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Coimisiún Meabhair-Shláinte | Mental Health Commission

Eist Linn Child & Adolescent In-patient Unit

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

EIST LINN CHILD & ADOLESCENT IN-PATIENT UNIT

Eist Linn Child & Adolescent In-patient Unit, Bessborough, Blackrock, Cork

Date of Publication:
Friday 29 January 2021

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2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
22 December 2019

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Morrison, General Manager, Mental Health Services – Cork Kerry Community Healthcare

Inspection Team:
Mary Connellan, Lead Inspector
Susan O'Neill

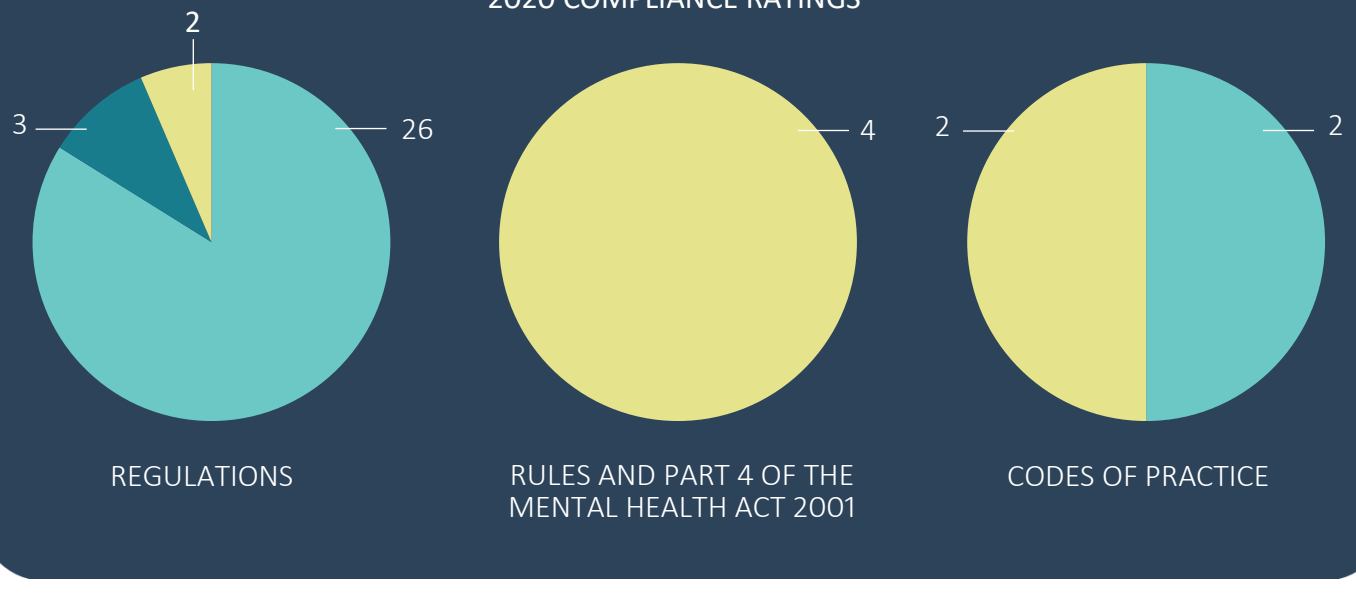
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
15 – 18 September 2020

Previous Inspection Date:
12 – 14 February 2019

Inspection Type:
Announced Annual Inspection

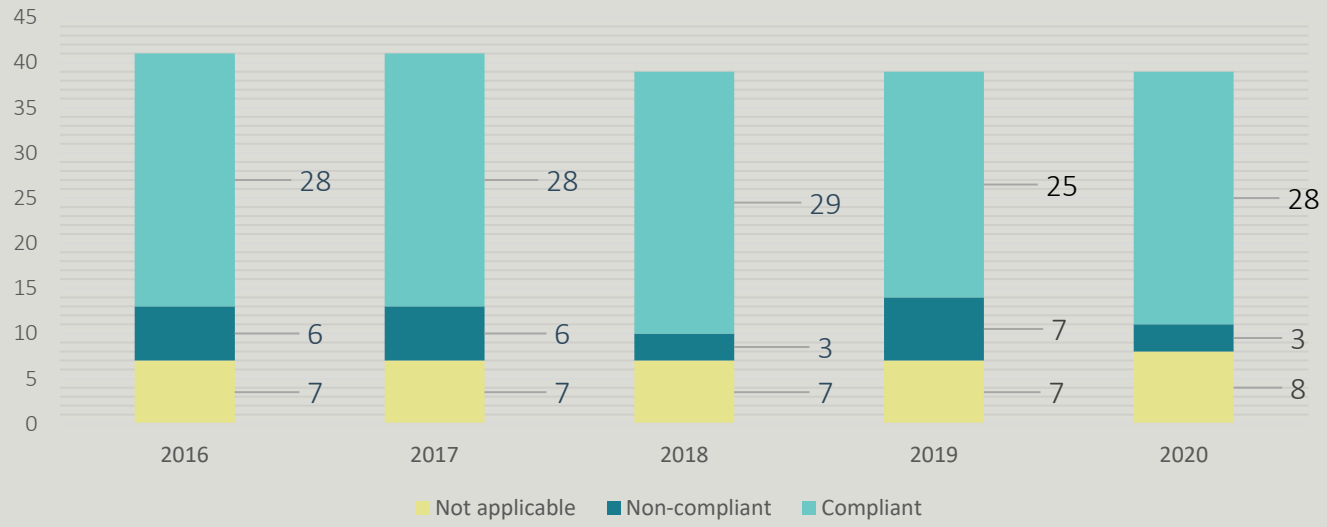
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

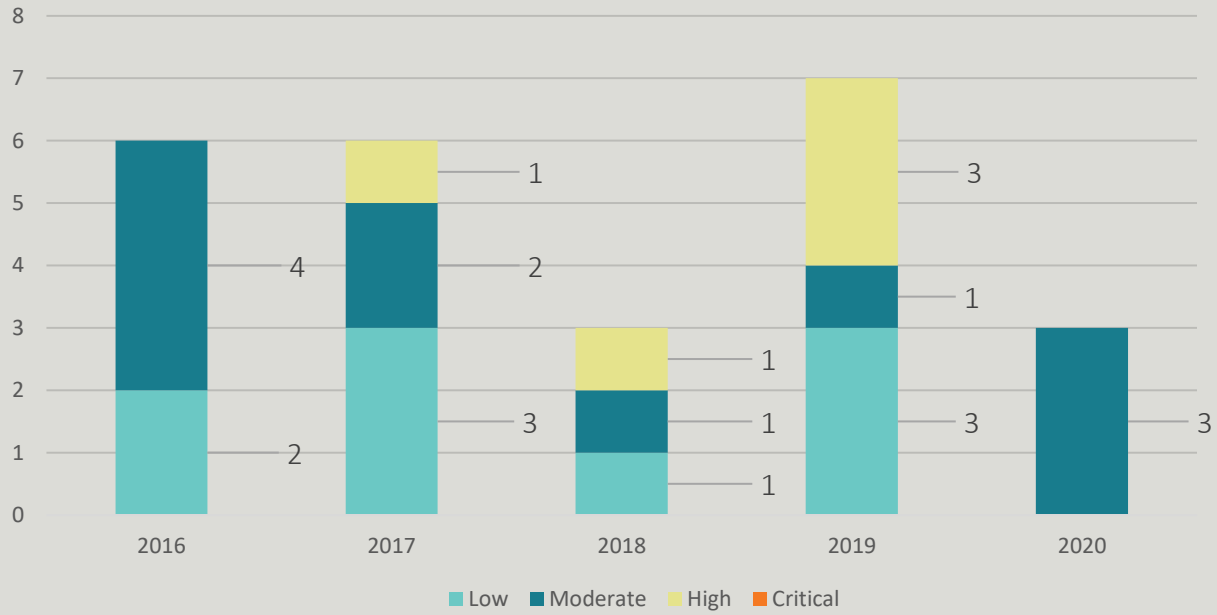
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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 2016 – 2020



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with regulations rules and codes of practice.

In line with Public Health guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with regulations, rules and codes of practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

Eist Linn Child & Adolescent In-patient unit one of four national in-patient child and adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry and Cork. Seventeen community child and adolescent teams referred into the approved centre, nine from Cork and Kerry to include the Eating Disorder team, and eight from the remaining counties. Registered bed numbers had been reduced to 16 since the previous inspection.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	82%	82%	91%	78%	90%
Regulations Rated Excellent	0	2	8	9	N/A

Conditions to registration

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

Condition 1: *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 1.

Safety in the approved centre

- The ordering, prescription, storage and administration of medication was compliant with the relevant regulation.
- Kitchen areas were clean and food was stored in a safe manner.
- Works were ongoing to minimise ligature anchor points.
- Hazards were reduced to a minimal level.

Appropriate care and treatment of residents

- Each young person had an individual care plan (ICP).
- The therapeutic services provided by the approved centre were evidence-based. Therapeutic services were provided in a separate, dedicated room containing facilities and space for individual and group therapies.
- Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Records were available demonstrating residents' completed general health checks and associated results.
- Refurbishment works commenced since the last inspection were nearing completion. These comprised of an extra care self-contained suite named *Suimhneas.* This included one en suite bedroom, a de-escalation room, living and dining space and an elevated enclosed outdoor space.

However:

- The ICPs did not identify appropriate goals for two of the five resident files reviewed. An example of a poor goal was *"observe in group".* It was noted that the goals identified did not always carry over from week to week; they were included one week, not documented the next week, but included again the subsequent week.

Respect for residents' privacy, dignity and autonomy

- Searches were only conducted for the purpose of maintaining a safe and therapeutic environment for residents and staff. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. Each resident's consent was sought and documented prior to a search and there was due regard to each resident's dignity, privacy and gender.
- All bedrooms were single with en suite facilities. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. Shared bathrooms were lockable and these locks had an override function for safety reasons.
- Seclusion was not used in Eist Linn.
- Visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private.
- The approved centre was clean.

However:

- The approved centre did not have a programme of decorative maintenance. Not all bedrooms had been maintained in good decorative condition and the couches in the day and night sitting rooms were worn and scuffed.
- En suite bathrooms did not have functioning locks for resident use. This was highlighted in the 2019 annual inspection. Toilets in the general area were kept locked and residents had to request that they be opened when required.
- Resident records were maintained in good order as a number of records contained loose pages, which was a potential confidentiality breach.

Responsiveness to residents' needs

- Residents were provided with wholesome and nutritious food in line with their needs and residents had at least two choices for meals every day.
- The approved centre provided access to recreational activities on weekdays and during the weekend. Opportunities were available for indoor and outdoor exercise and physical activity. The approved centre had a computer room, pool room, art room, and TV rooms upstairs and downstairs.
- The approved centre had a dedicated school in the approved centre. Child residents were assessed in terms of their individual educational requirements.
- Residents were provided with an information booklet on admission. Residents were provided with written and verbal information on diagnosis and medication in a format appropriate to the resident needs.
- There was a comprehensive complaints procedure in the approved centre.
- A board named '*You said we did*' aimed at providing visual feedback to suggestions made in the approved centre was placed alongside the suggestion box. This initiative was to show young people clearly how suggestions made by them were actioned.

Governance of the approved centre

- The approved centre was under the governance and management of the Cork Mental Health Area Management Team which reported to the Cork and Kerry Community Healthcare Organisation (CHO 4). There were two executive management teams, one for each county.
- There were separate and regular COVID-19 management meetings since the onset of the pandemic. In line with wider Cork Mental Health Services, there was a well-developed and proactive COVID-19 preparedness plan. Staff representatives were members of the wider COVID-19 management team.
- Risk Management processes were evident in the approved centre. There was a local risk management and health and safety committee. The risk register had been reviewed at least quarterly and risks were added and escalated as appropriate.
- An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.
- The voice of the service user was sought by the staff of Eist Linn from the *"Fred the Frog"* suggestion box, and community meetings held in the approved centre.

However:

- The approved centre's local business meeting had not taken place since February 2020 and only two meetings were documented for the year 2019, despite a schedule of meetings.
- While the Area Lead for Mental Health Engagement was a member of the Cork Mental Health Management Team, this role did not involve working specifically with the CAMHS inpatient service.
- A Youth Advocacy Programme (YAP), available in other child and adolescent services, was not offered in Eist Linn.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The development of a new care suite known as *Suimhneas* was almost completed. This will provide an expansive space for a young person to be cared for in a single setting. This included a de-escalation room, single bedroom with en suite and living and dining facilities. There was an elevated external outdoor space and a sensory room. The sensory room by its location could be used by all young people in the approved centre, with staff support.

2. An overview and analysis of all the audits that had been conducted in the approved centre had been completed in June 2020.

3. A 'ReSet' day for nursing staff had been planned and facilitated. This initiative enabled nursing staff to look at self-care, group supervision, the nursing milieu and strategies to prevent burnout. A workshop in Trauma Informed Care (TIC) was also presented.

4. An alternative version of the Make Every Contact Count (MECC) programme was developed and piloted in the approved centre. Specifically for those aged under 18 years of age, it was also developed as an aid for frontline healthcare professionals to start a conversation with young people which may lead to an early intervention in the positive management of a physical, mental, emotional or social health change.

5. A process was developed in the approved centre to minimize error and ensure consistent resident identifiers on documentation. When collected data regarding name, age, and other specific identifiers at admission was inserted into a dialogue box, this then replicated into allocated spaces throughout the clinical documentation.

6. A staff Health and Wellbeing committee had been established within the approved centre.

7. A board named 'You *said we did*' aimed at providing visual feedback to suggestions made in the approved centre was placed alongside the suggestion box. This initiative was to show young people clearly how suggestions made by them were actioned.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Eist Linn Child & Adolescent In-patient unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. It was one of four national in-patient child and adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry and Cork. Seventeen community child and adolescent teams referred into the approved centre, nine from Cork and Kerry to include the CARED Eating Disorder team, and eight from the remaining counties. On the first day of inspection there were 9 children in the approved centre from counties Cork, Kerry and Tipperary. One child had been in the approved centre longer than six months. Registered bed numbers had been reduced to 16 since the previous inspection.

Refurbishment works commenced since the last inspection were nearing completion. These comprised of a low stimulus self-contained suite named *Suimhneas.* This included one en suite bedroom, a de-escalation room, living and dining space and an elevated enclosed outdoor space. There was a sensory room that could be accessed both from *Suimhneas* and the main upstairs accommodation area. As well as the single en suite room in *Suimhneas,* there were 15 single en suite bedrooms located on the upper floor. There was a TV room/lounge that was small for the numbers it was anticipated to accommodate, and the couch was in need of re-upholstery or replacement.

The lower floor comprised of day activities, group rooms, television/sitting rooms, dining room with a servery kitchen and staff offices. There was a pool room that had been redecorated and a small computer room with three PC's for young people's use under staff supervision. There was a school located across two internal gardens with classrooms, an activity kitchen and an expansive gym hall. A smaller gym had been developed with a treadmill, cross-trainer and fixed bicycle. Along with a number of identified visiting rooms there was a parent's flat with sleeping accommodation. At the time of inspection, this was used for day visiting due to COVID-19 restrictions. An office in the main reception area had also been redeployed as a visiting space, where visitors did not come directly into the approved centre.

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**9**
Number of detained patients	0
Number of wards of court	0
Number of children	9
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the governance and management of the Cork and Kerry Community Health Care Organisation. There were two executive management teams, one for each county. The approved centre was under the governance and management of the Cork Mental Health Area Management Team. Meeting monthly, agenda items included Compliance, Service Planning and Finance, Quality Patient Safety (QPS), Complaints and Compliments, Delayed Discharges and Mental Health Engagement. COVID-19 was now a standing item on the agenda, although there were separate and regular COVID-19 management meetings since the onset of the pandemic. There were also quarterly standalone QPS meetings.

The approved centre's local business meeting had not taken place since February 2020 and only two meetings were documented for the year 2019. While there was a plan, scheduled meetings had not taken place, however a number of these were for dates during COVID-19 management and restrictions. Local committees included a policy review group and an audit group.

Risk Management processes were evident in the approved centre. There was a local risk management and health and safety committee. The risk register had been reviewed at least quarterly and risks were added and escalated as appropriate. The person with responsibility for risk was identified and known by staff. The multi-disciplinary team were involved in risk management and a risk review meeting was held at least once weekly.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The authority and responsibility of line managers for the various disciplines were clear. Appropriate staffing resources were available to meet the needs of residents. There was only one nursing vacancy at the time of inspection and shortages were managed through overtime. Maternity cover had not been replaced amongst the allied health professional group. However, the resident numbers had not been at maximum capacity and it was considered that this had not impacted negatively on the care and treatment provided. For a short period during the summer when the school was closed and COVID-19 restrictions were in place, there were two occupational therapists; this was noted by a number of staff as very positive and beneficial to the young people.

While the Area Lead for Mental Health Engagement was a member of the Cork Mental Health Management Team, this role did not involve working with the young people or their families. A Youth Advocacy Programme (YAP) available in other child and adolescent services, was not offered in Eist Linn. The voice of the service user was sought by staff of Eist Linn from *"Fred the Frog"* suggestion box and community meetings held in the approved centre. A review of the community meetings minutes and requests from these meetings had been completed by a staff member in Eist Linn.

In line with wider Cork Mental Health Services there was a well-developed and proactive COVID-19 preparedness plan. Staff representatives were members of the wider COVID-19 management team. Information was disseminated to the staff in Eist Linn. Where formerly Multi-Disciplinary Team (MDT) members attended Individual Care Plan (ICP) and other meetings collectively, the impact of COVID-19 meant that new ways of working were required. Virtual attendance through technological solutions such as teleconferencing had been adopted. Direct one to one and group work provided by staff from within the

team in the approved centre had resumed and for the greater part had not been impacted during the initial phases of the pandemic. Activities such as art therapy, yoga, and dog therapy had ceased as these had been provided by external facilitators.

3.3 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.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 15: Individual Care Plan	✓		✓		✓		✗	Low	✗	Moderate
Regulation 21: Privacy	✓		✓		✓		✗	Low	✗	Moderate
Regulation 22: Premises	✓		✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 25: Use of Closed Circuit Television	As CCTV was used in the reception area (and for security purposes only), this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent facility, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre. As this was a service for young people, staff were informed that the inspection team were available to meet with any young person or their families if they wished.
- As this was an approved centre for children and adolescents, the Irish Advocacy Network (IAN) did not visit. There was no Youth Advocacy Programme available at the time of inspection.

Eight completed service-user questionnaires were returned. Six young people ticked to indicate that on admission to the approved centre a member of staff had explained what was happening in a way that was understood. The remaining two indicated 'no' to this question. Three respondents indicated that staff 'always' gave information regarding diagnosis and care and treatment, in a way that was understood. Three indicated 'sometimes' for this question and one indicated 'never'. The remaining one indicated that they did not want information.

Six completed questionnaires indicated that the young person knew who their multi-disciplinary team members were, with three of the eight indicating that they were 'always' involved in setting goals for their individual care plan. All remaining five stated 'sometimes' involved, one of whom indicated that this was by choice. Seven questionnaires indicated that the young person understood their individual care plan with the remaining one indicating 'no' for this question. Seven of eight young people stated that they knew who their keyworker was, with one young person commenting that the 'keyworker changes during the week'. This related to nursing keyworkers and which was more in practice with primary nursing. There was no keyworking within the wider Multi-Disciplinary Team (MDT).

Four young people indicated that they always felt able to discuss their worries or concerns with a staff member with the remaining four indicating 'sometimes'. All eight indicated that they were happy with how staff talked to them. Similarly, all the respondents felt that there were enough activities during the day. Four indicated that they had space for privacy and that their privacy and dignity was respected. Seven young people ticked that they 'always' felt safe in the approved centre, and the one remaining indicated 'sometimes' for this question.

On a scale of 1-10, with 1 being poor and 10 being excellent, one young person rated 9 out of ten for overall care and treatment, two residents rated 8 and two rated 7. The remaining three rated 6, 5 and 3 respectively.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Registered Proprietor Nominee and Acting Head of Service
- Business Manager
- Clinical Director
- Consultant Child and Adolescent Psychiatrist
- Interim Area Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Clinical Nurse Specialist
- Principal Teacher
- Occupational Therapy Manager
- Principal Social Worker

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals and a source of safe, fresh drinking water was available at all times in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Food was cooked off site and transferred to the approved centre in insulated boxes. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs. The dining room was configured to facilitate social distancing.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with emergency personal clothing, if required, that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. No residents wore nightclothes during the day as indicated by their individual care plan.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions, which was last reviewed in July 2019. An addendum to the policy in relation to COVID-19 had been added in July 2020.

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

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile, including self-directed activities, such as board games, pool table, books, computers and TV. The approved centre also facilitated structured recreational activities on weekdays and during the weekend. These included arts and crafts, cooking and baking, walks and gym, and planned outings.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits, which was last reviewed in January 2020. An addendum to the policy in relation to COVID-19 had been added in July 2020.

At the time of the inspection, visits to the approved centre were curtailed and in line with the approved centres policies and infection control measures. Reasonable times were identified during which a resident could receive visits and reasonable steps had been taken to ensure the safety of residents and visitors. A number of separate visiting rooms had been identified and the parents flat was also used as a visiting space. These were suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication, which was last reviewed in July 2018. An addendum to the policy in relation to COVID -19 had been added in July 2020.

Residents had access to a phone and internet (with supervision) unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Three tablets had also been acquired to facilitate further communication with family members during COVID-19 pandemic.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches, which was last reviewed in October 2017. It included all requirements related to:

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

Risk was assessed prior to the search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches and the request for consent and the received consent were documented for every search. The resident search policy and procedure was communicated to all residents and relevant staff were documented to have read and understood the policy on searches.

Residents were 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 searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who

was in attendance for the search. The clinical file of one resident was examined on inspection in relation to the search process.

Policy requirements were implemented when illicit substances were found as a result of a search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying, which was last reviewed in April 2019.

No deaths had occurred in the approved centre since the previous inspection and no end of life care was provided.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs did not identify appropriate goals for two of the five resident files reviewed. An example of a poor goal was "observe in group". It was noted that the goals identified did not always carry over from week to week; they were included one week, not documented the next week but included again the subsequent week. The care and treatment required to meet the goals was identified, including the frequency and responsibilities for implementing the care and treatment. The resources required to provide the care and treatment were identified. The ICPs were reviewed by the MDT weekly, in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. Educational requirements were included.

The approved centre was non-compliant with this regulation because not all ICP's identified appropriate goals for the resident.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

Therapeutic activities, one to one sessions and groups were provided by occupational therapy, social work, psychology, speech and language, dietetics, medical and nursing staff. Co-ordinated by a clinical nurse specialist in group work, there was a comprehensive timetable that included both the therapeutic and recreational activities for the week. Examples of group work included teen life-skills, a relaxation group and a group on resilience.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

All residents were assessed regarding their individual education requirements with consideration of their individual needs and age on admission.

Where appropriate to the needs and age of the young person, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities were available for the provision of education. Sufficient personnel resources were available for the provision of education to the residents within the approved centre.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the transfer of residents, which were last reviewed in July 2019.

The clinical file of one resident who had been transferred to another facility was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information about the resident was sent to a named individual, including a letter of referral that contained a list of current medications. Copies were retained within the clinical file. A resident transfer form had been completed. Required medication for the resident during the transfer process had been considered, and as applicable this had been documented.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy which was last reviewed in October 2019.

The approved centre had two emergency trolleys and staff had access at all times to an AED. Records were available of any medical emergency within the approved centre and the care provided.

Clinical files were examined in relation to provision of general health services during the inspection process. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

One resident had been in the approved centre over six months. The six monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index and weight.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents completed general health checks and associated results, including records of any clinical testing, e.g. lab results. Residents could access national screening programmes according to age and gender as applicable.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents, which was last reviewed in January 2020.

The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times; relevant advocacy and voluntary agencies, and; residents' rights.

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to resident 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 had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Residents were called by their preferred name and the general demeanour of staff and the way in which they dressed and communicated with residents was respectful. Staff were discrete when discussing the resident's condition or treatment needs and sought the resident's permission before entering their room, as appropriate.

The layout and furnishings of the approved centre were not all conducive to resident privacy and dignity. None of the bathrooms in the en suite bedrooms had functioning locks. Thumb-turn locks had been disabled as previously some were identified as faulty. They had been replaced with locks that could only be operated by staff and therefore were not conducive to resident privacy. Resident toilets in the communal day area of the approved centre were observed to have been locked at all times on the days of inspection. Residents had to request the toilets to be opened when required which was not respectful of their dignity.

All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy. Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

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

a) **En suite bathrooms did not have functioning locks for resident use.**
b) **Communal toilets were kept locked and residents had to request that they be opened when required.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Residents had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre, and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics and the lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre. Works were on going to ensure minimisation of ligature points to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally with some exceptions. Vacant bedrooms were noted to have blu tack remnant staining on the walls. Fixed garden furniture was observed to be rotting, and it was reported that it was planned that this be removed. There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment. There was no programme of decorative maintenance, however it was reported that maintenance was undertaken when requested by nursing staff. The approved centre was clean, hygienic, and free from offensive odours and rooms were centrally heated with pipe work and radiators were guarded. Current national infection control guidelines were followed. Additional high touch cleaning had been contracted to support infection control and prevention.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room.

All resident bedrooms were appropriately sized to address the resident needs. Couches in both the day and night sitting rooms were worn, with notably scuffed upholstery, and were in need of repair or replacement. The approved centre provided assisted devices and equipment to address resident needs.

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

a) **Not all bedrooms had been maintained in good decorative condition, notably blu tack staining was evident on the walls, 22(1).**
b) **The approved centre did not have a programme of decorative maintenance, 22(1)(c).**
c) **Not all furnishings were adequate and suitable having regard to the number and mix of residents in the approved centre, specifically the couches in the day and night sitting rooms were worn and scuffed, 22(2).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines, which was last reviewed in November 2017. An addendum to the policy in relation to COVID -19 had been added in July 2020. The policy included:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident, and; a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition: this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety of residents, staff and visitors and was last reviewed in November 2019. An addendum to the policy in relation to COVID -19 had been added in July 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to staffing, which was last reviewed in February 2019. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times. This was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Staff training could not be completed due to pandemic events and was therefore not inspected.

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

Staff in Approved Centre		
Staff Grade	Day	Night
Area Director of Nursing *	1 *	
Assistant Director of Nursing	1	
Clinical Nurse Manager 3	1	
Clinical Nurse Manager 2	1	1
Clinical Nurse Specialist	2	
Registered Psychiatric Nurse	4	3

Occupational Therapist	1
Social Worker	2
Psychologist	1
Dietitian	0.5 (WTE)
Speech and Language Therapist	0.6
Consultant Psychiatrist	1
NCHD	3

*in conjunction with wider community CAMHs service.

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating the creation of, access to, retention off and destruction of records, which was last reviewed in January 2020.

Resident records were secure, up-to-date, and in good order, and were physically stored together in a secure office on each unit. All resident records were reflective of the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in October 2019 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented and actioned appropriately. Details of complaints (not minor) made, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's ICP. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process had been made available to them. This was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management as well as a Safety Statement, which were last reviewed in November 2019. An addendum to the policy in relation to COVID -19 had been added in July 2020. The risk management policies and associated safety statement addressed all requirements of the regulation. The policy did not include processes specifically in relation to:

- Capacity risks relating to the number of residents in the approved centre.
- Risk to the resident group during the provision of general care and services.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored and documented within the risk register as appropriate. There was a local risk management and health and safety committee. There was a weekly risk review meeting. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were completed prior to and during physical restraint, in conjunction with medication requirements or administration, and resident transfer and discharge. Individual risk assessments were also completed at admission to identify individual risk factors, including general health

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

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed in a prominent position in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated September 2020. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection processes where a child is physically restrained.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: The clinical file of a resident that had been physically restrained was examined. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Completed clinical practice forms had been placed in the resident's clinical file. The resident was afforded the opportunity to discuss the episode with their multi-disciplinary team (MDT) and the episode had been reviewed by members of the MDT no later than two working days after the episode.

The parent/guardian had been informed of the child's physical restraint as soon as possible. Child protection policies and procedures were in place. There were also policies and procedures in place that addressed appropriate training for staff in relation to child protection.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in January 2019, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in July 2020, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in September 2020, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication and current mental state. A risk assessment and full physical examination had been completed. A nursing key working system was in place. The resident's family member was involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged evidenced a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and relevant members of the multi-disciplinary team. A preliminary discharge summary had been sent to the relevant agencies and a comprehensive discharge summary had been sent within 14 days that detailed diagnosis, prognosis and medication. As applicable, a follow up appointment had been arranged for the resident.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001417		**The approved centre was non-compliant with this regulation because not all ICP's identified appropriate goals for the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review current ICPs to ensure documentation of appropriate goals.	ICPs to be reviewed at monthly MDT meetings to ensure goals are appropriate	Realisitc	31/01/2021	Multidisciplinary Team
Preventative Action	Series of education and training meetings	Monthly audit of Care Plans.	Realisitc	31/03/2021	Multidisciplinary Team

Regulation 21: Privacy					
Reason ID : 10001418		**Communal toilets were kept locked and residents had to request that they be opened when required.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Bathrooms to remain open.	Ongoing Audit	Achieved	14/12/2020	Multidisciplinary Team
Preventative Action	Requirement that bathrooms remain open to be highlighted to Multidisciplinary Team Members.	To be reviewed at weekly staff meeting to include feedback from young people.	Realisitc	31/03/2021	Multidisciplinary Team
Reason ID : 10001419		**En suite bathrooms did not have functioning locks for resident use.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Meeting to be held to review current status and specification required	Meeting required	Achievable	31/01/2021	ADON, Consultant & Area Administrator
Preventative Action	Internal thumb-turn locks with override to be fitted	Maintenance plan to be put in place	Achievable	31/03/2021	ADON, Consultant& Area Administrator

Regulation 22: Premises					
Reason ID : 10001420		**Not all furnishings were adequate and suitable having regard to the number and mix of residents in the approved centre, specifically the couches in the day and night sitting rooms were worn and scuffed, 22(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Replacement furniture ordered from Pineapple with various colours to suit unit	Delivery awaited	Achievable	28/02/2021	ADON
Preventative Action	Maintenance Review Quarterly	Maintenance walk-through	Achievable	31/03/2021	ADON, Maintenance Officer & Area Administrator
Reason ID : 10001421		**Not all bedrooms had been maintained in good decorative condition, notably blu tack staining was evident on the walls, 22(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Observed blu-tack to be removed and apply stain stop	No stains visible on wall	Achievable	31/03/2021	ADON & Maintenance Officer
Preventative Action	Maintenance Review Quarterly	Maintenance walk-through	Achievable	31/03/2021	ADON, Maintenance Officer & Area Administrator
Reason ID : 10001422		**The approved centre did not have a programme of decorative maintenance, 22(1) (c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Maintenance Review Quarterly	Maintenance walk-through	Achievable	31/03/2021	ADON, Maintenance Officer & Area Administrator
Preventative Action	Develop Preventative Maintenance Review	Template to be constructed	Achievable	31/03/2021	Maintenance Officer & Area Administrator

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

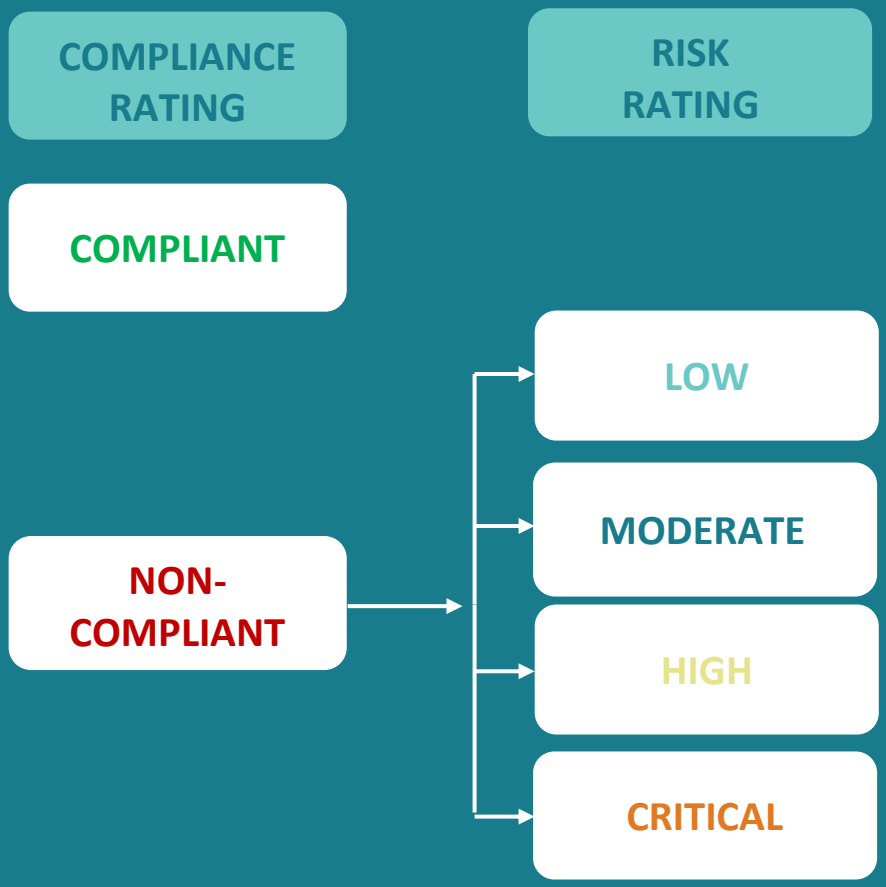
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.