies and procedures was conducted to identify opportunities to improve the processes for developing and reviewing policies.

Evidence of Implementation: All policies were specific to the approved centre because Willow Grove Adolescent Unit had not adopted any generic policies. Willow Grove Adolescent Unit's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff.

All operating policies and procedures required by the regulations were reviewed within three years.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework.*

Regulation 30: Mental Health Tribunals

NOT APPLICABLE

(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

Willow Grove was a Child and Adolescent Mental Health Services unit and did not have any involuntary patients. Therefore, this regulation did not apply.

Regulation 31: Complaints Procedure

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy dated March 2017 in relation to the management of complaints. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff were trained in the complaints management process during induction. There was documented evidence that all staff had read and understood the policy on complaints. Staff interviewed articulated the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: An audit of the complaints log and related records was completed, with findings documented and acted upon. Complaints data were analysed, discussed, and considered by senior management, with required actions identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person, the complaints officer, who was responsible for dealing with all complaints and was available to Willow Grove Adolescent Unit. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. Residents were provided with the complaints policy and procedure, in an information booklet at admission or soon thereafter.

The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint can be made.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Receipt of complaints was acknowledged within five days. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made.

Minor complaints were dealt with and recorded at unit level. All escalated complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

(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

Processes: Willow Grove had in excess of 20 policies on risk management. These were up to date and comprehensive and had been reviewed within the required three-year time frame. The policies included all of the requirements of the *Judgement Support Framework* and all of the policy-related regulatory requirements.

Training and Education: Relevant staff were trained in the identification, assessment, and management of risk. Staff were trained in health and safety risk management. Clinical staff were trained in individual risk management processes. Management staff were trained in organisational risk management. All staff were trained in incident reporting and documentation. Staff had read and understood the risk management policy. All training was documented.

Monitoring: The risk register was audited on a quarterly basis. All incidents in the approved centre were recorded and risk-rated on the Datix system and software.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable.

Clinical risks were identified, assessed, treated, monitored, and recorded in the risk register. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks and health and

safety risks were identified, assessed, treated, reported, and monitored by the approved centre. Corporate risks were documented in a risk register.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by members of the multi-disciplinary team at their regular meeting. A six-monthly summary of incidents was provided to the Mental Health Commission, in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level.

There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures. The requirements for the protection of children and vulnerable adults in Willow Grove Adolescent Unit were appropriate and implemented as required.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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 had up-to-date insurance. It indicated that coverage was provided for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

There was an up-to-date certificate of registration displayed in a prominent position, in the entrance hallway of Willow Grove Adolescent Unit.

The approved centre was compliant with this regulation.

10.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

NOT APPLICABLE

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also 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.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

As Electro-Convulsive Therapy was not used in Willow Grove Adolescent Unit, this rule was not applicable.

Section 69: The Use of Seclusion

NOT APPLICABLE

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

As seclusion was not used in Willow Grove Adolescent Unit, this rule was not applicable.

Section 69: The Use of Mechanical Restraint

NOT APPLICABLE

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

As mechanical means of bodily restraint were not used in Willow Grove Adolescent Unit, this rule was not applicable.

11.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NOT APPLICABLE

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

As there were no involuntary patients registered as residents of Willow Grove Adolescent Unit, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

12.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint and a separate written policy and procedures for training staff. The policies included relevant elements of the code of practice.

Training and Education: Willow Grove Adolescent Unit maintained a written record indicating that all staff involved in physical restraint had read and understood the policy. A record of training was maintained.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

As no physical restraint had been used in Willow Grove Adolescent Unit since the last inspection, only the processes and training and education pillars were assessed.

The approved centre was compliant with this code of practice.

Admission of Children

COMPLIANT

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: Willow Grove Adolescent Unit had policies and protocols in place in relation to the admission of a child, including a policy requiring each child to be individually risk assessed. Policies and procedures were in place with regard to family liaison, parental consent, and confidentiality.

Training and Education: All staff had received up-to-date Children First training. Staff were trained in child and adolescent mental health.

Monitoring: An audit was undertaken to monitor the admission of children processes.

Evidence of Implementation: Willow Grove was a Child and Adolescent Mental Health Services unit. Age-appropriate facilities and a programme of activities appropriate to age and ability were provided. Provisions were in place to ensure the safety of the child. The children had access to age-appropriate advocacy services. All children were given information on their rights and were provided with the *Headspace Toolkit* information booklet.

In relation to child protection issues, staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated and was arranged according to age and gender, including sleeping arrangements and bathroom areas. Staff were gender sensitive.

The educational needs of each child were met. Appropriate visiting times for families, including children, were available. Consent for treatment was obtained from at least one parent.

The approved centre was compliant with this code of practice.

Notification of Deaths and Incident Reporting

COMPLIANT

Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: There was a risk management policy in place, which covered the notification of deaths and incident reporting to the Mental Health Commission (MHC). The policy included all of the criteria of this code of practice.

Training and Education: All staff had read and understood the policy on the notification of deaths and incidents and this was documented. Staff interviewed articulated the policy requirements.

Monitoring: Deaths and incidents were reviewed to identify and correct any problems and improve the quality of processes. There had been no deaths in the approved centre since the last inspection.

Evidence of Implementation: The approved centre was compliant with Article 32 of the regulations. There was an incident reporting system in place (Datix), and a standardised incident report form was used and made available to inspectors. A six-monthly summary of all incidents was provided to the MHC.

The approved centre was compliant with this code of practice.

Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

NOT APPLICABLE

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

As there were no residents documented as having an intellectual disability in Willow Grove Adolescent Unit, this code of practice was not applicable.

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

NOT APPLICABLE

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

As Electro-Convulsive Therapy was not used in the approved centre, this code of practice was not applicable.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: There were written and up-to-date admission, transfer, and discharge policies in place. The policies included all of the items of this code of practice.

Training and Education: There was documented evidence that all staff had read and understood the policies on admissions, transfer, and discharge in the approved centre.

Monitoring: An audit was undertaken to monitor the admission and transfer processes.

Evidence of Implementation:

Admission: The approved centre complied with the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Residents' Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, Regulation 27: Maintenance of Records, and Regulation 32: Risk Management Procedures.

The clinical files of two residents were inspected against in relation to the admission process. Each resident was assigned a key worker. The admission assessment was comprehensive in each case. All assessments and examinations were documented within both clinical files inspected. A family member/carer/advocate was involved in the admission process (with the residents' consent).

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. Transfers under the code of practice were deemed not applicable because residents were discharged for the period of absence from the approved centre.

Discharge: The clinical files of two residents who had been discharged were inspected. The decision to discharge was made by a registered medical practitioner. A discharge plan was in place and documented as part of the residents' individual care plans. Each resident underwent a comprehensive assessment prior to being discharged. A comprehensive discharge summary was issued within 14 days.

The approved centre was compliant with this code of practice.