The Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	Adolescent In-patient Unit, St. Vincent's Hospital
IDENTIFICATION NUMBER	AC0076
APPROVED CENTRE TYPE	Child and Adolescent Mental Health Service
REGISTERED PROPRIETOR	St. Vincent's Hospital, Fairview
REGISTERED PROPRIETOR NOMINEE	Ms Caroline Grenham
MOST RECENT REGISTRATION DATE	29 January 2015
NUMBER OF RESIDENTS REGISTERED FOR	12
INSPECTION TYPE	Unannounced
INSPECTION DATE	14,15,16 September 2016
PREVIOUS INSPECTION DATE	5, 6 November 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Ms Orla O'Neill
INSPECTION TEAM	Ms Mary Connellan Mr Donal O'Gorman
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCRN 009711

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1.0 Mental Health Commission 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, and
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 shall 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 shall 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 shall 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. 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 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

The Adolescent In-patient Unit (AIPU) was located on the grounds of St. Vincent's Hospital, Fairview. The AIPU was accessed from Richmond Road. Signage for the AIPU, both on the public roadway and within the campus, was inadequate. The poor signage made it difficult to identify and locate the approved centre. Senior managers advised that they had applied for planning permission for new signage.

The long entrance roadway required families and visitors to pass by discarded materials from building works and a rubbish skip. Overall, the access path was not welcoming or appropriate.

The AIPU entrance door was locked and to gain entry visitors rang a bell. Reception staff were present in the reception hallway during office hours. Outside office hours nursing staff opened the door electronically from upstairs. The AIPU was accessed via a lift and was wheelchair accessible throughout.

The AIPU had twelve beds and all residents were accommodated in single en suite bedrooms. The premises was formerly part of the main St. Vincent's Hospital building which had been renovated to provide bright, age-appropriate accommodation for the AIPU. The approved centre had a well-equipped school on site as well as access to a large garden area. The AIPU was adjacent to Fairview village and residents had access to a range of local amenities and the structured therapeutic timetable regularly incorporated community based activities.

The AIPU accepted referrals from Child and Adolescent Mental Health Services (CAMHS) in the Health Service Executive's Dublin North East Area (Dublin North Central, Dublin North West, North Dublin, Meath and Cavan/Monaghan). The approved centre participated in the weekly national CAMHS bed management teleconference. Referrals had also been accepted and residents admitted from the Wexford area in 2016 owing to the unavailability of beds in the designated child and adolescent approved centre. The AIPU provided care and treatment for adolescents between the ages of 16 and 18 years. All residents were under the care of one consultant psychiatrist and a multi-disciplinary team. At the time of the inspection there were six residents in the AIPU.

The AIPU had a website. The website was significantly out of date and featured the name of a previously employed consultant psychiatrist. The website did not adequately represent the scope of the care and treatment provided for young adults and their families. This was regrettable as the internet was the information portal likely to be used by young adults.

Ten years on from the implementation of the Regulations pursuant to the Mental Health Act 2001, which required child residents to be provided with details of relevant advocacy services, there was still no advocacy service provided for children resident in the AIPU.

2.2 Conditions to Registration

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

2.3 Governance

There was no discreet executive management team for the AIPU. It was incorporated into the governance structure and processes of St. Vincent's Hospital. Fairview. This comprised a Board of Governors to whom the Chief Executive reported. Medical, nursing, administrative and "Patient Services" staff reported to the Chief Executive. The "patient services" staff included pharmacy, psychology, speech and language, occupational therapy and social work staff. There were ten committees listed under the umbrella of the Integrated Quality and Safety Committee. One such committee was the policy committee. The minutes of the policy committee meeting were requested on each day of the inspection by the inspection team but were not provided. There was an Adolescent Senior Management Meeting whose terms of reference stated that meetings would be convened bi-monthly. The minutes provided to the inspection team indicated that meetings were more sporadic than this and this was confirmed by the chief executive. The AIPU produced an annual activity report. Overall, the number of committees, the membership and frequency of meetings, the apparent overlap in the scope of committees, did not present a clear sense of a robust governance process for the AIPU.

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against – with the exception of non-applicable areas (please refer to section 2.9 below for non-applicable areas).

The inspection was undertaken onsite in the approved centre from:

14 September 2016 at 09:30 to 14 Sept 2016 at 17:00
15 September 2016 at 09:00 to 15 Sept 2016 at 17:00
16 September 2016 at 09:00 to 16 Sept 2016 at 16:30

2.5 Non-compliant areas from 2015 inspection

The previous inspection of the approved centre on the 5, 6 November 2015 identified the following areas that were not compliant:

Regulation/Rule/Act/Code	**Inspection Findings 2016**
Regulation 22 Premises	Non-compliant
Regulation 26 Staffing	Non-compliant
Code of Practice on the Use of Physical Restraint in Approved Centres	Non-compliant
Code of Practice on the Admission of Children under the Mental Health Act 2001	Compliant

2.6 Corrective and Preventative Action plan

Subsequent to the publication of the 2015 inspection report, the approved centre was requested to submit a Corrective and Preventative Action Plan (CAPA) for each regulation or code of practice with which they were non-compliant. Services submitted four CAPAs. The inspection team found that two CAPAs had not been implemented in relation to premises and the approved centre remained non-compliant with regulation 22 Premises. One CAPA had been completed related to staffing. Nonetheless, the approved centre remained non-compliant with regulation 26 Staffing. The approved centre had submitted to the MHC information required in relation to the CAPA for the code of practice on physical restraint. The approved centre remained non-compliant with the code of practice on the use of physical restraint.

2.7 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	**Risk Rating**
Regulation 8 Residents' Personal Property and Possessions	Moderate
Regulation 21 Privacy	Low
Regulation 22 Premises	Moderate
Regulation 26 Staffing	Moderate
Rule Governing the Use of Seclusion	Low
Code of Practice on the Use of Physical Restraint in Approved Centres	Moderate
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	Low
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	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.

2.8 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 17 Children's Education

2.9 Areas not applicable

The following areas were not applicable as the rule, regulation, code of practice or Part 4 of the Mental Health Act 2001 was not relevant to the approved centre at the time of inspection.

Regulation/Rule/Act/Code
Regulation 25 Use of Closed Circuit Television
Regulation 30 Mental Health Tribunals
Rules Governing the Use of Electro-Convulsive Therapy
Rules Governing the Use of Mechanical Means of Bodily Restraint
Part 4 of the Mental Health Act 2001 – Consent to Treatment
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients

2.10 Areas of good practice identified on this inspection

- The approved centre operated a screening assessment to evaluate the need for admission and to inform the initial treatment plan for any child admitted. This assessment was provided in a timely manner and the approved centre did not have an admissions waiting list.
- The approved centre participated in a programme of peer review run by the Quality Network for Inpatient CAMHS aimed at improving the quality of service provision.
- A weekly residents' community meeting was held with residents to elicit views and concerns. These meetings were documented.
- Parents and children were invited to complete a survey at the time of discharge to indicate their views and experience of the AIPU. The information was collated and analysed with a view to improve quality.

2.11 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.

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

All residents were children, therefore, this section of the Act did not apply.

2.13 Resident Interviews

Residents were invited to speak with the inspection team. One resident spoke with two members of the inspection team. The resident was positive about the admission process and said that following referral from their local CAMHs team, that they had been promptly screened and admitted to the AIPU within one week. The resident said that the care and treatment was good, and that staff were approachable and available to talk.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	6	0	6	6
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 2	Voluntary Residents	0	0	6	6
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 3	Voluntary Residents	6	0	6	6
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0

2.15 Feedback Meeting

A feedback meeting was held prior to the conclusion of the inspection and provided an opportunity to share initial findings of the inspection and to clarify any issues outstanding. The meeting provided an opportunity to the registered proprietor nominee and senior staff to make comment and query in relation to the inspection and to provide additional information. This was attended by the inspection team and the following representatives from the approved centre:

- Acting Director of Nursing (ADON)
- Chief Executive/Registered Proprietor
- Clinical Director
- Clinical Nurse Manager 1
- Clinical Nurse Manager 3/Service Manager
- Consultant Psychiatrist
- Principal Clinical Psychologist

A number of clarifications were provided regarding various issues which had arisen during the course of this inspection and these are incorporated into this report. Senior Managers stated that the approved centre had made application to the HSE to expand the scope of its inpatient service to include 12 to 15 year olds and had received no definitive response to date. The estimated cost of such a service expansion was reported to be €5 million. The issue of the vacant occupational therapy post was raised and the Chief Executive advised that the full-time senior grade post had been advertised with 0.5 whole time equivalent dedicated each to the AIPU and to CAMHS day services.

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

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: There was a policy dated October 2014 in place on the identification of residents within the approved centre. The policy included the roles and responsibilities in relation to the identification of residents.

The policy did not include:

- The required use of two resident identifiers prior to the administration of medications, therapies or other services.
- The required use of two appropriate resident identifiers before medical investigations.
- The process of identification applied for same or similar named residents.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on identifying residents. Staff interviewed could articulate the processes for identifying residents as practiced in the approved centre.

Monitoring: There was no evidence of an annual audit having been conducted to ensure that there were appropriate resident identifiers on clinical files. There was no evidence of an analysis having occurred to identify opportunities to enhance the resident identification process within the approved centre.

Evidence of Implementation: The approved centre used photographic identification, resident name, resident date of birth and resident hospital number as identifiers.

These four identifiers were used when staff administered medication, before providing therapies or other services and before medical investigations.

The identifiers were appropriate to the residents' communication abilities, were resident specific and excluded each resident's room number and physical location.

There was an alert system in place for same or similarly-named residents within the AIPU. A white sticker was placed on the charts of same or similarly-named residents to alert staff.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not excellent as the AIPU did not implement all of the *Judgement Support Framework* criteria under processes, training and education, and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.5 Regulation 5: Food and Nutrition

(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: There was a policy dated October 2016 in place on food and nutrition within the AIPU. The policy included the statement that the responsibility for food and nutrition was assigned to St. Vincent's Hospital, Fairview.

The policy did not include:

- Reference to individual and professional roles and responsibilities in regard to the provision of food and nutrition to residents.
- The management of food and nutrition for each resident and the process for monitoring residents' food and water intake.
- Explicit reference to the process of assessing the dietary and nutritional needs of residents.

Training and Education: Not all staff had signed to indicate that they had read and understood the food and nutrition policy. Staff interviewed could articulate the processes for food and nutrition.

Monitoring: There was no evidence of a systematic review of menu plans having been conducted to ensure residents were provided with wholesome and nutritious food compatible to their needs. There was no documented analysis completed to enhance the food and nutrition processes.

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food choices. Each day residents were given two hot choices for their main meal including a vegetarian option and salad choice. The main meal of the day was served early evening and a light snack was available later. The menu had been developed by catering staff and had not been reviewed by a dietician. There was safe, fresh drinking water available to residents at all times, with easy access to water fountains throughout the approved centre. Both hot and cold drinks were also offered regularly to residents.

The approved centre catered for all diets by request. A Halal menu and diet was provided for one resident at the time of inspection. An evidence-based nutritional screening tool was used and weight charts were maintained for all residents. A sessional dietician attended the approved centre and saw residents on referral by the Multi-Disciplinary team (MDT). Dietetics assessment and specified diet and nutrition plans were in place for a number of residents and these were incorporated into the individual care plans (ICPs).

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not excellent. Not all of the *Judgement Support Framework* criteria under processes, training and education, monitoring, and evidence of implementation were in place.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.6 Regulation 6: Food Safety

(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: There was a policy dated October 2014 in place on food safety within the approved centre.

The policy included the statement that responsibility lay with St. Vincent's Hospital to ensure that food consumed on the premises complied with food safety requirements. The policy outlined the legislative food safety requirements.

The policy did not include:

- Roles and responsibilities of individual professionals in respect of food safety.
- The process of food preparation, handling, storage, distribution and disposal controls.
- The processes and procedures for the management of catering and food safety equipment.

Training and Education: Not all staff had signed to indicate that they had read and understood the food safety policy. Staff were not able to articulate the processes for food safety as stated in the policy but were able to describe the food safety policy requirements as practised in the approved centre.

All catering staff had completed up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP) processes and this was documented.

Monitoring: There was no documented evidence of food safety audits periodically completed. There was no documented evidence of analysis completed to identify opportunities to improve food safety processes. Actions identified from Environmental Health Officer reports had been followed up, completed or were awaiting actions.

Evidence of Implementation: There was appropriate and sufficient catering equipment. The servery and dining area were clean and supported food safety requirements.

Main meals were prepared and cooked in the main hospital kitchen. A light lunch of sandwiches, salad and breakfast were prepared in the approved centre. The provisions for these meals were delivered directly from the main kitchen in St. Vincent's Hospital, Fairview.

There was a small domestic style fridge in the kitchen servery area of the AIPU. The internal door for the freezer was broken and a new fridge had been ordered and was due delivery. This fridge was used only to store milk and ready prepared food prior to service.

There was appropriate and sufficient catering equipment, crockery and cutlery. Catering staff wore appropriate personal protective equipment (PPE) during the catering process and had suitable areas for hand washing.

The approved centre was compliant with this regulation. The quality rating was satisfactory and not excellent. The approved centre did not implement all of the *Judgment Support Framework* criteria under processes, training and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.7 Regulation 7: Clothing

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: There was a policy dated October 2014 in relation to residents' clothing within the approved centre. The policy included all of the criteria of the *Judgement Support Framework.*

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on residents' clothing. Staff interviewed could articulate the processes for resident's clothing as stated in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored and documented on an on-going basis. The prescribed use of night clothes during the day was not the practice within the AIPU.

Evidence of Implementation: Residents were supported to keep and use personal clothing as residents had access to laundry facilities on site and staff assisted the residents in cleaning and drying their personal clothing where necessary.

Residents clothing was clean and appropriate to the residents' needs and all residents were appropriately dressed and well-groomed at the time of inspection. Residents had an adequate supply of their own clothing, which was stored in their bedrooms and wardrobes.

There was a contingency plan to provide emergency clothing to residents where necessary. The senior social worker on the multidisciplinary team used emergency funding for emergency clothing for a resident. This was a rare occurrence as admissions were pre-planned. The approved centre had recently received a supply of new pyjamas.

No resident was wearing night clothes during the course of the inspection.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not excellent. The approved centre did not implement all of the *Judgement Support Framework* criteria under training and education.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.8 Regulation 8: Residents' Personal Property and Possessions

(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: There was a policy dated October 2014 in place on residents' personal property and possessions within the approved centre. The policy set out the staff roles and responsibilities to support residents to manage their personal property and possessions. The policy covered the communication with the residents and their representatives regarding the resident's right to bring personal property and possessions into the approved centre at admission and on an on-going basis.

The policy did not include the process to record, secure and manage the personal property and possessions of the resident, including money.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on residents' personal property and possessions. Staff interviewed could articulate the processes for residents' personal property and possessions as set out in the policy.

Monitoring: Personal property logs were maintained and monitored by nursing staff. There was no documented evidence of analysis to identify opportunities to improve the processes for resident's personal property and possessions.

Evidence of Implementation: On admission, nursing staff, in conjunction with parents, assessed the child's ability to take responsibility for their own property and possessions. The resident was entitled to bring personal possessions in with them as agreed with staff on admission.

Each resident had their own room with adequate storage space for personal property and possessions.

Staff lodged resident monies in the approved centre's general office and two members of staff were required to sign records of the amount lodged and retained for the resident. This did not happen often as parents were encouraged to take monies home with them. Residents were supported to manage their own property, and retained their own possessions, unless otherwise indicated in their individual care plan.

Some residents had access to secure lockable facilities in their bedrooms, however, not all of the bedrooms had lockable presses in them due to damage caused by residents. Only five out of 12 bedrooms had functioning lockable presses. Residents' possessions could be safely secured in a locked store room.

There was no evidence that the approved centre maintained a comprehensive signed property checklist of residents' personal property and possessions. Staff only made records with regard to potential harmful objects that were taken from the residents. Regular items, such as clothing which were brought into the unit by residents on admission, were not recorded on the property sheet.

The approved centre was non-compliant with this regulation because the approved centre did not maintain a record of residents' personal property and possessions as required by 8 (3) of this regulation.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There was a policy dated March 2015 available in relation to the provision of recreational activities to residents. The policy set out the roles and responsibilities of the registered proprietor for providing adequate and appropriate recreational equipment and space, and for ensuring it was maintained in good working order. The policy outlined the process for determining residents' needs, likes and dislikes in relation to activities.

The policy did not include:

- Who specifically was responsible for the direct provision, supervision and development of recreational activities.
- Risk assessment of residents concerning recreational activities.
- The process applied for the development of recreational activity programmes.
- The facilities available for recreational activities.
- The discovery of suitable locations for recreational activities both within and external to the approved centre.
- The process to support resident involvement in contributing input relating to the recreational activities available.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on recreational activities. Staff interviewed could articulate the processes for recreational activities as set out in the policy.

Monitoring: There was no documented record of the occurrence of planned recreational activities and resident participation records were not maintained. There was no documented analysis completed to define opportunities to improve recreational activity processes.

Evidence of Implementation: A weekly timetable on recreational activities was provided to each resident in an understandable and accessible format. The approved centre provided access to recreational activities on weekdays and during the weekend.

The recreational activities provided by the approved centre were appropriately resourced in terms of resources, materials, equipment and facilities. The approved centre was had funding to the amount of €1000 to buy arts, crafts and physical recreation facilities.

Residents had a weekly trip to a local gym and opportunities were provided for indoor and outdoor activities, and physical activity. The residents were also given opportunities to contribute ideas, preferences and feedback in relation to recreational activities at the weekly community meeting.

The communal areas provided were suitable for recreational activities. There was a large sitting room which contained a TV, music players, DVDs and DVD player, electronic game consoles, fuss ball table, books, table games and a daily newspaper. There was also a multi-purpose activities room equipped with drum kits, guitars, arts and crafts materials. In addition, there was an outdoor tennis court.

A documented record of recreational activities attended by the residents was maintained within each resident's clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement all of the *Judgement Support Framework* criteria under processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: There was a policy dated March 2015 available regarding the approved centre's facilitation of religious practices. The policy did not include the following criteria of the *Judgement Support Framework*:

- The process for identifying and recording resident's religious beliefs and preferences.
- Reference to the dietary needs or particular religious needs in relation to the delivery of healthcare or end of life care.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on religion. Staff interviewed could articulate the processes for facilitating residents in the practice of their religion as set out in the policy.

Monitoring: There was a documented review of the application of the processes undertaken by the chaplain.

Evidence of Implementation: Child residents were facilitated in the practice of their religion insofar as reasonably practicable.There was a multi-faith room on site and residents had access to a chaplain and to ministers of the main faiths if required. Each resident was facilitated to observe or abstain from religious practice in accordance with their wishes.

There was also a Roman Catholic church on site. Residents could access the church for weekly services, if deemed appropriate following risk assessment. The chaplain provided a weekly educational session in the AIPU school as part of the curriculum. The chaplain also provided an open group within the AIPU which focused on relaxation and positive self-image. Both of these sessions were reviewed and documented.

Any specific religious requirements relating to the provision of services, care and treatment were clearly documented. At the time of inspection, one resident was provided with a halal diet.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement all the *Judgement Support Framework* criteria for: processes and training and education.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.11 Regulation 11: Visits

(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 visiting a resident.

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

Inspection Findings

Processes: There was a policy dated March 2015 available in relation to visits. The policy did not include the following elements of the *Judgement Support Framework*:

- The individual staff roles and responsibilities in relation to people visiting the approved centre and its residents.
- The process for restricting visitors based on resident request, and identified risk to a resident or to ensure the safety of residents.
- The required visitor identification methods, including contractors.
- The availability of appropriate locations for resident visits.
- The arrangements of appropriate facilities for children visiting a resident.

Training and education: Not all staff had signed to indicate that they had read and understood the policy. Staff interviewed could articulate the processes for visits as outlined in the policy.

Monitoring: There was no evidence of the implementation of the policy on visits having been reviewed on a three yearly basis, to ensure it was suitable to the defined needs of the residents. There was no documented analysis of visiting processes. Restrictions on residents' rights to receive visitors was monitored and reviewed on an ongoing basis.

Evidence of Implementation: Within the approved centre, visiting times were publicly displayed. These were 18.00 to 20.00 Monday-Friday. The visiting times for Saturday and Sunday were 14.00 to 16.00 and 18.00 to 20.00. These times were compatible with the timetables of therapies and programmes throughout the week.

Residents received visitors in accordance with the consent and approval of parents or guardians. A list of approved visitors was drawn up for each resident and was recorded in the respective clinical files with a copy maintained at the reception. This was monitored by staff in consultation with parents or guardians. All visitors signed a book at reception before gaining entry to the approved centre.

There was a general visitors' room available but it was more usual for the residents to receive visitors in their bedrooms. Any child visiting a resident was accompanied by an appropriate adult, who was on the list of allowed visitors. The unit and the designated visitor's room, were observed to be child-friendly and suitable for children visiting.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement all of the *Judgement Support Framework* criteria under: processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.12 Regulation 12: Communication

(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

Processes: There was a policy dated March 2015 available in relation to communication. The policy included requirements of the *Judgement Support Framework* such as the roles and the responsibilities in relation to resident communication processes. The communication services available to the resident were detailed in the policy.

The policy did not include:

- Information on the circumstances in which resident communications may be examined by senior staff.
- The individual risk assessment requirements in relation to resident communication activities.
- How the assessment of resident communication needs should be assessed and by whom.
- The need to have access to an interpreter service for the residents within the approved centre.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on communication. Staff interviewed could articulate the processes for communication as set out in the policy.

Monitoring: There was no documented evidence of resident communication needs and restrictions on communications having been monitored on an ongoing basis. There was no documented evidence of analysis of communication processes to identify opportunities to improve communication processes.

Evidence of Implementation: There were no restrictions placed on the free communication of any current resident. The clinical files showed that individual risk assessments were completed for residents as deemed appropriate in relation to any risks associated with their external communication and this was documented in the individual care plan.

Residents had access to telephones and could send and receive mail. Residents had limited access to approved sites on the internet within the school setting.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement all of the

Judgement Support Framework criteria under processes, training and education and monitoring.				
	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.13 Regulation 13: Searches

(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 policy dated October 2014 available in relation to the implementation of resident searches by the approved centre. The policy covered the processes and procedures for searching a resident, each resident's belongings and their environment. The policy also included the processes in place for finding illicit substances. The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent were detailed in the policy.

The policy did not include the processes for communicating the approved centre's policies and procedures to residents and staff.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on searches. Staff interviewed could articulate the searching processes as set out in the policy.

Monitoring: A log of environmental searches was maintained in the approved centre. There was documented evidence of analysis having been completed to identify opportunities for the improvement of search processes. The approved centre had undertaken quarterly and bi-annual audits on parental general consent and resident consent.

Evidence of Implementation: Searches were only carried out for the purpose of maintaining a safe and therapeutic environment. No current resident had been searched. Environmental

searches occurred four times a day, children and their families were informed of this upon admission and consent was recorded.

As no resident in the approved centre had been searched, compliance for this regulation was assessed on the basis of processes, training and education and monitoring.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement the *Judgement Support Framework* criteria under processes, training and education.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.14 Regulation 14: Care of the Dying

(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

Processes: There was a policy available dated October 2015 in relation to care of the dying. There was also a separate sudden death policy.

The policy on care of the dying included reference to the responsibilities of all health care professionals to read, understand and comply with the policy and the protocols in the approved centre.

The policy on care of the dying did not include:

- The specific roles and responsibilities in relation to care of the dying.
- Reference to the process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere. (e.g. for general health care services).

The approved centre had a separate sudden death policy which covered the procedures for managing the sudden death of a child resident, the supports available to other staff in the event of a resident dying suddenly, and the process and responsibilities for reporting the death of a resident to the required external bodies, which included the Mental Health Commission and an Garda Síochána.

The policy on sudden death did not include:

- Any reference to the support available to other residents following a sudden death.

- The process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere. (e.g. for general health care services).

Training And Education: Not all staff had signed to indicate that they had read and understood the policy on care of the dying. Staff interviewed could articulate the processes for end of life care as set out in the policy.

As there had been no resident deaths in the approved centre to date this regulation was assessed under two pillars only. It was not assessed under monitoring or evidence of implementation. The regulation was assessed on processes and training and education only.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.15 Regulation 15: Individual Care Plan

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 dated March 2015 available in relation to the development, use and review of individual care plans by the approved centre. The policy set out the roles and responsibilities relating to the development of the individual care plan. In addition, the policy covered the residents' involvement in their own ICP, the Multi-Disciplinary Team involvement and the family or chosen advocate, where appropriate, (with the child's consent).

The policy did not include:

- The required content in the set of documentation comprising the individual care plan.
- The timeframe for the assessment, planning, implementation and evaluation of the individual care plan.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on individual care planning. Staff interviewed could articulate the processes relating to individual care planning as set out in the policy. There was no documented evidence that all multi-disciplinary team members were trained in individual care planning.

Monitoring: Individual care plans were audited on a quarterly basis to address compliance with the regulation. There was no documented evidence of analysis having been completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: The clinical files of all residents were inspected against and every resident had an individual care plan.

All ICPs were developed by the MDT following a comprehensive assessment which included an assessment of risk. The ICPs were reviewed and updated weekly by the MDT.

ICPs identified resident needs, appropriate goals and the resources required to meet these goals, including specific responsibilities of members of the MDT. The ICP for each child included their educational needs. The ICP identified a key worker.

The AIPU routinely implemented a suite of age-appropriate standardised assessments to both evaluate residents' needs on admission and outcomes post-care and treatment.

Residents and their parents had input into the development and review of their ICPs. Residents signed their ICP and there was a record of whether the resident wanted and received a copy of their ICP.

The ICP was kept in the clinical file in a composite set of documentation.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement the *Judgement Support Framework* criteria under processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.16 Regulation 16: Therapeutic Services and Programmes

(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: There was a policy dated March 2015 available in relation to therapeutic services and programmes in the approved centre. The policy included reference to each child being given the opportunity to provide written feedback on the care and therapeutic programme each week.

The policy did not include:

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- The planning and provision of therapeutic services and programmes.
- The provision of therapeutic services and programmes by external providers in external locations.
- The resource requirements of the therapeutic services and programmes.
- The recording requirements for therapeutic services and programmes.
- Assessing residents to the appropriateness of services and programmes (including risk).
- The procedure for reviewing and planning of therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy relating to therapeutic services and programmes. Staff interviewed could articulate the processes for the provision of therapeutic services and programmes as set out in the policy.

Monitoring: There was ongoing monitoring of the range of services, and programmes provided, to ensure they met the assessed needs of residents within the approved centre. There was no documented evidence of analysis having been completed to improve the quality of therapeutic services and programmes.

Evidence of Implementation: There was a weekly timetable of therapeutic services and programmes. The timetable was posted up on resident notice boards and hard copies of the timetable were provided to each resident also.

Therapeutic services provided were in accordance with Individual Care Plans (ICPs) and included evidence-based components. The timetable provided a balance of therapeutic activities aimed at promoting physical and psychosocial wellbeing.

There were adequate resources and facilities available to provide therapeutic services. There was a large communal sitting room, general activities room, quiet room, interview

room and outdoor garden space. Residents used a local gym and cinema. There was also a school facility which included a kitchen where residents could cook a meal.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not considered excellent as the approved centre did not implement all of the *Judgement Support Framework* criteria under processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.17 Regulation 17: Children's Education

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 policy dated January 2015 available in relation to the provision of children's education in the approved centre. The policy included all of the requirements of the *Judgement Support Framework.* The policy set out the roles and responsibilities of the registered proprietor, in relation to the residents' educational service as well as the legislative requirements regarding the provision of education to children and the assessment of the educational needs of child residents.

Training and Education: Individual providers of educational services on behalf of the approved centre were appropriately qualified in line with their role and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs. All teachers within the school were qualified secondary school teachers. Three staff had further training of special education needs. All staff completed *Children First* training.

Monitoring: A class attendance log, daily attendance log and weekly attendance was maintained on the T-Drive (Teachers Drive) for each resident. This was linked to the approved centre and could be accessed by both school staff and approved centre staff including the multi-disciplinary team (MDT).

Evidence of Implementation: The school within the approved centre was established in 2001 and was awarded a 'special educational school' status. All staff were employed by the Department of Education.

Each child resident was assessed and an individual educational plan was developed appropriate to each child's age and educational requirements.

Each child had a key teacher for the duration of their time in the school. The key teacher linked with the key worker in the approved centre. The principal or a designated teacher attended the Multi-Disciplinary Team (MDT) meeting each Monday and the review/planning meeting in the approved centre each Thursday.

The school provided for the Junior Certificate and Leaving Certificate curriculum and examinations, including the applied and vocational programme. The AIPU school also supported residents to pursue National Learning Network courses.

There were adequate personnel resources, with the ratio being 1:6 teacher to pupil. At the inspection time there were nine children attending the school. Suitable facilities were provided for the provision of education to residents. The school was in a separate building away from the hospital and also accommodated children from the day hospital. There were six classrooms, a music room, art and craft room, home economics kitchen with well-maintained grounds and a football area. School times were from 09.30 to 13.00 Monday to Friday.

The approved centre was compliant with this regulation. The quality assessment was excellent as the approved centre met all of the criteria of the *Judgement Support Framework* under processes, training and education, monitoring and evidence of implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.18 Regulation 18: Transfer of Residents

(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: There was a policy dated March 2015 available in relation to the transfer of residents. The policy set out the processes for the transfer of a resident and information relating to the resident, from the approved centre to another receiving centre, hospital or place.

The policy did not include:

- The process for managing resident medications during transfer from the approved centre.
- Parental consent to transfer the child resident.
- The process for emergency transfers.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy relating to the transfer of residents. Staff interviewed could articulate the processes for the transfer of residents as set out in the policy.

Monitoring: A transfer log was maintained for each resident. There was no documented evidence of transfers being reviewed and analysed for quality improvement purposes.

Evidence of Implementation: No current resident had been transferred to another facility.

Regulatory compliance was evaluated on the basis of processes, training and education and monitoring as no resident had been transferred.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not fully implement the *Judgement Support Framework* criteria under: processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.19 Regulation 19: General Health

(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: There was a policy dated March 2015 available in relation to the provision of general health services to residents. There was a separate medical emergency policy dated March 2015. The policies set out the processes for assessing, managing and monitoring general health needs of residents within the approved centre as well as the processes for responding to medical emergencies.

The policy did not include:

- Any information on managing, responding to and documenting a medical emergency, in the form of anaphylaxis.
- Staff training requirements on Basic Life Support (BLS).
- The resource requirements for general health services including equipment needs.
- The protection of resident privacy and dignity, during the general health assessments.

Staff Training and Education: Not all staff had signed to indicate that they had read and understood the policies relating to general health needs of residents and responding to medical emergencies. Staff interviewed could articulate the processes for the provision of general health services and for responding to medical emergencies.

Monitoring: No resident was an in-patient for six months. The only national screening programme applicable to the age group was diabetic retinal screening but as no resident had diabetes, this was not applicable. There was no evidence of analysis or systematic review of general health processes having been completed for the purpose of quality improvement.

Evidence of Implementation: The approved centre had a resuscitation trolley and staff had access at all times to an AED. Weekly checks were completed on the resuscitation trolley and on the AED and logs were maintained. There had been no medical emergency since the last inspection.

Clinical files inspected showed evidence that a registered medical practitioner assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care.

All resident ICPs showed evidence that residents received appropriate general health care interventions in line with their individual care plans. Clinical files inspected also reflected that adequate arrangements were in place for access by the residents to general health services, and for their referral to other health services as required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement all of the *Judgement Support Framework* criteria under processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.20 Regulation 20: Provision of Information to Residents

(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 was a policy dated March 2015 available in relation to the provision of information to residents. The policy included the staff roles and responsibilities in relation to the provision of information to residents and the information provided to residents at admission and on an ongoing basis.

The policy did not include:

- Information and details of relevant advocacy and voluntary agencies.
- How the child's information processing needs were to be evaluated or assessed.
- The methods for providing information to residents with specific communication needs, including appropriate translation services.
- Interpreter services available within the approved centre.

Training and Education: Not all relevant staff had signed to indicate that they had read and understood the policy on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents as set out in the policy.

Monitoring: There was no documented evidence of the provision of information to residents having been monitored on an ongoing basis. There was no evidence of analysis having been completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: Residents and their parents were provided with information as specified in this regulation. There was an information booklet for young persons and a separate booklet for their parents. The booklet communicated information on housekeeping arrangements of their hospital stay such as personal property and mealtimes, the complaints procedure, visiting times and arrangements, details of relevant voluntary agencies, details of their multi-disciplinary team and residents' rights.

The booklets also referenced advocacy services, however, there were no age-appropriate advocacy services available to children in approved centres in Ireland unless privately contracted.

There were age-appropriate information leaflets about specific diagnosis and medications. Residents were given verbal and written information on their diagnosis unless deemed damaging to their wellbeing.

Medication information sheets, including the side effects of medication, were provided to each resident. Indications for the use of all medication to be administered to the resident was detailed in the medication information sheet.

Publicly displayed health and safety procedures were in formats easily understood and took account of the special communication needs of people using the building.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement the *Judgement Support Framework* criteria under processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: There was a policy dated March 2015 available in relation to resident privacy. The policy set out the staff roles and responsibilities and processes for ensuring residents' privacy and dignity was appropriately respected.

The policy did not include:

- The method for identifying and ensuring, where possible, the resident's privacy, dignity, expectations and preferences.
- The approved centre's layout and furnishing requirements to support resident privacy and dignity.
- The mechanism to be applied where resident privacy and dignity was not respected by staff.

Training and Education: Not all staff had signed to indicate that they had read and understood the policies relating to resident privacy and dignity. Staff interviewed could articulate the processes for ensuring resident privacy and dignity as set out in the policy.

Monitoring: There was no evidence of a documented review, or analysis of processes relating to residents' privacy taking place with a view to improve the processes relating to residents' privacy and dignity and to ensure that the premises and facilities in the approved centre were conducive to resident privacy.

Evidence of Implementation: Staff addressed and communicated with residents in a respectful manner and residents were called by their preferred names. Staff were dressed neatly and casually. Staff only discussed residents' conditions in an appropriately private location.

The layout and furnishings of the approved centre showed evidence of being conducive to resident privacy and dignity. All sleeping accommodation was single en suite. Bedrooms had opaque glass panels and curtains. Resident rooms were not overlooked by public areas. All bathroom, showers and toilet doors had locks suited to the residents needs unless there was an identified risk. Locks had an override function.

The large whiteboard in the nurses' office was visible through a window which overlooked the main corridor of the unit. The whiteboard listed the residents by initials and indicated their legal status (voluntary/involuntary). This board was visible to residents and visitors and the information on display meant that resident's privacy was not appropriately respected at all times.

The approved centre was not compliant with this regulation as resident privacy was not appropriately respected due to the confidential nature of information on a publicly visible noticeboard.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
X			

3.22 Regulation 22: Premises

(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: There was a policy dated October 2014 available in relation to premises which covered requirements of the *Judgement Support Framework* with the exception of the process for identifying hazards and ligature points in the premises.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on premises. Staff interviewed could articulate the processes relating to the maintenance of the premises as set out in the policy.

Monitoring: There was no evidence of a hygiene and infection control audit having been conducted within the approved centre.

The approved centre had completed a ligature audit point in September 2016 and underwent an extensive ligature audit action plan in August 2014.

A documented analysis was completed within the approved centre to identify opportunities to improve the premises. The Quality Network for Inpatient CAMHS (QNIC) audit, which was undertaken in 2015-2016, had addressed issues in relation to the approved centre's environment and facilities.

Evidence of Implementation: Physical Environment: Residents within the approved centre had their own en suite bedroom and access to personal spaces such as the activity room, group room, and large enclosed corridor. The communal rooms provided were suitably

sized. The accommodation within the approved centre was comfortably furnished and met the assessed needs of residents.

Rooms were adequately ventilated. Residents could open the bedroom windows for ventilation safely as there were window restrictors. The communal space lighting was bright, adaptable and compatible with residents' needs. Residents also had access to recreational and private space to move around freely. In addition, residents had access to a large outdoor enclosed garden.

Ligature points were minimised.

Maintenance: The approved centre was in a good state of repair internally with modern facilities, but not externally. There was poor signage to indicate where the approved centre was located and large refuse bins were visible to anyone en route to the unit.

The approved centre was not adequately heated. Residents had made complaints in terms of the heating and temperature of the unit. Rooms were centrally heated with underfloor heating in place. Heating could not be controlled by either the residents or staff.

The approved centre was observed to be clean, hygienic and free from offensive odours. There was a programme of general maintenance and cleaning in place which were recorded.

Facilities and furnishings: All resident bedrooms were single en suite rooms which were appropriately sized for resident needs. Suitable furnishings were provided to support resident independence and comfort. There was an adequate number of toilets and showers for resident needs. Toilets were accessible and clearly signed, and were situated close to day and dining areas.

There was no sluice room on site in the approved centre. The approved centre did not have a designated cleaning room for equipment and cleaning products. These were stored in the laundry room which was used by residents, albeit under supervision.

There was no separate changing room for catering staff. There was a single shower, lavatory and changing room for all staff within the approved centre.

The approved centre was non-compliant with Regulation 22 because:

(a) The heating temperature within the AIPU could not be regulated by staff or residents Therefore, the approved centre was not adequately heated. (22(b)).
(b) There was inadequate provision of lavatory and changing facilities for staff. Therefore, this did not show due regard to the safety and well-being of residents and staff. (22(3)).

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

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

(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: There was a policy dated July 2015 available in relation to ordering, prescribing, storing and administration of medicines. The policy set out the staff roles and responsibilities and the processes for ordering, prescribing, storing and the administration of medicines within the approved centre.

The policy did not include:

- The process for self-administration of medicine.
- The relevant legislative requirements to be complied with during the ordering, prescribing, storing and administration of medication.

Training and education: Not all staff had signed to indicate that they had read and understood the policy on the ordering, prescribing, storing and administration of medicines. Staff interviewed could articulate the process 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 staff received training on the importance of reporting medication incidents, or near misses. This was not documented.

*Monitoring: Q*uarterly audits of the Medication, Prescription and Administration Records (MPARs) took place with nursing metrics used and incident reports were recorded for medication errors and near misses. Analysis was conducted to discover opportunities for the improvement of medication management processes.

Evidence of Implementation:
Every resident had a Medication Prescription and Administration Record (MPAR). Four MPARs were reviewed in detail. Each MPAR evidenced a record of appropriate medication management practices, including the record of resident identifiers, records of all medications administered, route, dose/amount to be given and frequency, Medical Council Registration Number (MCRN), and the signature of the medical practitioner prescribing the medication. A record was kept when medication was refused by a resident or withheld.
However, micrograms and nanograms were not written in full, these were abbreviated.

Prescription and Administration (General): All medication was administered by a registered medical practitioner or nurse. No current resident was on a controlled drug at the time of the

inspection. Appropriate resident identifiers and good hygiene practices were observed to be used.

Ordering and Storage: Medication was ordered from a pharmacy and brought to the approved centre by the hospital porter. Medication was reconciled by a nurse upon receipt at the approved centre. Medication was stored in a locked medication trolley, a locked cupboard and a locked fridge within a locked room. Controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. Refrigerators used for medication were used only for this purpose and a log was maintained of the temperature.

There was no evidence, within the approved centre of an inventory of medication having been conducted on a monthly basis to check the name and dose, quantity and expiry date of medication.

A system of stock-rotation was implemented to avoid accumulation of old stock and stock not in use was returned to the pharmacy.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not considered excellent as the approved centre did not meet the full criteria of the *Judgement Support Framework* under processes, training and education and implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.24 Regulation 24: Health and Safety

(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 policy dated October 2014 available in relation to ensuring the health and safety of staff, residents and visitors. The policy included:

- Personal Protective Equipment (PPE).
- Hand washing and the safe disposal of sharp and infectious waste.

The policy did not include:

- The management of spillages, the raising of awareness of residents and their visitors to infection control measures, responses to sharp or needle stick injuries, availability of staff vaccinations and immunisations, management and reporting of an infection outbreak.
- Support provided to staff following exposure to infectious diseases and specific infection control measures in relation to infection types, e.g. C. difficile, MRSA and Norovirus.
- First aid response requirements, falls prevention initiatives and vehicle controls.
- The staff training requirements in relation to health and safety.
- The process for the monitoring and continuous improvement requirements implemented for health and safety processes.

Staff Training and Education: Not all staff had signed to indicate that they had read and understood the policy on health and safety. Staff interviewed could articulate the processes relating to health and safety as set out in the policy.

Monitoring: The health and safety policy was monitored pursuant to Regulation 29: Operational Policies and Procedures.

Implementation: The health and safety policy was up-to-date.

The approved centre was compliant with the regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not meet the full criteria of the *Judgement Support Framework* under processes, and training and education.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.25 Regulation 25: Use of Closed Circuit Television

(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 anytime on request.

Inspection Findings

CCTV was not used in the approved centre and therefore; this regulation was not applicable.

3.26 Regulation 26: Staffing

(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: There was a policy dated August 2015 available in relation to the recruitment, selection and vetting of staff including Garda vetting requirements. The policy included the recruitment, selection, vetting and appointment processes within the approved centre.

The policy did not include:

- The roles and responsibilities in relation to the recruitment, selection, vetting and appointment processes within the approved centre.
- The roles and responsibilities in relation to staffing processes and staff training within the approved centre.
- The job description requirements.
- Staff rota details and the methods applied for its communication with staff and ongoing staff training requirements.
- The organisational structure of the approved centre, including lines of responsibility.
- The staff planning requirements to address the number and skill mix of staff appropriate to the assessed needs of residents as well as the size and layout of the approved centre.
- The orientation and induction training for all new staff.
- The ongoing staff training requirements.
- The frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes, both internal and external.
- The staff performance and evaluation requirements.
- The required content of staff personnel records and the use of agency staff.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy relating to staffing as the staff signature log was not fully complete. Staff interviewed were able to articulate the processes relating to staffing as set out in the policies.

Monitoring: No staff training plan was provided. There was evidence that the number and skills mix of staff was reviewed against the levels recorded in the approved centre's registration. Analysis was completed to identify opportunities, to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of implementation: Staff were recruited and selected in accordance to the approved centre's policy and procedure for recruitment, selection and appointment. While staff within the approved centre had the appropriate qualifications, skills, knowledge and experience to do their job, the majority of nursing staff had not completed additional post registration training in CAMHS.

There was an organisational chart in place. A planned and actual staff roster was provided to the inspectors which showed that there was an appropriate number of staff on duty and an appropriately qualified member of staff in charge at all times. There was no occupational therapist (OT) on the MDT. The OT post had been vacant for two years. In this regard, the skill mix of staff available to residents was deemed inadequate to the needs of residents in the approved centre.

There was no evidence of annual staff training plans having been completed or a strategic overview of staff training needs in relation to providing a specialist CAMHS inpatient service. All staff had completed orientation training and induction training.

The training records provided were not complete for all personnel and those provided showed that not all staff were trained in fire safety, Basic Life Support, (BLS), management of violence and aggression and the Mental Health Act 2001.

A number of staff were trained in manual handling, infection control and prevention (including sharps, hand hygiene techniques and use of PPE), dementia care, care for residents with an intellectual disability, end of life care, and resident rights.

All clinical staff were trained and educated on the use of risk assessment tools. The main hospital had a board room with equipment to facilitate staff in-service education and training.

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

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

Ward or Unit	***Staff Grade***	***Day Staff***	***Night Staff***
AIPU	CNM3	1 shared	1-night time supervisor
	CNM1	1	0
	CNS	1 shared	0
	RPN	4	RPN X3
	Consultant Psychiatrist	1	0
	NCHD	2	0- on call NCHD
	Senior OT	0	0
	Senior Social Worker	1	0
	Psychologist	2	0
	Speech and Language Therapist	0.2 sessional	0
	Chaplain	0.3 sessional	0

Clinical Nurse Manager (CNM), Clinical Nurse Specialist (CNS),Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Occupational Therapist (OT)

The CNM3 (day) CNS (night) staff, and the night time supervisor were each shared with community CAMHS

The School staff were Dept of Education employed and not Adolescent Inpatient Unit employed and comprised 1 Principal and 4 Teachers.

WTE: Whole time equivalents

There was a School Principal and four teachers assigned to the on-site school. These staff were employed directly by the Department of Education and Skills.

The approved centre was non-compliant with this regulation because:

a) Not all staff were trained in the four training areas stipulated by the Mental Health Commission as a requirement for best contemporary practice 26(4).
b) There was no occupational therapist and hence the skill mix of staff was not appropriate to the assessed needs of residents, the size and layout of the approved centre 26 (2).

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.27 Regulation 27: Maintenance of Records

(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: There was a policy dated September 2014 available in relation to the maintenance of records. The policy set out the roles and responsibilities, privacy, confidentiality and legislative requirements concerning the maintenance of records. The required resident record creation and content was detailed in the policy. Those authorised to access and make entries in the residents' records as well as the destruction of records was covered within the policy.

The policy did not include:

- The residents' access to their records.
- General safety and security measures in relation to records (stored in locked room or press).
- Record review requirements.
- How entries in the residents' records are made, corrected or overwritten.
- The process for making a retrospective entry in residents' records.
- Record retention periods.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on the maintenance of records. Staff interviewed could articulate the processes for the creation of, access to, retention of and destruction of records as set out in the policies.

All clinical staff were trained in best-practice record keeping. Training was rolled out by the health care records manager to doctors and nurses. Other clinical staff received training at their induction.

Monitoring: There was no evidence that resident records had been audited. There was evidence of analysis having been completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: All resident records were observed to be secure, in good order, up-to-date and maintained and used in accordance with legislative requirements and

relevant Acts. Records were kept in a manner that ensured completeness, accuracy and ease of retrieval.

Resident records were reflective of the resident's current status and the care and treatment being provided and resident records were physically stored together where possible.

The resident records were maintained through the use of an identifier that was unique to the resident or some other effective method.

Resident records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Resident records were stored in a filing cabinet in the nursing office and only authorised staff made entries into resident records or specific sections therein.

The documentation of food safety, health and safety and fire inspections was maintained in the approved centre.

The approved centre was compliant with the regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement all of the *Judgement Support Framework* criteria under: processes, training and education and monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.28 Regulation 28: Register of Residents

(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 maintained a Register of Residents which met the full information requirements specified in Schedule 1 of this regulation.

The register was up-to-date, maintained and was made available to the Mental Health Commission.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.29 Regulation 29: Operating Policies and Procedures

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: There was a policy dated October 2014 available in relation to the development, management and review of operating policies and procedures. The policy set out the processes for developing operating policies and procedures, required by the regulations. The policy also covered the dissemination of operating policies, retaining and making obsolete old ones and training staff on new versions of updated operating policies.

The policy did not include:

- The roles and responsibilities in relation to the development, management and review of operating policies and procedures.
- The process for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on developing and reviewing operating policies. Staff could articulate the processes for developing and reviewing operational policies as set out in the policy.

Monitoring: There was a policy committee in the approved centre, however, there was no evidence that an annual audit been undertaken to determine compliance with review timeframes. There was no evidence of analysis of operating policies and procedures having been undertaken to identify opportunities for developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures required by the regulations were approved every three years and were up to date.

There were only clinical staff representation on the policy committee, managerial staff were not on the policy committee. Therefore, the operating policies and procedures of the approved centre were not developed with input from managerial staff, in consultation with relevant stakeholders (including service users) as appropriate.

The approved centre was compliant with the regulation on operating policies and procedures. The quality assessment was satisfactory but not rated excellent as the approved centre did not meet the full criteria of the *Judgement Support Framework* under processes, training and education, monitoring and evidence of implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.30 Regulation 30: Mental Health Tribunals

(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

All residents within the approved centre were under 18 years of age, therefore; this regulation did not apply**.**

3.31 Regulation 31: Complaints Procedures

(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: There was a policy dated October 2014 available in relation to complaints. The policy included the full requirements of the *Judgement Support Framework*. The policy set out the staff roles, responsibilities and processes 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.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy relating to complaints. Staff interviewed were able to articulate the processes of making, handling and investigation of complaints as set out in the policy. Relevant staff, including the Complaints Officer, were trained with regard to the complaints management process.

Monitoring: There was no evidence of scheduled audits of the complaints log and related complaints records taking place. There was no documented evidence of analysis of complaints data undertaken in the approved centre.

Evidence of Implementation: There was a nominated person for dealing with all complaints. The complaints procedure including the nominated person was publicly displayed and available at both unit level and within the reception area, which was located within the entrance to the unit.

The methods for the resident and their representatives to make a complaint were clearly detailed within the approved centre complaints policy and procedure. Complaint methods

included verbal, written, electronically by e-mail, telephone, through complaint feedback or suggestion forms.

There were no advocacy services provided within the approved centre, and there are no national public advocacy services available.

All minor complaints were recorded in a complaints log. All details of complaints were kept separate from the residents' Individual Care Plans.

All complaints (that were not minor complaints) were dealt with by the nominated person and recorded in the complaints log.

All complaints were addressed promptly within 48 hours of the approved centre receiving the complaint. This was demonstrated on inspection of two letters of complaints - the complaints had been promptly responded to and the issues were addressed. There was a community meeting weekly on the unit whereby minor complaints were addressed locally and documented.

The complaints log showed no evidence of the complainant's satisfaction or dissatisfaction, with the investigation findings.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not implement all of the *Judgement Support Framework* criteria under training and education, monitoring and evidence of implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.32 Regulation 32: Risk Management Procedures

(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: a

(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: There was a comprehensive up-to-date written policy dated July 2015 available in relation to risk management and incident management procedures and processes. The policy included the full requirements of the *Judgement Support Framework.* The policy *set* out the roles, responsibilities and processes for identifying, managing, responding and monitoring risks within the approved centre.

The policy included:

- The roles and responsibilities in relation to risk management, recording risks and risk register protocols.
- The identification and assessment of risks throughout the approved centre.
- The processes for the identification, recording, investigating and learning from serious or untoward incidents or adverse events involving residents.
- The precautions in place to control identified risks such as resident absent without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for documenting, reporting, reviewing and monitoring incidents and learning from incidents.
- The process for the protection of children and vulnerable adults from abuse within the care of the approved centre.
- The process for notifying the Mental Health Commission (MHC) about incidents involving residents of the approved centre.
- The approved centre had a comprehensive policy in place on medical emergencies and had processes in place for responding to specific emergencies.

Training and Education: Not all staff had signed to indicate that they had read the policy relating to the management of risk within the approved centre. Staff could articulate the risk management processes as set out in the policy. Relevant staff had been trained in the identification, assessment and management of risk. In addition, relevant staff were trained in health and safety risk management. Clinical staff were trained in individual risk management processes.

There was no evidence that management staff were trained in organisational risk management. While risk management was addressed in induction and orientation training to staff, there was no evidence that all staff were trained in incident reporting and documentation.

There was no evidence of risk management training having been documented.

Monitoring: The Risk Register was audited to determine compliance with the approved centre's risk management policy. All incidents were recorded and risk rated and then forwarded to the Director of Nursing. The approved centre had an ongoing process of auditing risks and action planning to address identified risks.

Evidence of Implementation:.
The Acting Chief Executive was the approved centre's Risk Manager and was responsible for ensuring the approved centre had a comprehensive risk management policy in place. The Clinical Nurse Manager and each Head of Department had responsibility to implement the policy and ensure staff were aware of it. The Risk Manager was known to staff and they were aware of their own responsibilities in assessing and reporting risk.

Clinical risk was assessed on admission and on an on-going basis and recorded in the clinical file and incorporated into a resident's ICP. Health and safety risks were identified, assessed, treated, monitored and recorded in a risk register.

Corporate risks were not identified, assessed, treated, reported and monitored by the approved centre. Corporate risks were not documented in the risk register.

The approved centre was actively involved in the identification and removal of ligature points. Child protection requirements were implemented as required. There was an emergency plan in place in relation to possible emergencies.

All incidents were recorded on the standardised Risk Management Occurrence form (incident reporting system) and escalated upwards to senior management who used the national incident management system (NIMS) in terms of rating incidents.

Clinical incidents were reviewed by the Multi-Disciplinary Team (MDT) at their weekly team meeting. Incident reports were recorded on a standardised form and entered into the incident management system (NIMS). At unit level, staff completed incident reports which were then escalated to the Director of Nursing and the Risk Management Review Group.

A six monthly summary of incidents was provided to the Mental Health Commission.

The approved centre was compliant with the regulation. The quality assessment was satisfactory but not rated excellent as the approved centre did not meet all of the criteria of the *Judgement Support Framework* under: training and education and evidence of implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.33 Regulation 33: Insurance

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 was indemnified under the State Claims Agency insurance. The approved centre's insurance covered: Public Liability, Employers' Liability, Clinical Indemnity and Property.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.34 Regulation 34: Certificate of Registration

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 prominently displayed in the ground floor entrance hallway.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

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

Electro-Convulsive Therapy (ECT) was not administered in the approved centre and, therefore; this rule was not applicable.

4.2 Section 69: The Use of Seclusion

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

Inspection Findings

Processes: There was a policy dated November 2015 available in relation to the use of seclusion. The policy covered who carried out the seclusion, the provision of information to the resident when not prejudicial to their health and wellbeing and an outline of how to reduce seclusion rates. The policy required all healthcare staff to be familiar with the processes.

There was also a policy in place regarding training staff in relation to seclusion called '*Policy on Training in Physical Restraint and Seclusion'.*

The policy did not include:

- The identity of specific appropriately trained staff to give training.
- Who will receive training.

Training and Education: Staff had signed to say that they had read and understood the policy on seclusion. Attendance of nursing staff at training was also recorded.

Monitoring: There was an annual report that showed that monitoring had taken place regarding seclusion processes.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities in the en suite shower and toilet. The seclusion room was designed with furniture and fittings which did not endanger patient safety.

One clinical file of a resident who had been in seclusion was inspected. Seclusion was only implemented in the resident's best interests, in a case of rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a thorough risk assessment of the resident.

The approved centre first considered all other interventions to manage unsafe behaviour. Cultural awareness and gender sensitivity was evident where a child was being secluded.

The resident was informed of the reasons, duration and circumstances which would lead to discontinuation of seclusion unless detrimental to the resident. The next-of-kin was informed and this was recorded in the resident's clinical file. Resident consent was not given by the resident as the resident did not have capacity to give consent. The resident wore their own clothing during seclusion. Refractive clothing was not applicable in the case of this resident. The resident did not have access to hazardous objects.

The resident was under direct observation by a registered nurse for the first hour and had continuous observation thereafter. There was a record of the resident made by the nurse every 15 minutes. It included the level of distress and behaviour. Following the risk assessment, a nursing review took place every two hours and there was a minimum of 2 staff (one registered nurse) who entered the seclusion room. The resident received a medical review every four hours.

The ICP addressed the assessed needs of the patient with the goal of ending seclusion. The patient was informed of the ending of seclusion. The reason for ending seclusion was recorded in the clinical file. The patient had the opportunity to discuss the episode with members of the MDT.

All use of seclusion was recorded in the clinical file of the resident. All episodes of seclusion were recorded in the Seclusion Register. A copy of the seclusion order sheet was placed in the clinical file. Each episode of seclusion was reviewed by the MDT and documented in the clinical file within two working days.

The approved centre was non-compliant with the rules on the use of seclusion as:

(a) the policy did not include the identity of specific appropriately trained staff to give training (11.1 (d)).
(b) The policy did not detail who will receive training (11.1 (a)).

	Compliant	Non-Compliant
Compliance with Rule		X

Risk Rating			
Low	Moderate	High	Critical
X			

4.3 Section 69: The Use of Mechanical Restraint

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

Mechanical restraint was not used within the approved centre and, therefore, this rule was not applicable.

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

5.1 Part 4: Consent to Treatment

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

Part 4 of The Mental Health Act (2001) Consent to Treatment was not applicable as all residents were under 18 years of age and of voluntary status.

6.0 Inspection Findings and Required Actions – 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.

6.1 The Use of Physical Restraint

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 policy dated November 2015 in place on physical restraint which met requirements of this code of practice with the exception of the following: the training policy did not include the frequency of training.

Training and Education: Not all staff had signed to indicate that they had read and understood the policy on physical restraint.

Monitoring: There was an annual report on the use of physical restraint which was forwarded to the Mental Health Commission (MHC).

Evidence of Implementation: The clinical file of two residents who had been physically restrained were inspected and there was a total of two episodes of physical restraint.

All relevant forms were completed, the notification of next-of-kin and medical review details were included. In each case the consultant psychiatrist was notified of the use of physical restraint. A medical review took place three hours after the start of the episode of physical restraint which was within the required timeframe.

Gender sensitivity was evident. There was evidence of the use and involvement of security personnel in the physical restraint of residents within the approved centre.

Training included the recording requirements for physical restraint, breakaway and de-escalation techniques and the safe application of physical restraint. Fourteen of 20 staff were trained in the Professional and Management of Aggression and Violence (PMAV).

The approved centre was non-compliant with this code of practice because:

(a) The training policy did not include the frequency of training. (10.1 (c)).
(b) Not all staff had signed to indicate that they had read and understood the policy on physical restraint (9.2(b)).
(c) Six staff were not trained in the Professional Management of Aggression and Violence (PMAV) (10.1(e)).

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
	X		

6.2 Admission of Children

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: There was a policy in place on the admission and assessment of children which included the requirement for each child to be individually risk assessed. There were associated policy procedures concerning family liaison, parental consent and confidentiality.

Training and Education: Staff had received training relating to the care of children. *Children First* training was provided monthly for any new staff members.

Monitoring: There was evidence of an audit having been conducted on the consent process.

Evidence of Implementation: The approved centre was a specific unit for the admission of children, with age and ability-appropriate programmes of activities and facilities provided.

Consent for treatment was obtained from one or both parents. Provisions were in place to ensure the safety of the child, ensuring the right of each child to have his/her views heard. All staff in the approved centre had been Garda Vetted in line with national policy.

Copies of the relevant children-related acts and guidelines were available to relevant staff.

Each child had their own single room and en suite bathroom. There were separate sleeping and living areas with two different corridors, which also provided appropriate recreational spaces. There was an additional nursing station located in the bedroom area.

The current resident population was all female with mixed gender staffing. Staff were cognisant of gender sensitivity and organised roster and duties around this.

Residents of the approved centre could access the separate school facility located across the garden. An individual education plan was developed for each child and educational needs were incorporated into each child's ICP.

There were no age appropriate advocacy services for children at the time of the inspection.

Each child had both their rights and information about the ward and facilities explained to them in a manner and format which was suited to their needs. Their understanding of the explanation given was recorded within in their clinical files.

The approved centre was compliant with this code of practice on the admission of children.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

6.3 Notification of Deaths and Incident Reporting

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 an in date policy available on the notification of deaths and incident reporting. The policy included the roles and responsibilities of members of staff in relation to reporting incidents. The staff responsibilities in relation to reporting deaths were detailed within the care of the dying/sudden death policy.

The policy did not include:

- The notification of deaths and incident reporting to the Mental Health Commission.
- The named risk manager.
- The roles and responsibilities in relation to the completion of death notification forms.
- The roles and responsibilities in relation to the the completion of six monthly incident summary reports and the submission of forms to the Mental Health Commission.
- The person responsible for the completion of six monthly notifications.

Training and Education: Staff were aware of the policies, understood the policies and could articulate the processes.

Monitoring: A six monthly summary of all incidents was provided to the Mental Health Commission.

Evidence of Implementation: No deaths had occurred in the approved centre. There was an incident reporting system in place called the *Risk Occurrence Management System* (ROM), which was used to manage risk occurrences and served as an in-house database within the approved centre. All incidents were reported through the National Incident Management System (NIMS). A standardised incident report form was used on ROM which was transferred to NIMS.

The approved centre was non-compliant with this code of practice as:

The policy on the notification of deaths and incident reporting did not include:

- The notification of deaths and incident reporting to the Mental Health Commission.
- The named risk manager.
- The roles and responsibilities in relation to the completion of death notification forms.
- The roles and responsibilities in relation to the completion of six monthly incident summary reports and the submission of forms to the Mental Health Commission.
- The person responsible for the completion of six monthly notifications.
-

	Compliant	Non-Compliant	
Compliance with Code of Practice		X	
Risk Rating			
Low	Moderate	High	Critical
X			

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

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

Processes: There was a policy available on the guidance for persons working in mental health services with people with intellectual disabilities.

The policy included staff roles and responsibilities, the protocols in place for person-centred treatment planning and presumption of capacity. The policy reflected least restrictive interventions.

In addition, there was a policy regarding the management of problem behaviours. There was also a policy in place on staff training in working with people with intellectual disability.

The policy included induction training for new staff, identified who should receive training, areas to be addressed in training, frequency of training, identifying appropriately qualified people to give training and the evaluation of training programmes. The policy also outlined Inter-agency collaboration.

Training and Education: 13 staff had received intellectual disability training, which comprised training and education to support the principles and guidance in the Code of Practice.

Education and training covered: person-centred approaches, relevant human rights principles and training that focused on preventative and responsive strategies to problem behaviours.

Monitoring: There was evidence of policies being reviewed every three years. The approved centre also reviewed the use of restrictive practices periodically.

Evidence of Implementation: This was not applicable as there was no current resident with an intellectual disability.

This code of practice was assessed against processes and training and education only. The approved centre was compliant with this code of practice.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

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

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

Electro-Convulsive Therapy did not use Electro-Convulsive Therapy, therefore; this code of practice was not applicable.

6.6 Admission, Transfer and Discharge

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 discharge, transfer and admission policies in place and these were in-date.

ADMISSION: The admission policy covered staff roles and responsibilities of the MDT with regards to assessment after admission, the processes for planned admission and the procedures for involuntary admission. The admission policy did not include the protocol for urgent referrals and the protocol for those who self-present.

TRANSFER: There was a policy on transfer in place. The transfer policy did not include emergency transfers and transfers abroad.

DISCHARGE: The discharge policy included the information on resident prescriptions on discharge.

The discharge policy did not include:

a) The supply of medication on discharge.
b) The procedures for the management of discharge against medical advice
c) The protocol for discharge of people with intellectual disabilities.
d) The protocol for discharging homeless people.

A follow up policy was in place which covered the processes in relation to following up with residents after discharge. The follow up policy did not include a way of following up and managing missed appointments.

Training and Education: Not all staff had signed to indicate that they had read and understood the policies on admission and discharge. Staff had not signed to indicate that they had read and understood the policy on transfers.

Monitoring: The clinical audit folder had evidence that an audit had taken place on the consent process only in relation to admissions. There was no evidence in the clinical audit folder of an audit of the implementation of and adherence to discharge policy having been conducted.

Evidence of Implementation:
Admission*:* The approved centre complied with the following regulations associated with this code of practice: Regulations: 32: Risk Management Procedures, Regulation 20 Provision of Information to Residents, Regulation 15 Individual Care Plan, Regulation 27 Maintenance of Records and Regulation 7 Clothing. The approved centre did not comply with Regulation 8: Personal Property and Possessions.

The approved centre had a copy of the admission policy in place in each unit within the approved centre. A hard copy was available and it was also available on the hospital

intranet. All assessments and examinations were recorded within the clinical file. There was also a keyworker system in place.

Three clinical files were inspected in relation to the admission process and there was a comprehensive psychiatric assessment and full physical examination in place for all three residents. All assessments and examinations were recorded in each resident's clinical file.

Discharge: Two clinical files were inspected against in relation to the discharge process and while both had discharge summaries, in the case of one of the resident the discharge summary was not sent within 14 days of discharge.

Transfer: No current resident had been transferred.

The approved centre was non-compliant with this code of practice on Admission, Transfer and Discharge because:

a) The admission policy did not include the protocol for urgent referrals and the protocol for those who self-present.
b) The transfer policy did not include emergency transfers and transfers abroad.
c) The discharge policy did not include:
   - The supply of medication on discharge.
   - The procedures for the management of discharge against medical advice
   - The protocol for discharge of people with intellectual disabilities.
   - The protocol for discharging homeless people.
d) The follow up policy did not include a way of following up and managing missed appointments.
e) Staff had not signed to indicate that they had read and understood the policy on transfers.
f) There was no evidence in the clinical audit folder of an audit of the implementation of and adherence to discharge policy having been conducted.
g) The approved centre was not compliant with Regulation 8 Personal property and Possessions as required by this code of practice.
h) A discharge summary had not been sent to the relevant healthcare staff within the required timeframe.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
	X		

Return with supporting evidence to compliance@mhcirl.ie

MENTAL HEALTH COMMISSION
DRAFT INSPECTION REPORT: REVIEW AND COMMENT FORM

Section A		
	Approved Centre: AC0076 Adolescent In-patient Unit, St Vincent's Hospital	Date(s) of Inspection: 14th, 15th and 16th September, 2016
	Registered Proprietor: Ms Caroline Grenham	Inspection Team: Ms Orla O'Neill, Lead Inspector, Ms Mary Connellan, Assistant Inspector and Mr Donal O'Gorman, Assistant Inspector.
Section B		
	In completing this form please ensure to: 1. Review the draft inspection report provided; and 2. Type comments into the template in **Section D: Comments**; and 3. Attach evidence to support your comments and note this in **Section D: supporting evidence**; and 4. Provide sign-off by the Registered Proprietor (in the case of an HSE Approved Centre, please ensure sign-off by person with delegated responsibility as Registered Proprietor) in **Section F** of this form; and 5. Submit this form and supporting evidence by email to **compliance@mhcirl.ie** no later than 15th of March 2017. Please note, this form is not for the completion of a Corrective and Preventative Action (CAPA) plan, which should be included in the body of the inspection report.	
Section C		
	The Lead Inspector will reply within 3 days of receipt of the completed form. Thank you.	

Section D				**Section E**	
Inspection Report		Comments	Supporting evidence	For MHC use only	
Page	Reference			Accept/ Reject	Reason(s)
72	Code 6.1 Point 12 CAPA	As per hospital policy, in line with Code of Practice in the use of physical restraint : – The hospital's Security staff are all fully trained in T.M.A.V. – They never initiate restraint – If required to be involved, they are always made aware of relevant entries in the resident's Care Plan pertaining to their needs by the nurse initiating and leading the physical restraint. We are of the opinion that this is in compliance with the Code	Training in: Children First T.M.A.V.		

Return with supporting evidence to compliance@mhcirl.ie

Continued				Continued	
Inspection Report		Comments	Supporting evidence	For MHC use only	
Page	Reference			Accept/ Reject	Reason(s)

Section F				Section G	
	Completed by: [block capitals]	CAROLINE GRENHAM	Approved by: [block capitals]	For MHC use only	
	Date:	24/3/2017	Date:	Date received:	[Date]
	Signature:		Signature:	Date reviewed:	[Date]
				Reviewed by:	[Lead Inspector]
				Date returned to Approved Centre:	[Date]

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016

Completed by approved centre: Adolescent In-Patient Unit, St Vincent's Hospital **Date submitted:** 23 March 2017

<<To be included in the final report:>> For each finding of non-compliance the registered proprietor was requested to provide a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.

<<Instruction to registered proprietor (or nominees), to be removed from the final report: Please provide a corrective action and a preventative action (CAPA) plan for each area of non-compliance, listed below. The areas of non-compliance have been taken directly from the Inspector's findings in the draft inspection report. The corrective action must address the specific area of non-compliance and the preventative action must mitigate the risk of non-compliance reoccurring. CAPA plans must be **Specific**, **Measureable**, **Achievable**, **Realistic** and **Time-bound** (SMART).

Please note, the CAPAs will be published as submitted, including spelling, grammar, font, formatting etc>>

Regulation 8: Residents' Personal Property and Possessions (inspection report reference 3.8)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. The approved centre did not maintain a record of residents' personal property and possessions as required by 8 (3) of this regulation.	Corrective action(s): **The Approved Centre will maintain a record of resident's personal property and possessions** Post-holder(s): **CNMII**	Audit will be carried out yearly and outcomes disseminated	No barriers to implementation	Immediate implementation and yearly review
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017

Regulation 21: Privacy (inspection report reference 3.21)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
2. Resident privacy was not appropriately respected due to the confidential nature of information on a publicly visible noticeboard.	Corrective action(s): **Reconfigure content and visibility of patient identification board respecting patient's privacy** Post-holder(s): **CNMIII/ADON**	Observation Staff Education	No barriers to implementation	Immediate implementation and yearly review
	Preventative action(s): <<insert preventative action>> Post-holder(s):			

Regulation 22: Premises (inspection report reference 3.22)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
3. The heating temperature within the AIPU could not be regulated by staff or residents Therefore, the approved centre was not adequately heated.	Corrective action(s): **Individual temperature regulation system now in place in each bedroom** Post-holder(s): **CNMIII**	Temperature audit carried out 5 days a week and outcomes disseminated	No barriers to implementation	Completed
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
4. There was inadequate provision of lavatory and changing facilities for staff. Therefore, this did not show due regard to the safety and well-being of residents and staff.	Corrective action(s): **There is adequate provision of lavatory and changing facilities and all staff are aware of their location** Post-holder(s): **CNMII**	Communiated with all staff	No barriers to implementation	Completed
	Preventative action(s): <<insert preventative action>> Post-holder(s):			

Regulation 26: Staffing (inspection report reference 3.26)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
5. Not all staff were trained in the four training areas stipulated by the Mental Health Commission as a requirement for best contemporary practice 26(4).	Corrective action(s): **A Training Needs Analysis on the four areas is completed and a plan to ensure all staff are trained is being rolled out** Post-holder(s): **ADON**	Mandatory Training Needs monitored quarterly	No barriers to implementation	Q3 2017
	Preventative action(s): Audit Post-holder(s):			Quarterly
6. There was no occupational therapist and hence the skill mix of staff was not appropriate to the assessed needs of residents, the size and layout of the approved centre 26(2).	Corrective action(s): **0.5WTE Occupational Therapist has been recruited and in place since November 2016** Post-holder(s): **CNMIII**	Completed	No barriers to implementation	Completed
	Preventative action(s): <<insert preventative action>> Post-holder(s):			

Section 69: The Use of Seclusion (inspection report reference 4.2)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
7. The policy did not include the identity of specific appropriately trained staff to give training (11.1(d)).	Corrective action(s): **There will be a register of names of accredited trainers who provide training of T.M.A.V. for the service on the hospital Training Database** Post-holder(s): **DON / HR**	Audit of all accredited trainers annually	Audit of all accredited trainers annually	Q3 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
8. The policy did not detail who will receive training (11.1(a)).	Corrective action(s): **There will be a register of names of all appropriate staff referred to in the policy who have received training in T.M.A.V. kept on the hospital training database.** Post-holder(s):**DON / HR**	Annual review of training database	No barriers to implementation	Q4 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017

Code of Practice: The Use of Physical Restraint (inspection report reference 6.1)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
9. The training policy did not include the frequency of training. (10.1(c)).	Corrective action(s): **The policy now includes required timelines for refresher / training** Post-holder(s): **DON /HR**	This will be monitored quarterly as part of the Training Database	No barriers to implementation	Q4 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
10. Not all staff had signed to indicate that they had read and understood the policy on physical restraint (9.2(b)).	Corrective action(s): **All staff have been informed of their obligation to read and understand the policies** Post-holder(s): **CNMII / Clinical Lead**	Audit and outcomes acted upon.	No barriers to implementation	Q2 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017

Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
11. Six staff were not trained in the Professional Management of Aggression and Violence (PMAV) (10.1(e)).	Corrective action(s): **A Training Needs Analysis on the four areas is completed and a plan to ensure all staff are trained is being rolled out** Post-holder(s): **DON / HR**	Mandatory Training Needs monitored quarterly	No barriers to implementation	Q3 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
12. Security personnel were involved in physical restraint of residents (6.1).	Corrective action(s): **Please see Review and Comment form with reference to page 72, Code 6.1, Part 12 CAPA** Post-holder(s): **DON / Chief Executive**			Q3 2017
	Preventative action(s): <<insert preventative action>> Post-holder(s):			

Code of Practice: Notification of Deaths and Incident Reporting (inspection report reference 6.3)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
13. The policy did not include: • The notification of deaths and incident reporting to the Mental Health Commission. • The named risk manager. • The roles and responsibilities in relation to the completion of death notification forms. • The roles and responsibilities in relation to the completion of six monthly incident summary reports and the submission of forms to the Mental Health Commission. • The person responsible for the completion of six monthly notifications.	Corrective action(s): **The policy on Notification of Deaths and Incident Reporting will be updated** Post-holder(s): **Risk Manager / Chief Executive**	A 6 month report is generated by the Risk Manager for the Mental Health Commission Audit to be completed to ensure application of and compliance with this policy	No barriers to implementation	Q3 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017

Code of Practice: Admission, Transfer and Discharge (inspection report reference 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
14. The admission policy did not include the protocol for urgent referrals and the protocol for those who self-present.	Corrective action(s): **The Admission and Transfer Policy and the Discharge Policy will be updated** Post-holder(s):**Policy Committee**	Audit	No barrier to implementation	Q3 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
15. The transfer policy did not include emergency transfers and transfers abroad.	Corrective action(s): **The Admission and Transfer Policy and the Discharge Policy will be updated** Post-holder(s):**Policy Committee**	Audit	No barrier to implementation	Q4 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017

Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
16. The discharge policy did not include: • The supply of medication on discharge. • The procedures for the management of discharge against medical advice • The protocol for discharge of people with intellectual disabilities. • The protocol for discharging homeless people.	Corrective action(s): **The Admission and Transfer Policy and the Discharge Policy will be updated** Post-holder(s):**Policy Committee**	Audit	No barrier to implementation	Q4 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
17. The follow up policy did not include a way of following up and managing missed appointments.	Corrective action(s): **The Admission and Transfer Policy and the Discharge Policy will be updated** Post-holder(s):**Policy Committee**	Audit	No barrier to implementation	Q4 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017

Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
18. Staff had not signed to indicate that they had read and understood the policy on transfers.	Corrective action(s): **All staff have been informed of their obligation to read and understand the policies** Post-holder(s): **CNMII / Clinical Lead**	Audit and outcomes acted upon.	No barriers to implementation	Q3 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
19. There was no evidence in the clinical audit folder of an audit of the implementation of and adherence to discharge policy having been conducted.	Corrective action(s): **Audit** Post-holder(s): **Audit Committee**	Audit and outcomes actioned	No barrier to implementation	Q4 2017
	Preventative action(s): **Audit** Post-holder(s):			Q4 2017
20. A discharge summary had not been sent to the relevant healthcare staff within the required timeframe.	Corrective action(s): **There is now a Medical Discharge letter sent on the day of discharge** Post-holder(s): **Clinical Lead**	Copy of letter kept in the Clinical File	No barrier to implementation	Q1 2017

	Preventative action(s): <<insert preventative action>> Post-holder(s):			