Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard

ID Number: AC0097

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard
Cherry Orchard Hospital Campus
Ballyfermot Road
Ballyfermot
Dublin 10

Approved Centre Type:
Child & Adolescent Mental Health Care

Most Recent Registration Date:
10 December 2015

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Brady, Head of Service, Mental Health – CHO7

Inspection Team:
Leon Donovan, Lead Inspector
Carol Brennan-Forsyth
Martin McMenamin
Karen McCrohan

Inspection Date:
5 – 7 June 2018

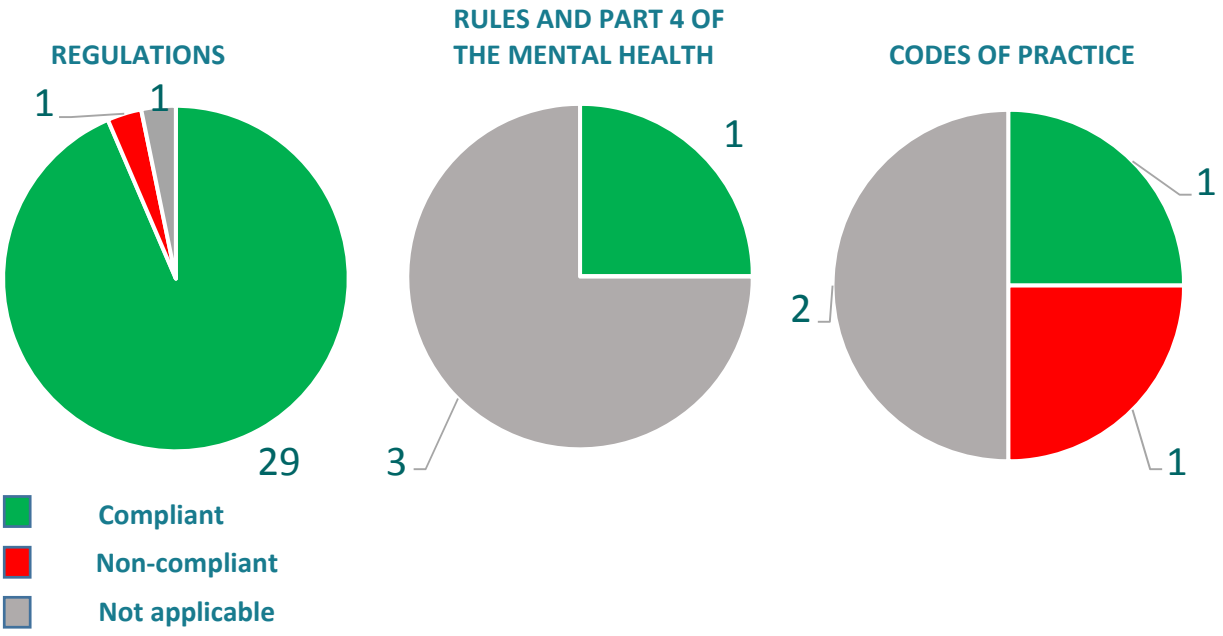
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
7 – 10 March 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
14 February 2019

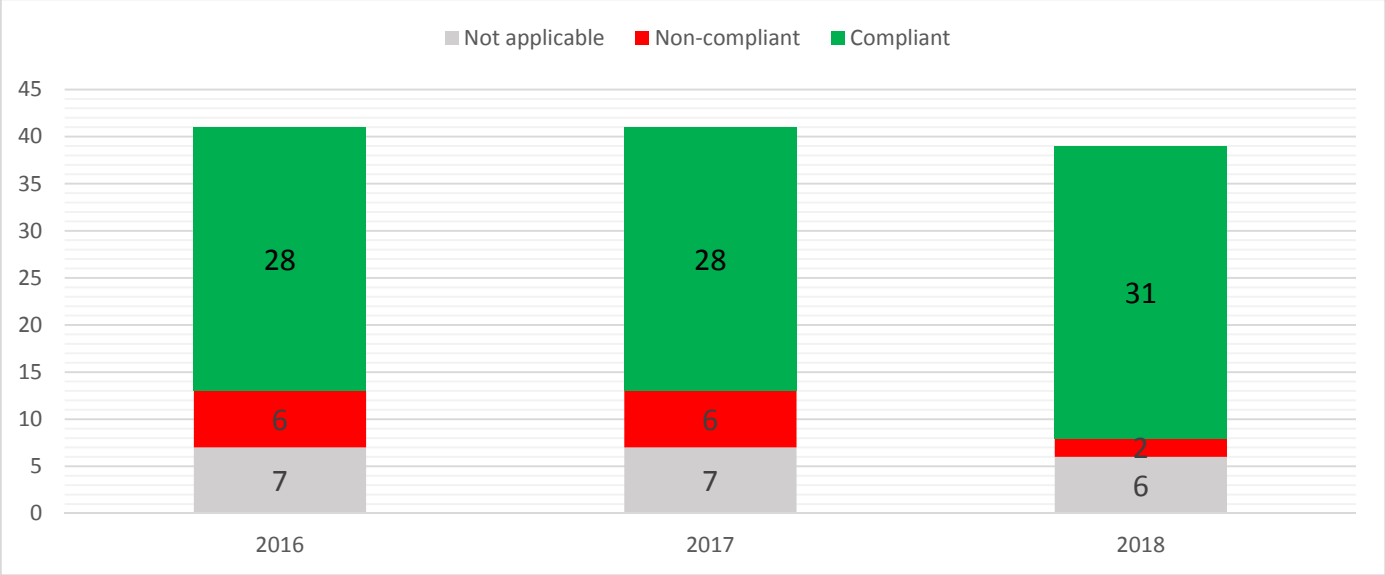
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

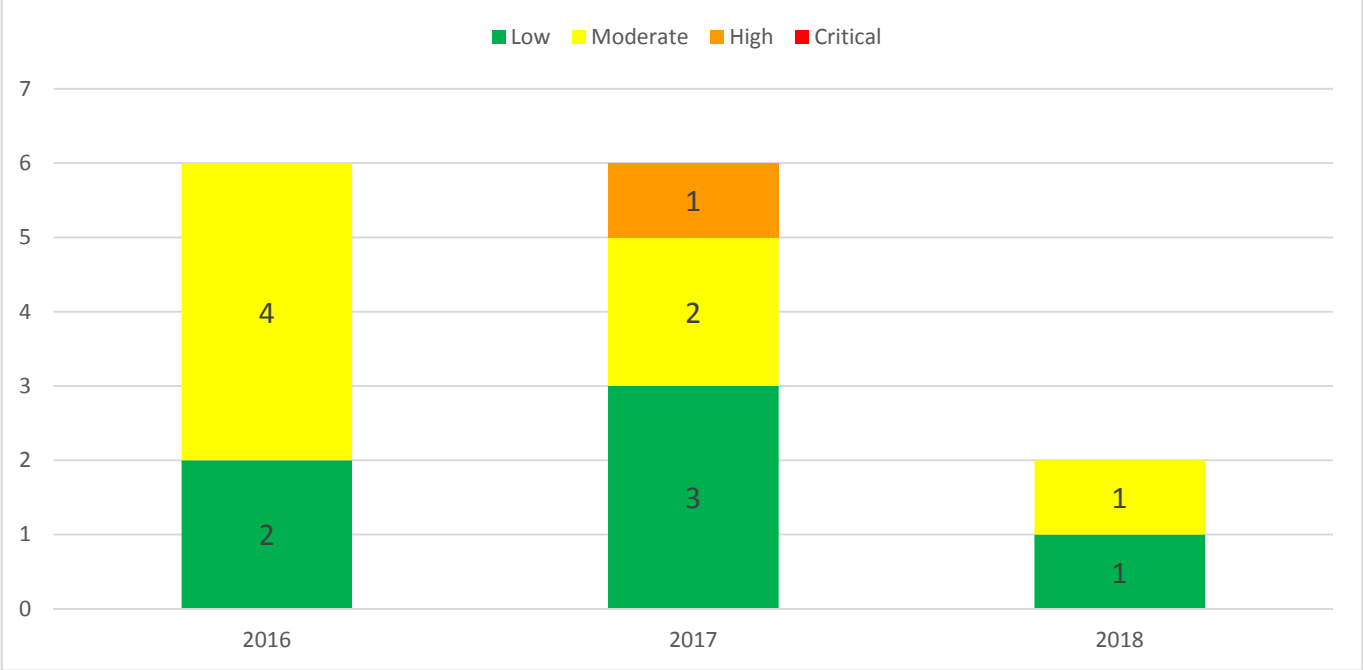
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

Chart 2 – Comparison of overall risk ratings 2016 – 2018



Contents

1.0 Introduction to the Inspection Process

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

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

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

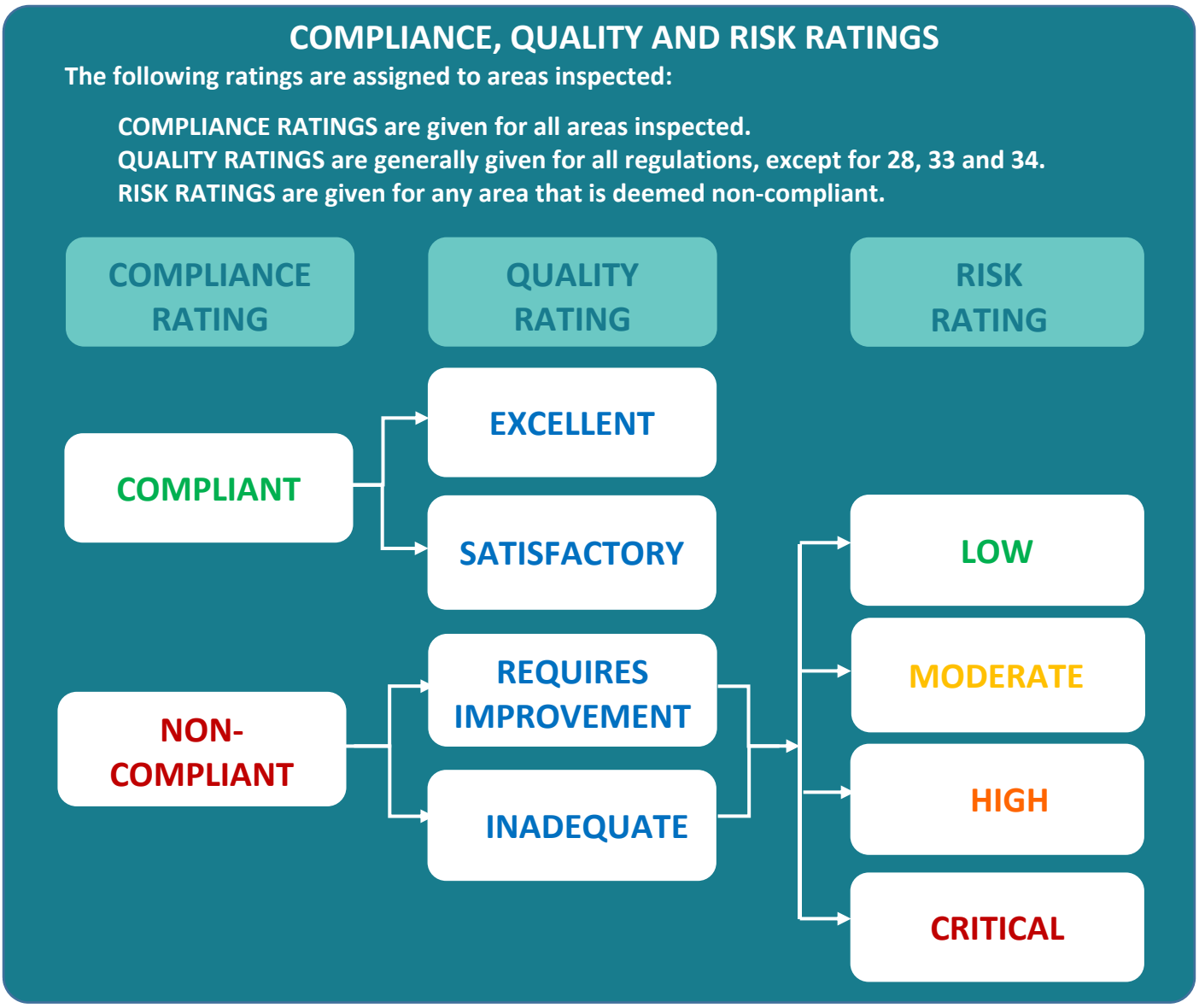
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

Linn Dara Child and Adolescent Mental Health Services (CAMHS) in-patient unit was located on the Cherry Orchard Hospital campus in Ballyfermot, Dublin 10. It consisted of two 11-bed units, giving a total of 22 beds, as well as a two-bed high observation unit. It provided treatment for young people under the age of 18.

During the inspection, the approved centre was operating at a reduced capacity of 13; Hazel was occupied by 11 residents, and Rowan and Oak were each occupied by one resident. Due to the resident profile within Oak unit, the approved centre was closed to admissions. Compliance with Regulations, Rules and Codes of Practice has remained consistently high, with an improvement to 94% compliance on this inspection.
Seven compliances were rated as excellent quality.

Safety in the approved centre

All young people in the approved centre had personal identifiers. Food audits were not carried out regularly but kitchen areas were clean. Medication ordering, prescribing, storage and administration was carried out in a safe manner. Ligature anchor points were minimised. Whilst the majority of staff were trained in Fire Safety, Basic Life Support, and the Management of Violence and Aggression, a small number of health care professionals' training remained outstanding.

Appropriate care and treatment of residents

Each resident had a multi-disciplinary care plan, which was developed with the resident and parents/carers. There was a wide range of therapeutic services and programmes that met the needs of the resident as outlined in their individual care plan. Physical health was monitored and access to any necessary medical treatment was facilitated. Educational needs were accommodated in a school on-site. The admission and discharge process required auditing as per the Code of Practice.

Respect for residents' privacy, dignity and autonomy

Each resident had a single en suite bedroom. Consent for treatment and interventions was provided by the child's parents or guardian, but the views of the child were taken into consideration. Visitors could be met in private and each child had an approved visitor list. Residents did not have access to drinking water unless they requested it, due to the high percentage of residents with eating disorders. When residents were searched, they were informed of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender. CCTV monitoring was carried out in compliance with the relevant regulation.

Seclusion and physical restraint complied with the relevant Rule and Code of Practice.

Responsiveness to residents' needs

The approved centre was well designed and appropriate for the age of the residents. It was clean and well maintained. There was a wide range of recreational activities available. Residents had access to mail, fax, e-mail, internet, and telephone, unless otherwise risk assessed with due regard to the residents' well-being, safety, and health. Information was available about diagnosis, medication and the approved centre. There was a complaints process in place which was satisfactory.

Governance of the approved centre

The approved centre was part of the Linn Dara Child and Adolescent Mental Health Services and within Area 7 – Community Healthcare Dublin South, Kildare, and West Wicklow management team governance.

A local approved centre governance meeting was convened, on average, every two months. This team comprised heads of discipline and senior managers as well as the school principal and consultant psychiatrists. The Linn Dara CAMHS operational team meeting generally took place weekly. A standing item on the agenda was the continued occupancy of Oak ward and there was clear evidence of a proactive approach in relation to monitoring and managing this issue. The Linn Dara CAMHS Management meeting was scheduled monthly and membership of this comprised heads of clinical disciplines and senior managers. There was evidence of transparent governance structures and processes, clear roles and responsibilities, and proactive management and planning of services.

There was no occupational therapy (OT) manager in place at the time of the inspection. The Clinical Director, Director of Nursing and School Principal were on site every day. Psychology operated a dual reporting system where senior grades reported to two principal psychologists, one for day to day management issues and the other for clinical issues. Three heads of discipline had completed postgraduate training in quality improvement. The risk register was reviewed regularly.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- The family/carers group established the annual “Summer Fest” celebration.
- A physical restraint pathway document had been drawn up which assisted the approved centre in complying with the Code of Practice.
- Training on searches was being rolled out for relevant staff.
- Use of the ‘Choice and Medication’ website in relation to the provision of information was being piloted.
- Peer led resilience (PILAR) support group for family members of a person with an eating disorder was facilitated in conjunction with Bodywhys (The Eating Disorder Association of Ireland).
- The Croga Programme was developed with resident input. This programme was evidence based and designed to support residents with eating disorders.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Linn Dara Child and Adolescent Mental Health Services (CAMHS) in-patient unit was located on the Cherry Orchard Hospital campus in Ballyfermot, Dublin 10. There was ample parking directly outside the approved centre and within the grounds of the extended campus.

Linn Dara consisted of two 11-bed units, Hazel and Rowan, and a two-bed high observation unit called Oak. It provided treatment for young people under the age of 18. Rowan was generally reserved for young people between 16 and 18 years old and Hazel generally accommodated under 16 year olds. Each young person had their own en suite bedroom. There was a school within the approved centre, which also incorporated an art and crafts room and a home economics kitchen. There was a sports hall, gymnasium, and outdoor basketball court as well as internal courtyards which were landscaped and suitable for outdoor recreation. The approved centre incorporated a three-bedroom family apartment to facilitate families staying over when their child was admitted. The approved centre was attractively decorated and furnished with bright and age-appropriate furniture and artwork.

Between May to October 2017, Hazel unit was closed due to nursing staff shortages. This reduced the approved centre's operational bed capacity from 23 beds to 12 beds during this time.

During the inspection the approved centre was operating at a reduced capacity of 13; Hazel was occupied by 11 residents, and Rowan and Oak were each occupied by one resident. Due to the resident profile within Oak unit, further admissions could not be facilitated. A subsequent admission of a resident requiring high observation facilities necessitated admission into Rowan, and this resulted in the temporary reduction in capacity of Rowan to accommodate this resident. The approved centre achieved this initially by granting a number of residents evening and weekend leave.

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

Resident Profile	
Number of registered beds	***24***
Total number of residents	**13**
Number of detained patients under Section 25	1
Number of wards of court	0
Number of children	13
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

Linn Dara was a CAMHS Inpatient Unit for young people under the age of 18. The approved centre was part of the Linn Dara Child and Adolescent Mental Health Services and within Area 7 – Community Healthcare Dublin South, Kildare, and West Wicklow management team governance.

The inspection team was provided with minutes of the weekly Linn Dara CAMHS Operational Meeting, Management Meetings with Community Teams and Linn Dara CAMHS Management Team. Additionally, the minutes of the monthly Health and Safety Committee, the Approved Centre's Quality and Safety Committee, the bi-monthly Approved Centre Governance Committee, as well as, the terms of reference for the service wide policy group were received.

A local approved centre governance meeting was convened, on average, every two months. This team comprised heads of discipline and senior managers as well as the school principal and consultant psychiatrists.

The Linn Dara CAMHS operational team meeting generally took place weekly, and was attended by the clinical director, the director of nursing, the business manager, a health and social care professional (Principal Psychologist), clinical nurse managers, consultant psychiatrists, the school principal, and the approved centre's administrator. These meetings included discussion of local and wider service issues, health and safety, and incident management. A standing item on the agenda was the continued occupancy of Oak ward and there was clear evidence of a proactive approach in relation to monitoring and managing this issue.

The Linn Dara CAMHS Management meeting was scheduled monthly and membership of this comprised heads of clinical disciplines and senior managers. An annual CAMHS management day had also taken place and this explored themes such as staffing, service delivery, quality improvement, governance, and estates.
A local Linn Dara CAMHS Approved Centre Quality and Safety Committee were scheduled monthly. These were attended by senior managers from the approved centre, as well as the Quality and Patient Safety Advisor. A Health and Safety Meeting also took place on a monthly basis and this was attended by local senior managers. This meeting discussed a number of topics including fire protocols, training, and environmental issues.

A review of the minutes provided for the various governance meetings, together with interviews with heads of discipline, evidenced transparent governance structures and processes, clear roles and responsibilities, and proactive management and planning of services.

The inspection team sought to meet with heads of discipline during the inspection. The Area Lead from the HSE Mental Health Engagement Office was also contacted.

The inspection team met with the following CAMHS staff:

- Clinical Director.
- Director of Nursing.
- Principal Psychologist.
- Principal Social Worker.
- School Principal.

There was no Occupational Therapy (OT) Manager in place at the time of the inspection. A competition to fill this vacancy was ongoing at the time. The Principal Social Worker was recently appointed to provide temporary cover for Occupational Therapists on day-to-day management issues. An Occupational Therapy Manager from Adult Mental Health was providing the Occupational Therapists with clinical supervision in the interim.

The Principal Social Worker was on leave at the time of the inspection. Detailed feedback via email was forwarded the following week regarding their roles as Principal Social Worker and as the temporary line manager for the occupational therapists.

All other heads of discipline (HODs) made themselves available to speak with the inspection team during the inspection and each provided an outline of the governance within their respective disciplines.

All HODS were based within the Cherry Orchard Hospital campus. The Clinical Director, Director of Nursing and School Principal were on site every day. The Principal Social Worker visited two to three times a week and a Principal Psychologist attended at least once a week. Defined lines of responsibility were evident in each discipline.

Psychology operated a dual reporting system where senior grades reported to two Principal Psychologists, one for day to day management issues and the other for clinical issues. All HODs identified strategic aims for their teams and discussed potential operational risks with their departments. Most HODs cited staffing issues as an operational risk, with recruitment and retention of qualified experienced staff being the biggest risk. The unavailability of the high observation unit was also cited as an operational risk as it was difficult for the approved centre to cater for new admissions who required a low stimulus environment.

There was an established culture of supervision within all disciplines. Staff supervision was facilitated within each discipline and regular meetings were scheduled with staff to ensure that they were adequately supported. The Principal Social Worker had just begun to put a structure in place to provide senior OTs with external supervision. Formal performance appraisals were not used by HODs; however, the Principal Social Worker advised that professional development plans were in use for social workers and there were plans to implement these for OTs as well.

All HODs outlined various initiatives to support quality improvement within their disciplines. These varied from clinical audits to the establishment of the Croga eating disorder group and the family and carers group. Three HODs had completed postgraduate training in quality improvement.

4.5 Use of restrictive practices

Practices such as bedrooms being locked and the showers switching off after short periods were reported by residents. The residents understood the reasons for this in some cases, but felt its unilateral application was quite restrictive.

5.0 Compliance

5.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2017 and 2016 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 26	✗	Moderate	✗	Moderate	✗	Low
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	Moderate	✓		✗	Moderate

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

5.2 Areas of compliance rated "excellent" on this inspection

Regulation
Regulation 8: Residents' Personal Property and Possessions
Regulation 10: Religion
Regulation 12: Communication
Regulation 13: Searches
Regulation 17: Children's Education
Regulation 19: General Health
Regulation 22: Premises

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As this was a Child and Adolescent Mental Health Service unit, Mental Health Tribunals did not take place and this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there was no child in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Admission of Children	Does not apply to this CAMHS Unit.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.

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

Twelve residents met with the inspection team in a group setting and a number of topics were discussed. Some residents found that the water from the hot tap in their bedroom was too hot. A number of residents advised the inspection team that the showers would function for about a minute when the button was pushed and only five button pushes were permitted, after which the shower would stop functioning. The residents understood the reason for this in some cases, but felt its unilateral application was quite restrictive. They also found that, on occasion, the bedrooms could be locked in the evening and could not be accessed. They were under the impression that this was down to staff shortages.

The residents were concerned about the lack of activities taking place in the approved centre at the time of the inspection and advised that the group activities that used to take place were no longer happening. Residents also felt that visiting times at the weekends were not long enough with two hours allocated between 2pm – 4pm.

7.0 Feedback Meeting

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

- Clinical Director
- Area Director of Nursing
- Director of Nursing (CAMHS)
- Assistant Director of Nursing (CAMHS Community)
- Head of Mental Health, CHO7
- Service Manager
- Consultant Psychiatrist x 2
- Clinical Nurse Manager 3
- Acting Clinical Nurse Manager 1
- Staff Nurse
- Senior Dietitian
- Principal Psychologist

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Clarification was provided regarding various issues that had arisen during the course of this inspection, and these are incorporated into this report.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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 written policy in relation to the identification of residents, which was last reviewed in January 2016. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had not been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: Where the resident did not consent to having their photograph taken, the name, date of birth, and personal identification number of the resident was used by staff. Identifiers were person specific, as name and photograph were used. Name and photograph were also used for the provision of therapeutic services and programmes. Same name alert stickers were used for residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in February 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the monitoring of food and water intake.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: For all residents, menus were reviewed on an on-going basis, by collaborating with the catering department. The approved centre used specific diet plans for residents with eating disorders, as the food pyramid was not always appropriate. There was an eating disorder folder on each unit. Residents were offered hot and cold drinks regularly. Residents did not have access to drinking water unless they requested it due to the high percentage of residents with eating disorders. Water was however available on request. Hot meals were provided three times daily.

For residents with special dietary requirements, an evidence-based nutrition assessment tool was used. The dietician linked in with residents' families in relation to any contraindications with medication.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had not been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Food was delivered to the approved centre from the central hospital kitchen. Only sandwiches were prepared in the unit kitchen. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Satisfactory**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' clothing, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. This was not documented. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: A small stock of emergency clothing was available on Rowan Unit. This included different sizes, and male and female clothing. Residents changed out of night clothes during day time hours unless specified otherwise in the resident's individual care plan. Residents had an adequate supply of individualized clothing.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Items not required by the resident were sent home and others were stored in general storage, based on individual risk assessment. Secure facilities were provided for the safekeeping of the residents' monies, valuables, personal property, and possessions, as necessary. Before admission the resident and parent or guardian were informed of the necessary items allowed and items that were not permitted.

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

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record was not maintained of the occurrence of planned recreational activities. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: Residents had access to a wide range of appropriate recreational activities. This included TV rooms, DVDs, books, board games, jigsaw puzzles, arts and crafts, table tennis, and foosball. Residents had access to an indoor sports hall and enclosed garden. Residents could also avail of time spent out with family if documented in their ICP. Nursing staff reported that the approved centre provided access to recreational activities on weekdays and during the weekend. The residents reported to the inspection team that there were not enough activities available in the unit. Residents decisions on whether or not to participate in activities were not documented.

Information was provided to residents in an accessible format in the form of a whiteboard containing a list of the recreational activities which were decided by the residents at weekly community meetings. The unit timetable was generic and did not specify exact recreational activities. For residents with eating disorders, restrictions on physical exercise were documented in their ICP. Documented records of attendance were not retained for recreational activities in group records or within the resident's clinical file.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

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

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable, and there were facilities provided for residents' religious practices. Residents had access to chaplains, and they were facilitated to observe or abstain from religious practice in accordance with their wishes. The care and services provided within the approved centre were respectful of the residents' religious beliefs and values.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

(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: The approved centre had a written policy in relation to visits, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on residents' rights to receive visitors were not monitored and reviewed on an ongoing basis. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate and reasonable, and nursing staff reported that residents could also avail of therapeutic leave, if appropriate. Residents voiced concern that the weekend visiting time was restrictive. Resident's visitor restrictions were determined by their parents/guardians on admission within the 'approved visitor and telephone list'. Visitors could utilize the family room, family observation, room or relaxation room. Appropriate steps were taken to ensure the safety of residents during visits. The visiting rooms and areas were suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, e-mail, internet, and telephone, unless otherwise risk assessed with due regard to the residents' well-being, safety, and health. Individual resident assessments were undertaken at admission in relation to any risks associated with their external communication and documented in the individual care plan. The clinical director and/or senior staff member only, as designated by the clinical director, examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches, which was last reviewed in February 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Some searches were carried out in response to a missing item. Reactive searches or proactive searches occurred where there was an existing risk. Where possible, resident consent was always sought prior to a personal search. Consent for personal property searches was requested upon admission and was contained in one of the three specific parental consent forms completed on admission. The resident search policy and procedure was communicated to all residents. Residents were informed by those implementing the search of what was happening during a search and why.

The clinical file of one resident was inspected against in relation to search processes. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender. A same gender nurse conducted the search. A written record of every search of a resident was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches, which were conducted twice daily at 10.30am and 19.30pm. Residents were aware and prepared for the search.

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for ensuring that the approved centre was informed in the event of the death of a resident who has been transferred elsewhere.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

There had been no deaths since the last inspection. The approved centre was only assessed under the two pillars of processes and training and education.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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 policy in relation to the development, use, and review of Individual Care Plans (ICPs), which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members had not received training in individual care planning.

Monitoring: Residents' ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICP's were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. An ICP was developed by the MDT following a comprehensive assessment, within seven days of admission. The approved centre used the Functional Analysis of Care Environments risk profile. ICPs was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

ICPs identified appropriate goals for the resident. ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. ICPs identified the resources required to provide the care and treatment identified. ICPs were reviewed by the MDT in consultation with the resident weekly. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. Residents had access to their ICP and were kept informed of any changes. Child residents and their family or next of kin signed their ICP. ICPs of child residents included their educational requirements.

One ICP did not record whether a copy of the ICP had been offered to the child resident. No reason was given for such.

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

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in February 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The review and evaluation of therapeutic services and programmes.
- The provision of therapeutic services and programmes by external providers in external locations.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre was not monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Examples of therapeutic services offered were: wellness and recovery sessions, exercise programmes, art therapy, and music therapy.

A weekly timetable was available of all therapeutic services and programmes in the approved centre. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. There was a dedicated Occupational Therapy room and group rooms in the unit area. Participation, engagement, and outcomes achieved in therapeutic services were recorded in the progress notes.

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

Regulation 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of education to child residents, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had been trained on the policy relating to children's education and its implementation throughout the approved centre. Individual providers of educational services on behalf of the approved centre were appropriately qualified in line with their roles and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs.

Monitoring: A record was maintained of the attendance of child residents at internal and external educational services.

Evidence of Implementation: Initial education requirements were identified on admission. All child residents were provided with an induction questionnaire to identify their educational requirements, as well as their favourite subjects and teaching methodologies. Child residents were assessed in relation to their educational requirements with consideration of their individual needs and age on admission. With parental consent, communication was initiated with the young person's current school, and if appropriate, to identify their needs, support requirements, strengths, and weaknesses. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum.

The educational provisions available within the approved centre were effectively communicated to child residents and their representatives. A daily activity timetable for schooling was given to the child resident upon commencement of school.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was not maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: An assessment of the resident was completed prior to the transfer, including an individual risk assessment relating to the transfer and the resident's needs. This was documented and provided to the receiving facility. A medical transfer letter, nursing transfer form, individual care plan, risk assessment, and medication prescription and administration record were sent when the resident was moving from the approved centre to another facility, in this instance an emergency department. A letter of referral and resident transfer form were issued as part of the transfer documentation. No medications were required for the transfer.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in February 2018. The medical emergencies policy was also last reviewed in February 2018. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: When medical emergencies occurred in the approved centre, staff called the emergency services phone line for help. The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator (AED) at all times. The AED was checked daily and first line drugs were checked weekly. This was recorded and documented. Registered medical practitioners assessed residents' general health needs on admission and on an ongoing basis as part of the approved centre's provision of care. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly general health assessment documented a physical examination, family and personal history, body mass index, weight, and waist circumference. It also documented blood pressure, smoking status, nutritional status, dental health, and a medication review.

Residents on antipsychotic medication received an annual assessment of glucose regulation, blood lipids, prolactin levels, and an electrocardiogram. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. There was a no smoking policy in place in the approved centre.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

(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 written policies and procedures in relation to the provision of information to residents, which were last reviewed in February 2018. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policies.

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Required information was provided to child residents and/or their representatives on admission in an admission pack, which included an information booklet, the Headspace toolkit, information on “Your Service Your Say”, and information on religious services. The booklet was available in the required formats to support child resident needs. Information was clearly and simply written in this regard. The admission information pack provided the following: housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure in operation in the approved centre; visiting times and arrangements; and child residents’ rights. Residents were provided with the details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnoses unless, in the treating psychiatrist’s view, provision of such of such information might be prejudicial to the child resident’s physical and/or mental health, wellbeing, or emotional condition. The justification for restricting information regarding a child resident’s diagnosis was documented in the clinical file. Medication information sheets, as well as verbal information, were provided in a format appropriate to child resident needs. Information on psychotropic medications was conveyed to the child resident, parents, and/or carers. This information included indications for the use of all medications to be administered, including any possible side-effects.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity based on the resident profile.

Evidence of Implementation: The manner in which staff addressed and communicated with residents was appropriate and respected their dignity. Residents in the approved centre were called by their preferred name. Staff displayed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

All residents were observed to be wearing clothes that respected their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to the resident. There were glazed secure vision panels on doors of treatment rooms, which provided privacy. Rooms in the approved centre were not overlooked by public areas. Private phone booths were available to residents to make phone calls.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The Hazel and Rowan units of the approved centre each had two sitting rooms with a television, an arts and crafts room, and occupational therapy (OT) kitchen, a sensory room, a sports recreation room and several areas with window seats overlooking an outdoor space. Child residents had a heating control mechanism in their room whereby they could raise or lower the room temperature by three degrees. Child resident's rooms were fitted with windows overlooking an outdoor space, facilitating adequate room ventilation. Sound absorbing materials were used in the approved centre minimise excessive noise and acoustics.

Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised in the approved centre. Minimization of ligature points was actively managed, and some issues were escalated to the Health and Safety Committee, for example a toilet paper dispenser in the public toilets. The approved centre was kept in a good state of repair both externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained of such.

The approved centre was observed to be clean, hygienic, and free from offensive odours. Heating was remotely controlled. Bedrooms in the approved centre were en suite. There was a wheelchair accessible toilet in the reception area for public use. There was also a wheelchair accessible toilet located in the school area for use by young people of the school, who required such facilities. One bedroom in each unit had the potential for accessibility aids to be installed to meet the needs of a young person, based on risk assessment. All resident bedrooms were appropriately sized to address the resident needs.

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

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in February 2018 (version 2). The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The processes for medication management at admission, transfer, and discharge.
- The process for medication reconciliation.

Training and Education: All nursing and medical staff, as well as pharmacy staff, had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff, as well as pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff, as well as pharmacy staff, had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten MPARS were reviewed on inspection. All entries in MPARs were legible and written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition. This was documented in the clinical file. Where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs (except those for self-administration), were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber, and any advice provided by the resident's pharmacist regarding the appropriate use of the product.

The expiration date of the medication was checked prior to administration. Expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage. Food and drink were not stored in areas used for the storage of medication. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

Medication dispensed supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication trolley and medication administration cupboard remained locked at all times and secured in a locked room. One of the ten MPARs inspected did not record all medications administered to the resident.

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in February 2018. It also had an associated safety statement, dated 2018. The policies and safety statement addressed requirements of the *Judgement Support Framework*, with the exception of support provided to staff following exposure to infectious diseases.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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

Evidence of Implementation: Regulation 24 was only assessed against the approved centre's written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

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

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in February 2018. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The maintenance of CCTV cameras by the approved centre.
- The process to cease monitoring a resident using CCTV in certain circumstances.

Training and Education: All relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes relating to the use of CCTV as set out in the policy.

Monitoring: Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras or other monitoring systems were located throughout the approved centre. Redundant cameras have been identified and there were plans to have them removed. Child residents were monitored solely for the purposes of ensuring the health, safety, and welfare of the residents. The use of CCTV or other monitoring systems had been disclosed to the Mental Health Commission and/or the Inspector of Mental Health Services. The CCTV cameras were incapable of recording or storing a resident's image in any format, and were only used to observe a resident. They do not transmit images other than to a monitor that was viewed solely by the health professional responsible for the child resident.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating LOW

(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: The approved centre had written policies and procedures in relation to its staffing requirements, which was last reviewed in February 2018. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including the Garda vetting requirements.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

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

Evidence of Implementation: There was an organisational chart that identified the leadership and management structure and the lines of authority and accountability of the approved centre's staff. A planned and actual staff rota, showing the staff on duty at any one time during the day and night was maintained in the approved centre. The numbers and skill mix of staffing were sufficient to meet child resident needs. Staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment. All staff, including permanent, contract, and volunteers, were vetted in accordance with the approved centre's recruitment, selection, and appointment policy and procedure.

Information from referees was sought and documented. An appropriately qualified staff member was on duty and in charge at all times. This was documented. All health care professionals were trained in the Mental Health Act 2001 and Children First. All staff were trained in line with the assessed needs of the resident group profile and of individual child residents, as detailed in the staff training plan. All staff

training was documented. The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available in the nurse's station.

There was no written staffing plan for the approved centre. Whilst the majority of staff were trained in Fire Safety, Basic Life Support, and the Management of Violence and Aggression, a small number of health care professionals training remained outstanding.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Rowan	CNM2	1	0
	CNM1	1	0
	RPN	3	3

Ward or Unit	*Staff Grade*	*Day*	*Night*
Hazel	CNM2	1	0
	CNM1	1	0
	RPN	3	2

Ward or Unit	*Staff Grade*	*Day*	*Night*
Staff covering all units:	Occupational Therapist	2.0 WTE	0
	Social Worker	1.8 WTE	0
	Psychologist	2.0 WTE	0
	Dietitian	0.4 WTE	0
	CNM3	1.0WTE	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN).

Oak functioned as an intensive care area for Rowan and Hazel wards and staff were assigned when patients transferred from either unit. During the inspection there were no staff from the approved centre assigned to the unit. However, the care needs of the current resident were addressed through an entirely outsourced team of nursing staff.

The approved centre was non-compliant with this regulation because not all staff had been trained in fire safety, Basic Life Support, and the Management of Violence and Aggression, 26 (4).

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to the maintenance of records, which were last reviewed in February 2018. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, with the exception of the process for making a retrospective entry in child residents' records.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policies. All clinical staff had been trained in best-practice record keeping.

Monitoring: Resident records were not audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All child residents' records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Child resident records were reflective of the child residents' current status and the care and treatment being provided. The approved centre used a tab system to ensure that child resident records were developed and maintained in a logical sequence.

Records were written legibly in black indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorized access or use. Documentation of food safety, health and safety, and fire inspections were maintained and available to inspectorate staff in the approved centre.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

Evidence of Implementation: An electronic register of child residents was maintained with a printed off selection for current residents. The register of residents contained the following information, as per Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006: full name; address; gender; date of birth; country of birth; ethnic or cultural background; next of kin/representatives; admission date; discharge date; diagnosis on admission; diagnosis on discharge; voluntary or involuntary status. The register of child residents was up to date, and was made available to the Mental Health Commission, where requested.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in February 2018. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The multi-disciplinary team in the approved centre had input into the operating policies and procedures. Learning notices from HSE broadcasts and incident reviews were incorporated into the operating policies of the approved centre, as well as relevant legislation, evidence-based best practice, and clinical guidelines.

Any generic policies used were appropriate to the approved centre and the resident group profile. The format of policies and procedures did not include the names of the policy reviewers.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the management of complaints, which were last reviewed in February 2018 (Version 2). The policies and procedures addressed all requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policies.

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was not analysed. Required actions had not been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives through the information booklet, posters and suggestion boxes. However, during the resident interview, child residents reported that they did not know how to make a complaint. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were investigated promptly and handled appropriately and sensitively.

The registered proprietor ensured that the quality of the service, care, and treatment of a child resident was not adversely affected by a minor complaint. All minor complaints were recorded in a complaints folder and all had been resolved locally.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

(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: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in February 2018. The policy did not address the following:

- The responsibilities of the multi-disciplinary team.
- The person responsible for the completion of six-monthly incident summary reports.
- Organizational risks.
- Capacity risks relating to the number of residents in the approved centre.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: Clinical risks, corporate risks, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Structural risks, including ligature points, were removed or effectively mitigated. The approved centre implemented a plan to reduce risks to child residents while any works to the premises were being undertaken.

Individual risk assessments were completed prior to and during the following: resident seclusion; physical restraint; on admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm; resident transfer; resident discharge; in conjunction with medication requirements or administration. The requirements for the protection of children within the approved centre were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardized format.

Information provided at resident level was anonymous for Mental Health Services on Notification of Deaths and Incident Reporting. There was an emergency plan which specified responses by the approved centre staff to possible emergencies. The emergency plan incorporated evacuation procedures.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated February 2018. The policy addressed the provision of information to the child resident. The policy did not address the following:

- Who may implement seclusion.
- Ways of reducing rates of seclusion.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspection team.

Evidence of Implementation: Child residents in seclusion had adequate access to toilet and washing facilities. Seclusion facilities in the approved centre were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, as far as was practicable. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion was initiated by a Registered Medical Practitioner (RMP) and or Registered Nurse. The treating Consultant Psychiatrist (CP) was notified as soon as was practicable of the use of seclusion. When seclusion was initiated it only occurred after assessment (including risk assessment), and was recorded in the clinical file and seclusion register by the member of staff initiating seclusion. The RMP indicated the duration of the seclusion order, which was no longer than 8 hours. The seclusion register was signed by the responsible CP or CP on duty within 24 hours. Medical review of the patient occurred no later than four hours after the commencement of the episode of seclusion.

The approved centre was compliant with this rule

10.0 Inspection Findings – Mental Health Act 2001

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

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated April 2018. It addressed the following:

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

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

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

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. The approved centre complied with the code of practice on physical restraint across all episodes.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in March 2017, the transfer policy was last reviewed in February 2018, and the discharge process policy was last reviewed in February 2018. All policies combined included all of the policy related criteria of the code of practice.

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

Monitoring: Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident's family member/carer/advocate were involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

Discharge: The discharge plan included documented communication with the relevant general practitioner/primary care team and/or Community Mental Health Team (CMHT). A follow up appointment was confirmed prior to discharge. The discharge plan also included a reference to early warning signs of relapse and risks. Discharge was coordinated by a key worker. A preliminary discharge summary was sent to the general practitioner/primary care/CMHT within three days. Timely follow up appointments, where there was a recent history of self-harm or a suicide risk, occurred within one week prior to discharge.

The approved centre was non-compliant with this code of practice because audits of the implementation of and adherence to the admission, transfer, and discharge policies did not occur, 4.19.

Appendix 1: Corrective and Preventative Action Plan Template - 2018 Inspection Report

Regulation 26: Staffing

Report reference: Page 45 & 46

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. Not all staff had been trained in fire safety, Basic Life Support, and the Management of Violence and Aggression, 26 (4).	Reoccurring	**Corrective Action(s):** All outstanding MDT staff attended training in BLS & TMVA July and September 2018. Remaining staff continued to assimilate into scheduled rolling training programmes, Oct, Nov & Dec 2018 to ensure compliance. **Post-Holder(s) responsible** Each Head of Discipline to monitor uptake of training on ongoing basis NCHDs in particular will be provided with the training schedule on induction	Training records for staff	Achieved	Completed Sept 2018
		Preventative Action(s): A more focused approach by the Approved Centre Governance Group has been instigated to ensure all grades of staff have assimilated into the annual training programme over the course of 2019 **Post-Holder(s) responsible:** Each Head of Discipline to monitor the uptake of training on an ongoing basis.	An additional training programme was commissioned for early Jan 2019 to capture the change over of medical staff. If necessary this will be repeated in July 2019. Staff training remains an agenda item at the Approved Centre Governance Meeting, this includes : • Quarterly review of the staff training log • Monitoring the uptake of training and addressing promptly any barriers	Availability of adequate training programmes (including the release of staff and appropriate numbers of tutors to provide them) may impact on the service ability to ensure all staff are up to date in each of the mandatory requirement modules. Staff returning from maternity leave, sick leave, and career break may on occasion have to wait to access the next scheduled training programme.	December 2019

			• An annual review of the staff training plan	The training schedule is planned to take account of same in so far as possible	

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 61

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
2. Audits of the implementation of and adherence to the admission, transfer, and discharge policies did not occur, 4.19.	New	**Corrective Action(s):** Audit occurred post inspection Post-Holder(s) responsible: CNM3	Audit records		July 2018
		Preventative Action(s): A bi annual audit is scheduled for 2019 on the implementation of and adherence to the admission, transfer and discharge policies. Monitoring of admission, transfer and discharge activities including audit remains an agenda item at the Approved Centre Governance Meeting **Post-Holder(s) responsible:** CNM3 Approved centre Governance Group	Minutes of Approved Centre Governance Group	None perceived	July & November 2019