## Mental Health Commission

### Approved Centre Inspection Report

*(Mental Health Act 2001)*

<table>
<thead>
<tr>
<th><strong>APPROVED CENTRE NAME:</strong></th>
<th>Eist Linn Child and Adolescent In-patient Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IDENTIFICATION NUMBER:</strong></td>
<td>AC0082</td>
</tr>
<tr>
<td><strong>APPROVED CENTRE TYPE:</strong></td>
<td>Child and Adolescent In-Patient Unit</td>
</tr>
<tr>
<td><strong>REGISTERED PROPRIETOR:</strong></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td><strong>REGISTERED PROPRIETOR NOMINEE:</strong></td>
<td>Ms Gretta Crowley</td>
</tr>
<tr>
<td><strong>MOST RECENT REGISTRATION DATE:</strong></td>
<td>3 December 2013</td>
</tr>
<tr>
<td><strong>NUMBER OF RESIDENTS REGISTERED FOR:</strong></td>
<td>20</td>
</tr>
<tr>
<td><strong>INSPECTION TYPE:</strong></td>
<td>Unannounced</td>
</tr>
<tr>
<td><strong>INSPECTION DATE:</strong></td>
<td>4, 5, 6 November 2015</td>
</tr>
<tr>
<td><strong>PREVIOUS INSPECTION DATE:</strong></td>
<td>12 June 2014</td>
</tr>
<tr>
<td><strong>CONDITIONS ATTACHED:</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>LEAD INSPECTOR:</strong></td>
<td>Ms Mary Corrigan</td>
</tr>
<tr>
<td><strong>INSPECTION TEAM:</strong></td>
<td>Mr Donal O’Gorman</td>
</tr>
<tr>
<td><strong>THE INSPECTOR OF MENTAL HEALTH SERVICES:</strong></td>
<td>Dr Susan Finnerty MCN009711 (Acting)</td>
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1.0 Mental Health Commission Inspection Process

The principal functions of the 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 under this Act.

The Mental Health Commission strives to ensure its principal legislative functions are achieved through the registration 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). 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 Mental Health Act (2001), 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 Section 4 of the Mental Health Act 2001 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 individual regulation, or rule, shall also be risk assessed.

The approved centre is required to act on all aspects identified as non-compliant or with a high / critical risk rating. Demonstration of immediate corrective rectifications, and ongoing preventative actions must be clearly identified. These actions are required to be specific, measurable, achievable and time-bound. All actions must have identified timeframes and responsibilities.

A copy of the draft report was forwarded to the service and comments and review on the report were invited from the Registered Proprietor. These comments were reviewed by the lead inspector and incorporated into the report, where relevant.

In circumstances where the Registered Proprietor fails to comply with the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules, the Mental Health 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 approved centre consisted of a purpose-built facility which incorporated an old church which had stood on the original site. The approved centre was opened in 2009. It was bright and airy with high ceilings and a sense of space. Decoration was mostly white but artwork in many forms compiled by the young people of the approved centre adorned the walls. The approved centre was linked with the school Coláiste Éist Linn by an enclosed garden.

Éist Linn was the approved centre for HSE South and covered Cork, Kerry, Waterford, Wexford, South Tipperary, Carlow and Kilkenny. Seventeen Community Child and Adolescent Services referred in to it and it formed part of the National Child and Adolescent Inpatient Mental Health Services referral system. Thirteen young people were attending the service during the time of inspection, twelve were voluntary and one was detained under the Mental Health Act 2001. A vacancy existed for a Consultant Psychiatrist in Child and Adolescence within the approved centre. The Clinical Director reported that this was the reason why the number of young people was lower than the registration number of twenty.

2.2 Governance

There was evidence of clear governance structures and processes. The approved centre’s management team met in the approved centre at least monthly to discuss ongoing issues within the approved centre. Members of the approved centre’s management team formed part of the area management structure and met monthly to discuss all areas of management within the Community Healthcare Organisation’s (CHO) area. The location of meetings was rotated to various approved centres within the CHO. An organogram and minutes of management meetings were furnished to the inspection team.

2.3 Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against, except the following which were not applicable to this approved centre:

Regulation 30: Mental Health Tribunals
Section 59: The use of Electro-Convulsive Therapy
Section 69: The use of Seclusion
Section 69: The use of Mechanical Restraint
Part 4: Consent to Treatment
Code of Practice for the Use of Electro-Convulsive therapy (ECT) for Voluntary Patients

The inspection was undertaken onsite in the approved centre from:

4 November 2015 at 09:45 to 6 November 2015 at 16:00
2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on 12 June 2014 identified the following areas that were not fully compliant:

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>Inspection Findings 2015</th>
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</thead>
<tbody>
<tr>
<td>Regulation 13: Searches</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>Compliant</td>
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<tr>
<td>Regulation 21: Privacy</td>
<td>Compliant</td>
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<tr>
<td>Regulation 22: Premises</td>
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<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>Not Compliant</td>
</tr>
<tr>
<td>Regulation 24: Health And Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Compliant</td>
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<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>Compliant</td>
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2.5 Conditions to Registration

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

2.6 Non-compliant areas on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
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</tr>
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</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these are included in the report, in the relevant areas.

2.7 Areas of compliance rated Excellent on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
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<tbody>
<tr>
<td>Regulation 5: Food and Nutrition</td>
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<td>Regulation 6: Food Safety</td>
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<tr>
<td>Regulation 7: Clothing</td>
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<td>Regulation 9: Recreational Activities</td>
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<td>Regulation 15 Individual Care Plan</td>
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<td>Regulation 16: Therapeutic Services and Programmes</td>
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<td>Regulation 17: Children’s Education</td>
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<td>Regulation 21: Privacy</td>
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<td>Regulation 24: Health and Safety</td>
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### 2.8 Areas of good practice identified on this inspection

- Range of therapeutic activities was excellent and involved areas such as art, sport, drama and music.
- Community Meetings; a weekly meeting young people attended that was facilitated by nursing staff. It was an opportunity to raise concerns about any aspect of day to day life within the approved centre and an opportunity to decide on activities and outings for the following week.
- Daily ‘Meet and Greet’ multidisciplinary meetings.
- Revised and updated Information Booklet for young people and their families.
- Peer learning for nurses held weekly, every Wednesday for 30 minutes.
- Eating Disorder Forum for Nurses underpinning best practice in this area.
- Staff in the approved centre were part of National Clinical Programmes for Early Onset Psychosis and Eating Disorders.
- The approved centre had joined the local library which was welcomed by young people.
- Hearing Voices Support Group had been set up in the community for young people in partnership with Community Child and Adolescent Mental Health Teams.

### 2.9 Reporting on the National Clinical Guidelines

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

### 2.10 Resident Interviews

The inspection team attended the Community Meeting on the 5 November 2015, in order to gain an opportunity to meet with the young people. Several opportunities were afforded to the young people to meet with the inspection team on an individual basis. However, no young person availed of this opportunity.

### 2.11 Feedback Meeting

The inspection team met with members of the senior management team at 15:00 on 6 November 2015. The Registered Proprietor Nominee, Executive Clinical Director (ECD), Clinical Director, Area Director of Nursing, CNM 3, CNM 2 and Senior Clinical Psychologist attended the feedback meeting in the approved centre. An expression of gratitude was extended to the staff of the approved centre that had facilitated and accommodated the
inspection team over the inspection period. Inspectors reiterated that an excellent rapport and respect was observed between staff and young people during the inspection period. Areas of good practice and initiatives were stressed. This meeting served to facilitate the provision of feedback regarding findings of the inspection together with an opportunity for representatives of the service to clarify any issues arising from the inspection.
### 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)

<table>
<thead>
<tr>
<th>Section</th>
<th>Regulation</th>
<th>Description</th>
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<td>3.1</td>
<td>Regulation 1: Citation</td>
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<td>3.2</td>
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<tr>
<td>3.3</td>
<td>Regulation 3: Definitions</td>
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</table>
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: The approved centre had a policy for identification of residents with clearly identifiable roles and responsibilities in relation to same.

Training: Staff were aware and understood the processes in relation to the identification of residents and this was documented as part of the induction training.

Monitoring of Compliance: There was no evidence of an annual audit undertaken.

Evidence of Implementation: A minimum of two identifiers were in place; date of birth, photograph and resident number. These identifiers were appropriate for the communication skills of the young people and the physical environment.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
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### 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:** The Catering Manager was based in St Stephen’s Hospital and had a clear role and responsibilities in relation to food and nutrition within the approved centre. There was a process in place for the management of food and nutrition for each young person.

**Training:** Staff were aware of the processes in relation to food and nutrition for young people. Hazard Analysis Critical Control Point (HACCP) training had been provided and this was documented.

**Monitoring of Compliance:** An annual audit was undertaken by the catering department.

**Evidence of Implementation:** A dietician played an active role in the dietary regime for young people in the approved centre; this was clearly evident in the meal plans for those with an eating disorder. Menus were reviewed for nutritional adequacy and choice. Special dietary requirements for religious, nutritional needs and personal preference were catered for. This was clearly documented in the individual care plan (ICP). Weight and fluid intake was monitored on a needs basis. At least two choices of a hot meal were available daily. Potable water was available in the dining area which was not always open. A clinical decision was made to place the water cooler in this area. In the past, some residents with an eating disorder had engaged in the process of water loading prior to being weighed. Other water coolers were available in therapy rooms and young people had access to water on request.

### Compliance Rating:

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<thead>
<tr>
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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:
A policy was in place outlining responsibilities in relation to food safety. Processes were in place for food preparation, handling, storage, distribution and disposal.

Training:
Catering staff had received HACCP and food safety training.

Monitoring of Compliance:
Food safety audits were completed by the Catering Manager who was based off site.

Evidence of Implementation:
Catering staff were available. The dining room was of adequate size and of suitable layout and space to meet the requirements of the young people. There were appropriate hand washing facilities available for catering staff and they were observed wearing the appropriate personal protective clothing. Refrigeration temperatures were recorded and were within the appropriate range for food hygiene requirements and a log of same was maintained. Environmental Health Officer’s (EHO) report and audits of food hygiene standards were made available to the inspection team. Suitable and sufficient catering equipment, crockery and cutlery were provided within the approved centre.

Compliance Rating:

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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.

<table>
<thead>
<tr>
<th>Inspection Findings</th>
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<tbody>
<tr>
<td>Processes: The approved centre’s policy outlined the approved centre’s responsibility to support the young person to manage their clothing. Clothes were provided, if required, with due consideration given to the young person’s preferences, dignity and religious preferences.</td>
</tr>
<tr>
<td>Training: Staff were aware of and understood the policy and processes relating to young people’s clothing.</td>
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<tr>
<td>Monitoring of Compliance: Processes relating to young people's clothing were reviewed in response to need.</td>
</tr>
<tr>
<td>Evidence of Implementation: Young people had access to their own clothing and had laundry facilities within the approved centre. Staff assisted young people, if necessary, with laundry. However, a number of young people chose to send their laundry home. Money could be made available for clothing to be bought, if necessary, and staff were aware of this process. No night clothes were worn by young people during the day.</td>
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<th>Compliance Rating:</th>
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<td>Non – Compliant – Negligible Achievement (1)</td>
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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: The approved centre had a policy which outlined best practice in the storage of young people's personal property and possessions and their access to same. This process was outlined to young people and parents in the pre-admission process. The policy encompassed all parts of the regulation.

Training: Staff were aware of and understood the process relating to personal property and belongings.

Monitoring of Compliance: Processes in relation to personal property and possessions were not audited.

Evidence of Implementation: Adequate storage facilities were available for young people’s property and possessions. A system was in place for the storage of money and valuables which provided safeguards for staff and young people. A property list was completed for each young person and was signed by the admitting nurse and the young person.

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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: A policy outlining best practice and responsibilities in providing recreational activities for young people was available in the approved centre. Activities were provided primarily by nursing and occupational therapy staff. Consideration was given for young people’s likes and dislikes and their level of risk. A timetable was clearly displayed in the approved centre and each young person was given a copy of same.

Training: Staff were aware and understood the processes in relation to recreational processes. Training was received through their professional competency qualification.

Monitoring of Compliance: A ‘Suggestion Box’ on the approved centre gave young people an opportunity to make suggestions in relation to other recreational activities and this was facilitated where possible. No formal annual audit of process was completed.

Evidence of Implementation: A wide range of recreational activities was available to young people in the approved centre. The timetable began at 08:00 and ended at 22:30. It included free time, individual time with nursing staff, attendance at the Community Meeting and time away from the approved centre for an ‘outing’. The approved centre had two transport vehicles to facilitate same. The Community Meeting was the forum where the destination and type of outing was decided. Young people actively participated in this decision. Excellent facilities were available including a gym with sports equipment, indoor basketball, table tennis, arts and crafts, a games room with a pool table and computer games. There was access to computers, however, this was with staff supervision. Four TV rooms with comfortable seating were available to the young people. There were two outside spaces. These were large, pleasant enclosed gardens with seating areas and both were wheelchair accessible.

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### 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:** A policy was available in the approved centre which outlined the commitment to the facilitation of religious practice and to respect young people’s wishes to not participate in same.

**Training:** Staff in the approved centre were aware of the processes in relation to facilitating a young person practice their religion.

**Monitoring of Compliance:** Religion was documented as part of the admission process. There was no review of the process of facilitating young people in the practice of their religion.

**Evidence of Implementation:** No young person resident in the approved centre at the time of the inspection had requested access to a minister of their religion. However, this could be facilitated on request.

#### Compliance Rating:

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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 children visiting a resident.

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

Inspection Findings

Processes: A policy about visiting was available in the approved centre. This policy outlined how and why decisions about visiting were reached. A detailed explanation of how visits were conducted in the approved centre formed part of this policy. Processes to facilitate other children visiting the approved centre were outlined.

Training: Staff were aware of the policy and processes around visiting.

Monitoring of Compliance: The visiting process was under review regularly. Visit processes were reviewed and arrangements adjusted and care plans were changed dependent on the young person’s assessed need at a given time.

Evidence of Implementation: Visiting arrangements were communicated before admission as part of the pre admission process and throughout the young person’s time in the approved centre. Visiting times were adjusted dependent on the young person’s assessed needs and were not facilitated during a period of time that a young person was attending school or therapeutic groups. An approved list of visitors compiled in conjunction with parents, young people and staff was available in each clinical file. Visiting times were not publicly displayed. However, times were discussed at family meeting, preadmission assessment and were clearly documented in information given to families and young people. Visiting was arranged to facilitate learning for the family; for example, one parent attended to learn about meal planning so the same therapeutic intervention could continue at home while the young person was on leave and post discharge.

Visitors entered the approved centre through a Reception area which was staffed between 08:30 and 16:30. After this time, the visitors were in intercom contact with nursing staff who facilitated visitors entering and leaving the approved centre. Visitors were not allowed to wander around the approved centre unaccompanied. On entering and leaving the approved centre each visitor had to sign the Fire and Evacuation Book. Thus, the approved centre was aware of exactly how many people were on the premises in the event of a fire. A visitors’ room was available that could also be used if children visited the approved centre.
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- **Non-Compliant – Poor Achievement (2)**
- **Compliant – Good Achievement (3)**
- **Compliant – Excellent Achievement (4)**
- **Not-Applicable**
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: A policy was available in the approved centre that outlined the approved centre’s responsibility in relation to young people’s communication.

Training: Staff were aware of and understood the processes in relation to communication. Training was provided as part of the induction process and this was documented.

Monitoring of Compliance: No formal audit of the process was undertaken.

Evidence of Implementation: Individual risk assessments were completed pertaining to any risks associated with communication and this was reflected in their ICP. An approved contact list was documented in each young person’s clinical file; this was agreed with young people, parents and staff as part of the admission process. Young people had access to internet and email under supervision. Post was delivered to the approved centre and given to the young person directly. No mobile phones were in use within the approved centre and this was agreed prior to admission. Facilities were made available for a young person to have a phone conversation in private - a cordless phone and room were made available to them. An interpretation service was available.

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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: A written operational policy outlining the roles and responsibilities in relation to the implementation of searches with and without consent was available. Young people were made aware of the policy on searches on admission, and consent was sought and given by parents and young people for environmental and safety sweeps. The policy stated that all staff continually assess risk based on clinical judgement and the individual young person’s potential to be exposed to an unsafe environment. Emergency and routine searches were outlined in the policy and it specified searches were to be conducted by two registered nurses. Policy outlined items that were to be removed and the process to be followed if illicit substances were found.

Training: Nursing staff were aware of and understood the policy and processes that surrounded searches.

Monitoring of Compliance: An incident form was completed in relation to search items found. However, no annual audit of the process was undertaken.

Evidence of Implementation: Consent was sought and given by parents and young people to facilitate searches on admission. Individual risk assessments were conducted and documented in the clinical file. Information on searches formed part of the approved centre’s Information Booklet. Two registered nurses were always in attendance when searches were conducted and had regard for the young person’s dignity, respect, privacy and gender. A written record of searches was maintained in the approved centre.
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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: Two policies were available - one for the care of a young person requiring palliative care, and the second outlining the management of sudden death in the approved centre. The policies encompassed all elements of the regulation.

Training: Staff were aware of and understood the policies.

Monitoring of Compliance: The policy had been reviewed and updated. However, no deaths had occurred since the last inspection.

Evidence of Implementation: As no deaths had occurred since the last inspection, compliance was assessed against the policies, processes and training in place at the approved centre.

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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: The approved centre had a written operational policy on individual care plans (ICPs) which outlined the purpose and procedures for ICPs. Members of the young person’s team and members of the multidisciplinary team (MDT) that had input into the ICP were specified. The process was for each young person to have an ICP that was reviewed weekly. There was also a process for young person involvement and for incorporating goals and personal views into the ICP.

Training: ICPs were evidence-based and completion of same formed part of the induction process. Whilst no formal training was provided, staff were aware of the process of individual care planning.

Monitoring of Compliance: An annual audit was undertaken.

Evidence of Implementation: Young people and their families were actively involved in the ICP process and this was formulated with input from both parties. An initial care plan was developed, following admission, with an MDT care plan developed at the first MDT meeting. The ICP involved all aspects of the young person’s care and treatment. Evidence-based assessments were used. Risk assessment and the discharge plan formed part of the ICP. ICPs were evaluated by the MDT in conjunction with the young person. Education requirements and documented goals formed part of the ICP. There was evidence of the use of recovery-focused language within the ICP. A copy of the ICP was not routinely offered but a copy was made available on request. Whilst every young person had, and could name, their key worker this named person was not clear from the ICP document.

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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 high-level policy on the provision of therapeutic services and programmes. However, processes ensured best practice underpinned programmes and their delivery. There was a process to meet assessed needs with a therapeutic programme aimed at achieving and maintaining the young person’s optimal levels of emotional, physical and psychological wellbeing.

Training: Staff were trained to provide therapeutic services and programmes as part of their professional training and qualification. The type of training provided was based on a training needs analysis of the approved centre and this was provided through service planning and development.

Monitoring of Compliance: Staff reviewed programmes as part of their programme development. However, no annual audit of processes was conducted.

Evidence of Implementation: Therapeutic services and programmes met the assessed needs of young people and this was reflected in the ICP. A timetable with a variety of therapeutic groups including ‘Talking and Feelings’, cognitive behavioural therapy, psychotherapy and teen life skills were available to young people. Individual therapies were available with the Speech and Language Therapist and Occupational Therapist. Excellent facilities were available to facilitate same.

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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: A policy was available that outlined processes in relation to the provision of education. In addition, the school had policies for attendance, enrolment and discipline.

Training: All teaching staff were appropriately qualified in a range of subjects including English, geography, maths, sciences and languages. All teachers were registered with the Teaching Council and were employed by Education and Training Board and were all Garda-vetted.

Monitoring of Compliance:
Teaching staff met and reviewed all education plans at the beginning of each school year. Teaching staff made recommendations at MDT level for assessment of learning difficulties by, for example, the Speech and Language Therapist, Psychologist and Occupational Therapist.

Evidence of Implementation: Teaching staff attended the first MDT and attendance at school was based on the young person’s mental state. If the young person could not attend school immediately, teaching staff reviewed this with the MDT on a daily basis and the young person started at the earliest opportunity. School attendance was facilitated at a time and pace set by the young person. A school assessment form was completed, at a time agreed by the MDT. This established the young person’s level of education attained to date and established the need for resources. This assessment also examined attendance and school relationships. Learning goals were strategized; students set the goal and set the pace and teaching staff worked with them at a level appropriate to the young person’s cognitive ability and mental state. A lesson plan was completed daily. Teaching staff liaised closely with nursing staff to ensure school attendance. A school attendance list was in the nursing office so nursing staff were aware of who was going to school and for what length of time. Nursing staff accompanied young people to school and remained with them in the classroom if their assessed need required it. Fidget toys were used by young people in the classroom if their assessed need required it. Teaching staff liaised with the young person’s mainstream school once consent from the parents and young person was given. This allowed for staged reintegration back into mainstream school and allowed an opportunity for the mainstream school to plan and apply for necessary resources to facilitate reintegration. School progress could be then shared in both directions. Teaching staff numbers were sufficient at the time of inspection. Hours were allocated through the Education and Training Board. Colaiste Éist Linn was not recognised by the Department of Education. School opened Monday 10:00 to 15:30, and Tuesday to Friday 10:00 to 13:00.

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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: A policy was available outlining the process of transfer of a young person in different circumstances. The following instances were described in the policy: transfer of an involuntary young person from one approved centre to another; transfer of involuntary and voluntary young people from an approved centre to an accident and emergency department for urgent or routine review; and attendance at an outpatient appointment. The processes were clear and well defined.

Training: All staff were aware of the processes involved in the transfer of a young person in each of the circumstances outlined in the policy.

Monitoring of Compliance: No annual audit of the process was conducted.

Evidence of Implementation: No young person resident in the approved centre at the time of inspection had been transferred out of the approved centre. Therefore, compliance was assessed against the policies, processes and training in place at the approved centre.

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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: The approved centre had a written operational policy on Medical Emergency Response. This outlined the management, response and documentation of a medical emergency. A separate policy outlined how the general health of young people in the approved centre was managed. This was cross-referenced with the transfer of resident policy which outlined the process of transfer to an accident and emergency department.

Training: Staff had received training in relation to general health processes and emergency responses.

Monitoring of Compliance: No formal review of processes was undertaken.

Evidence of Implementation: All young people had access to a registered medical practitioner and had a physical assessment completed on admission including physical examination and blood testing. Two young people were in the approved centre for more than six months and had a six-monthly physical assessment completed. All clinical and nursing staff had access to emergency equipment and weekly checks of this equipment were conducted and documented.

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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: The approved centre had a policy and clear processes in place relating to the provision of information to young people.

Training: Staff were aware of and understood the processes relating to the provision of information to young people.

Monitoring of Compliance: No formal audit of the processes was conducted.

Evidence of Implementation: Young people’s communication needs were assessed on admission and this was incorporated into the ICP and informed how information was provided. The Information Booklet for the approved centre contained information for young people and families including information on MDT members, visiting times, 'dos and don’ts' of the approved centre and safety. Information was given to young people regarding their diagnosis and medication and this was documented in the clinical file. This was given in verbal and written form. An opportunity for questioning was afforded and parental involvement was evident. No independent advocacy service was available. Translation services were provided if required.

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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: A policy was available and outlined roles and responsibilities of staff and cross referenced policies relevant to privacy such as Maintenance of Records, searches, CCTV, Grades of Supervision, Contact with persons who visit or telephone and Communication.

Training: Staff were aware of the processes that ensured privacy for young people.

Monitoring of Compliance: Privacy issues such as visiting, communication and grades of supervision were under review on a daily basis.

Evidence of Implementation: It was clear from observation that young people in the approved centre were respected and dignity and privacy were assured in all interactions with all members of staff. Staff used the young person’s preferred name. All residents had a single en suite bedroom. Observation panels in the doors had curtains that could be closed to ensure privacy. Appropriate dress for the approved centre was discussed with young people. A ‘Talking and Feelings Group’ was held which facilitated an opportunity to address behavioural boundaries and any other concerns young people had around privacy and dignity. Appropriate hedging in the garden area ensured privacy and the building was not overlooked.

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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

Inspection Findings

Processes: The policy detailed how equipment, furniture and decoration were maintained
and how issues in relation to facilities should be addressed.

Training: Staff were aware of the process and were observed using it.

Monitoring of Compliance: Staff in the approved centre actively reported maintenance
issues. However, there was no overall annual review of premises evident during
inspection.

Evidence of Implementation: The building was clean, bright, spacious, modern and well
maintained. The walls were decorated with young people’s artwork. A TV room had been
recently redecorated which encompassed ideas from young people within the approved
centre. All areas were wheelchair accessible. Heating was set centrally and could be
adjusted up or down as required in communal areas. A wall thermometer showed the
room temperature was 21°C. Individual rooms had a thermostat that could be adjusted as
required by a named member of staff. Water temperature was maintained at 65°C, to
prevent the presence of legionella within the water system. Water tanks were cleaned
annually. Large door mats were changed weekly by a contractor. Within the approved
centre, all rooms had safety devices and were anti ligature. The reception area had
recently had two doors installed. The self-closing mechanism could pose a ligature risk.
However, this area was never left unsupervised and young people would not be left alone
in this area. A clerical officer was responsible for liaising with the facilities department off
site in St Finbarr’s Hospital. Maintenance services were provided by staff from St
Finbarr’s. Premises were discussed at management meetings.
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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.


Inspection Findings

Processes: A policy outlined the process for ordering, prescribing, storing and administration of medicines and included preparation of leave medication, telephone orders and medication errors. A copy of the Telephone Order Form, Medication Incident Form and Consent Form were attached to the policy as appendices.

Training: Nursing staff had received training as part of their undergraduate degree. Peer learning was used to ensure and maintain same. Nursing Midwifery Board of Ireland (NMBI) Guidelines guided practice. Training was given by the Clinical Director on any new medications that were introduced.

Monitoring of Compliance: Two audits of drug administration charts’ compliance were conducted since the last inspection demonstrating a continued improvement.

Evidence of Implementation: On the second day of inspection, a medication administration round was observed with evidence of the use of the Five Rights of medication management - right dose to the right patient at the right time via the right route and in the right form. Medication was sent from another hospital to the approved centre and staff were aware of how this process worked and how to contact the pharmacist off site. Thirteen Medication Administration Records (MAR) were examined. Allergy sections were completed in 12. However, Medical Council Registration Numbers (MCRN) were missing in two MARs which was a breach of Section 43(8) of Medical Practitioners Act 2007, hence the approved centre was found to be non-compliant with Regulation 23.

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<table>
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<tr>
<th>Risk Rating</th>
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<tr>
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</table>
### 3.23 Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

<table>
<thead>
<tr>
<th>Date received</th>
<th>CAPAs</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable &amp; Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt; December 2015</td>
<td>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</td>
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<td>Corrective Action.</td>
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<td>Define the area of non-compliance addressed by this CAPA</td>
<td>Define the area of non-compliance addressed by this CAPA</td>
<td>State method of evaluation and monitoring of outcome</td>
<td>State feasibility of action</td>
<td>State time-frame for completion of action</td>
</tr>
<tr>
<td></td>
<td>Medical Council No. put on Drug Kardexs</td>
<td>Medical Council No. put on Drug Kardexs</td>
<td></td>
<td></td>
<td>Immediate – 2/12/15</td>
</tr>
<tr>
<td></td>
<td>Weekly review and Audit of all Prescription Drug Kardexs implemented from 2&lt;sup&gt;nd&lt;/sup&gt; December 2015.</td>
<td>Each drug Kardex reviewed to ensure 100% completion with special emphasis on documenting known allergies and Medical Council Numbers.</td>
<td>All Kardexes reviewed on Sunday. Corrective action taken immediately. Issues of non compliance reviewed at Monday MDT Meeting.</td>
<td>Weekly audit undertaken by Clinical Nurse Manager or designate. Achievable &amp; realistic.</td>
<td>First week of December 2015.</td>
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<td></td>
<td>6 monthly Induction of NCHD’s &amp; Registrars.</td>
<td>Lead Consultant instructs medical staff at induction regarding the correct completion of Drug Kardexes and the</td>
<td>Measured by Preventative &amp; Corrective actions as outlined above.</td>
<td>Achievable &amp; realistic.</td>
<td>December and June.</td>
</tr>
</tbody>
</table>

*Ref MHC – FRM – 001- Rev 1*
| Post-Holder(s): | 1. Dr Maura Delaney – Consultant Child & Adolescent Psychiatrist  
Michael O’Sullivan – Area Director of Nursing CAMHS | necessity to comply with Reg. 23. |
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: A health and safety policy was available and a detailed health and safety statement outlined procedures relating to the health and safety of residents, staff and visitors. Roles and responsibilities of staff were outlined. Companies responsible for checking of clinical equipment, fire alarms and lifts were named.

Training: Staff were trained in all aspects of mandatory training for Fire Safety, Basic Life Support, Manual Handling and Patient Management of Aggression and Violence.

Monitoring of Compliance: Processes were monitored and concerns placed on the risk register and discussed weekly. Staff vaccines were offered and a notice on this was evident in the nursing office.

Evidence of Implementation: A safety statement was available within the approved centre. The Environmental Health Officer Report, Fire Officer Reports and Health and Safety Statement were made available during the inspection period. A hand hygiene point was clearly signed in the reception area. Staff were aware of the health and safety legislative requirements and the use of the National Incident Management System.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
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3.25 Regulation 25: Use of Closed Circuit Television (CCTV)

(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.

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**Inspection Findings**

**Processes:** There was a policy on Closed Circuit Television (CCTV) and clear processes in place relating to its use which related to security only.

**Training:** Staff were aware of use of CCTV and this formed part of the induction process.

**Monitoring of Compliance:** No formal audit of processes were undertaken.

**Evidence of Implementation:** Clear signage was evident within the approved centre. CCTV cameras were focused on external entry and exit points at the main reception. CCTV in the nursing office was the only monitor that could view internal areas and was visible to healthcare professionals only. CCTV could not store or record images.

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**Compliance Rating:**

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<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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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 in place with clear processes in relation to staffing including the recruitment, selection and vetting of staff.

**Training:** Staff within the approved centre had the training relevant to their role. Staff were aware of the policies and processes in relation to staffing and this was documented as part of induction process.

**Monitoring of Compliance:** An overall plan for the staffing requirements was reviewed and monitored annually and this allowed for implementation of training plans to respond to the needs of young people in the approved centre.

**Evidence of Implementation:** An organisational chart clearly identified the leadership and management structure in the approved centre and staff were aware of this structure. Staff competencies were assessed as part of the probationary assessment. An opportunity to partake in Clinical Supervision was afforded to nursing staff. Staff had the relevant training and qualifications to meet their role within the approved centre. An identified member of staff was in charge of the approved centre at all times. There was evidence of good recordkeeping in relation to staffing. Staff completed Mental Health Act 2001 training and copies of relevant legislation, regulations and guidelines were available to staff in the approved centre.

**Compliance Rating:**

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<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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Ref MHC – FRM – 001- Rev 1  Page 38 of 59
### 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.


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.

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**Inspection Findings**

**Processes:** A policy outlined the processes required for good maintenance of records including the roles and responsibilities of staff of the approved centre.

**Training:** Training was as part of undergraduate degree and formed part of the induction process.

**Monitoring of Compliance:** Records were reviewed by the MDT, nursing and administration staff. No formal annual audit of record maintenance was carried out.

**Evidence of Implementation:** Records were up to date, in good order and were well constructed. A clear index at the front of each clinical file allowed the user to navigate with ease through the clinical file. Unique identification in the form of photos, medical record number and date of birth were used. Each resident had a clinical file. Files contained diagnosis (when formulated), treatment and ICP. The file was maintained in chronological order. MDT staff and administration staff could access the file. All records requested during the inspection period were furnished to the inspection team. Records were kept until the child was aged 25 years or for eight years after death to reflect HSE policy. Record management was discussed at the Business Team Meeting which involved administration staff. A secure locked file room within another locked room was used to store files of discharged young people.

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**Compliance Rating:**

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<th>Non–Compliant – Negligible Achievement (1)</th>
<th>Non–Compliant – Poor Achievement (2)</th>
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### 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

A register of residents was maintained in hard copy in the approved centre and updated on admission of a young person by the nursing staff. The register was maintained for every young person in the approved centre in the format determined by the Commission and contained all the information specified in Schedule 1. This was made available on request.

### Compliance Rating:

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<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
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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: The HSE policy ‘HSE Procedure for developing policies, procedures, protocols and guidelines’ was used to underpin local policies. There were defined processes in place.

Training: Training formed part of the induction process and peer learning.

Monitoring of Compliance: Policies were reviewed and updated within the relevant timeframes; however, no formal audit was completed.

Evidence of Implementation: Policies were easy to navigate and were in a clear well defined structure. Content of the policies was evidence-based. Clinical staff had input into policy development and review. A policy review group met in the approved centre monthly.

Compliance Rating:

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<th>Non – Compliant – Negligible Achievement (1)</th>
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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**

This regulation was not applicable to this approved centre as all residents were under 18 years.

**Compliance Rating:**

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3.31 Regulation 31: Complaints Procedure

(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 on Procedure for the Investigation of Complaints and clear processes in place relating to complaints.

Training: Training on the complaints policy and processes formed part of the induction training and staff in the approved centre were aware of the necessary processes.

Monitoring of Compliance: No annual audit of processes was conducted.

Evidence of Implementation: The roles and responsibilities for the management of the complaints process were understood and implemented in the approved centre. A nominated person was responsible for the management of complaints. Young people could make a complaint in a number of different ways - verbal, written or suggestion forms. No advocacy service was available for young people in the approved centre. The process of making a complaint was well publicised and accessible via the Information Booklet which was given to young people and their families. A local complaints log was maintained and stored in the Nurses' Office. All complaints were treated in a confidential manner and met the requirements of the Data Protection Acts. Records of complaints were retained for periods not less than four years.

Compliance Rating:

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<th>Compliant – Excellent Achievement (4)</th>
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3.32 Regulation 32: Risk Management Procedure

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

Inspection Findings

Processes: There was a policy on Risk Management which encompassed all aspects of the regulation. In addition to the approved centre’s risk management policy, there was a HSE policy Safety, Incident Management Policy.

Training: Training formed part of the induction process. Peer learning occurred with daily use of the risk register. Staff attended fire drills and met with fire officers. One individual received training in functional analysis, care and environment. Training about risk management formed part of nursing staff undergraduate training. Peer learning occurred on incident report and daily use of the risk register.

Monitoring of Compliance: All incidents and risk levels were reviewed at least weekly at the Risk Register Review Meeting. No formal annual trend analysis occurred. However, trends of incidents were analysed by staff and supervision levels of young people were adjusted accordingly.

Evidence of Implementation: Risk was actively considered in all aspects of care of young people in Éist Linn. Risk assessments were completed within three days of admission to the approved centre and reviewed and repeated as required. Risk was reviewed daily through daily review of the risk register, reviewed at least weekly by the MDT and at the Risk Register Review Meeting. The Risk Management Group met monthly and was attended by staff of the approved centre including the risk manager. Incident forms were completed and an entry placed in the clinical file. A risk management plan was formulated and care plan adjusted accordingly. A new Risk Review document had been developed and was planned to be introduced on 1 December 2015. The MHC was notified of incidents within agreed timelines.
## Compliance Rating:

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### 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 insured under the national indemnity scheme, the State Claims Agency. The certificate of insurance was inspected.

### Compliance Rating:

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<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
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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.

The approved centre’s current certificate of registration was displayed in a prominent position in the approved centre.

Compliance Rating:

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4.0 Inspection Findings and Required Actions - Rules

<table>
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<tr>
<th>EVIDENCE OF COMPLIANCE WITH RULES – MENTAL HEALTH ACT 2001 SECTION 52(d)</th>
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</thead>
</table>

### 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 or unwilling to give such consent –

(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.”

### Inspection Findings

As electro-convulsive therapy was not used in the approved centre, this rule was not applicable.

### Compliance Rating:

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<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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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

As seclusion was not used in this approved centre, this rule was not applicable.

Compliance Rating:

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<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
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### 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”.

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**Inspection Findings**

As mechanical restraint was not used in this approved centre, this rule was not applicable.

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**Compliance Rating:**

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<th>Non – Compliant – Negligible Achievement (1)</th>
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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 or unwilling to give such consent –

   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

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

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

(a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

(b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist.

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

Inspection Findings

As no child had been detained in the approved centre under Section 25 for longer than three months, Part 4: Consent to Treatment did not apply.
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<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
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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: The approved centre had a policy in relation to the use of physical restraint. The policy outlined the roles and responsibilities of staff in relation to physical restraint. Child protection processes were in place within the approved centre, in keeping with current legislation and regulations.

Training: Staff were aware of and understood the policy and processes of physical restraint. All nursing staff had received recognised training in prevention and management of aggression and violence (PMAV) and records of attendance were reviewed as part of the inspection process.

Monitoring of Compliance: An annual audit was undertaken and the policy was reviewed annually as is required.

Evidence of Implementation: Physical restraint was not regularly used in the approved centre. In all clinical files reviewed, alternative interventions were always explored in order to manage the young person’s unsafe presentation or behaviour. Risk assessments were used and, if physical restraint was used, it was for the minimal amount of time with minimal level of restraint used. All requirements of the code of practice were fulfilled.

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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: A policy outlined the referral process to the approved centre and the responsibilities necessary for the process. Appendices to this document were the Admission Assessment Document and Admission Consent Form.

Training: All staff of the approved centre had received Children First training. Copies of the Child Care Acts and Children First guidelines were available in the nursing office for review by staff. Nursing staff received limited training on the admission of children in their undergraduate degree. An induction course over the course of a week was provided to all staff. One was underway during the inspection period.

Monitoring of Compliance: Individual aspects of the process are audited regularly. However, an annual audit of the admission process for children was not undertaken in the approved centre.

Evidence of Implementation: This approved centre only admitted children under 18 years. There was evidence of consent signed by parents in the case of all children admitted voluntarily. Children aged over 16 years to 18 years also signed the consent form in the presence of the admitting doctor. This was clear from the four clinical files reviewed. One child had been admitted under Section 25 of the Mental Health Act, 2001. All relevant documentation was available in the clinical file and all notifications were provided to the Commission as required.

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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: A risk management policy was available that cross-referenced other relevant policies such as the supervision policy, induction policy, health and safety statement and the use of the risk register within the approved centre.

Training: Training was through the induction process and peer learning and discussed as a learning topic at the MDT.

Monitoring of Compliance: No annual audit was conducted. However, incidents were monitored through the daily risk register review, weekly Risk Meetings and the monthly Risk Management Meeting.

Evidence of Implementation:
Death Notifications:
Staff were aware of the processes required by the Commission. No deaths had occurred in the approved centre since the last inspection.

Incident Reporting:
A risk register was maintained for the approved centre. All incidents and near misses were logged in a register, a copy of which was inspected, and incidents were reviewed by the MDT. A copy of the incident was logged onto the National Incident Monitoring Scheme, and submitted to the Commission within the agreed timeframe. Two nominated people within the approved centre were responsible for this process.

Reflective meetings were held for staff of the approved centre which facilitated learning and afforded staff an opportunity to discuss difficult cases.

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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: A policy outlined the process and management of delivery of services to young people with an intellectual disability in relation to procedure, communication, capacity, training and use of prevention and management of violence and aggression.

Training: Eight nursing staff from the approved centre had attended specific training for working with young people with intellectual disability on 9 October 2015.

Monitoring of Compliance: An annual audit had been undertaken to determine compliance to the process of working with young people with a learning disability.

Evidence of Implementation: As no young person with an intellectual disability was resident in the approved centre at the time of inspection, compliance was assessed against the policies, processes and training in place at the approved centre.

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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

As electro-convulsive therapy was not used, this code of practice was not applicable.

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6.6 Admissions, 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 individual policies available for the admission, transfer and discharge processes which outlined clearly the processes required for each, incorporating specific care needs for children.

Training: Training was provided as part of the induction process.

Monitoring of Compliance: Processes were kept under review. However, no formal auditing process was undertaken.

Evidence of Implementation:

Admission:
Three clinical files were reviewed, two were of voluntary admissions and one was involuntary. In all cases, admissions were planned. Two young people who were voluntary had attended the approved centre for a day visit prior to admission. All admissions were referred from the National Child and Adolescent Inpatient National Health Services. Information was available through the referral process from local Community Child and Adolescent Mental Health Services (CCAMHs) teams as required by the protocol for admission to inpatient care. All received information was thoroughly reviewed by the MDT. All young people met the admission criteria, and there was a clear process in deciding to admit a young person. Comprehensive admission assessment was completed in each file including physical, psychological, social and risk assessment. All information was given to the young people and parents and consent was signed by both in the case of the two voluntary admissions, as both were between 16 and 18 years. An initial care plan for the first 72 hours was formulated followed by an MDT care plan formulated at the first MDT meeting. Each young person was discussed at the daily ‘Meet and Greet’. A key worker was assigned and, in all cases, this was a nurse. There was evidence of communication with the local CCAMHs team throughout the stay in hospital. There was evidence of contact with the community Social Worker in one clinical file. In all cases, records were kept and regulations on personal property and clothing were complied with. Family involvement was clearly evidenced throughout every aspect of care delivery. An Admission Checklist ensured that all documentation and processes were completed.

Transfer:
Two young people had been transferred to the approved centre from paediatric medical settings. No young person had been transferred out to another facility. A clear process was detailed during staff interviews.

Discharge:
One clinical file was reviewed. Clear evidence of a discharge plan was available in the clinical file. CCAMHs were contacted and full information given. This was evidenced throughout the stay in the approved centre not just at the point of discharge. Discharge was discussed at the MDT in the weeks prior to discharge. A clear decision to discharge was made and discharge occurred on the agreed discharge date. A Discharge Therapy Conference was convened and attended by the parents. The young person did not attend as they were at school. Staged discharge was evident with increasingly longer periods of leave. The young person was assessed prior to leave and same was clearly documented.
was no clear evidence that the keyworker coordinated the discharge. However, this was not part of the discharge process in this approved centre. Discharge was coordinated by the MDT. Full involvement of parents and family was evident in the discharge process and a week’s notice of discharge was given. A follow-up appointment was made with the local CCAMHs team and was for the actual day of discharge from the approved centre in the local area. Good records were kept and all property was returned. Transport had been provided by the family, a prescription was given and a safety plan was discussed.

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