Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital

ID Number: AC0081

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital
Merlin Park
Galway

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
9 December 2016

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, CHO2 – Mental Health Services

Inspection Team:
Elaine Healy, Lead Inspector
Dr Enda Dooley, MCRN004155
Martin McMenamin
Noeleen Byrne
Carol Brennan-Forsyth

Inspection Date:
18 – 21 September 2018

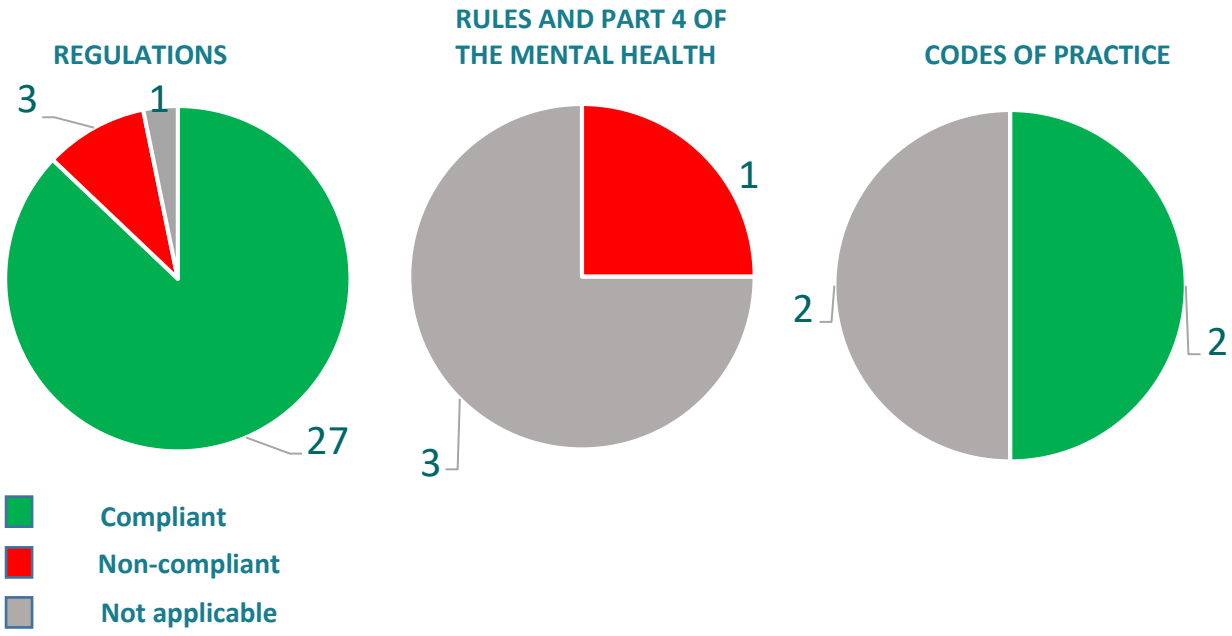
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
23 – 26 October 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
5th April 2019

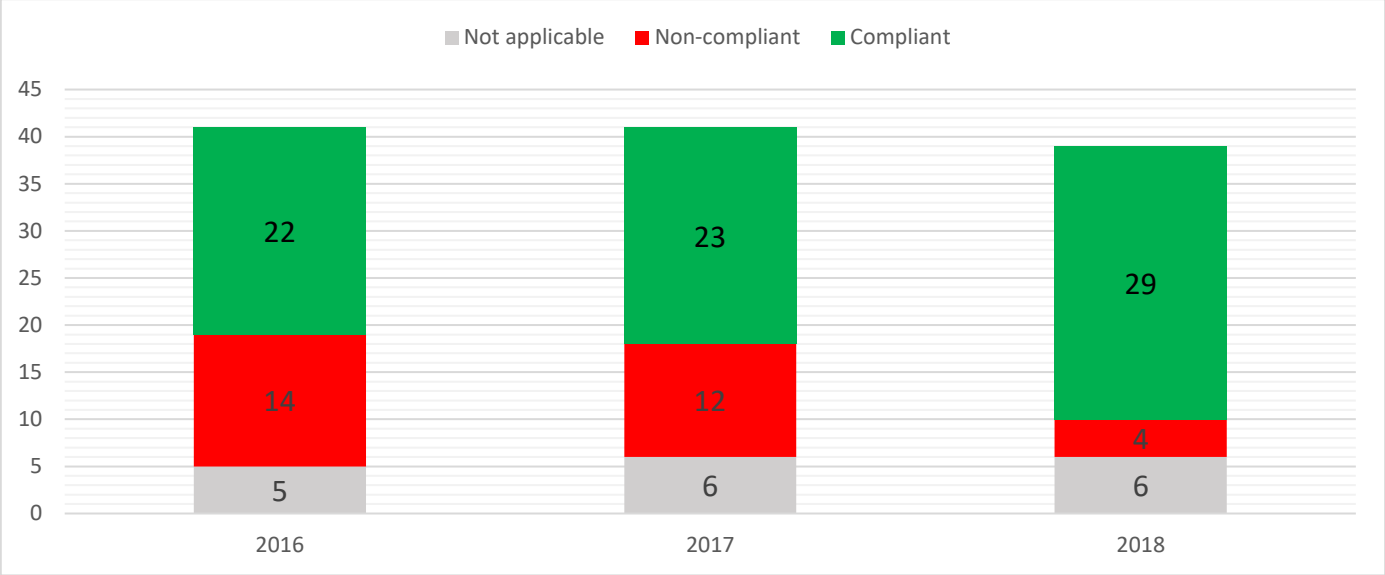
2018 COMPLIANCE RATINGS



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 4
2.0 Inspector of Mental Health Services – Review of Findings 6
3.0 Quality Initiatives 9
4.0 Overview of the Approved Centre 10
4.1 Description of approved centre 10
4.2 Conditions to registration 10
4.3 Reporting on the National Clinical Guidelines 10
4.4 Governance 11
4.5 Use of restrictive practices 11
5.0 Compliance 12
5.1 Non-compliant areas on this inspection 12
5.2 Areas of compliance rated “excellent” on this inspection 12
5.3 Areas that were not applicable on this inspection 14
6.0 Service-user Experience 14
7.0 Feedback Meeting 15
8.0 Inspection Findings – Regulations 16
9.0 Inspection Findings – Rules 58
11.0 Inspection Findings – Codes of Practice 62
Appendix 1: Corrective and Preventative Action Plan Template 65

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".

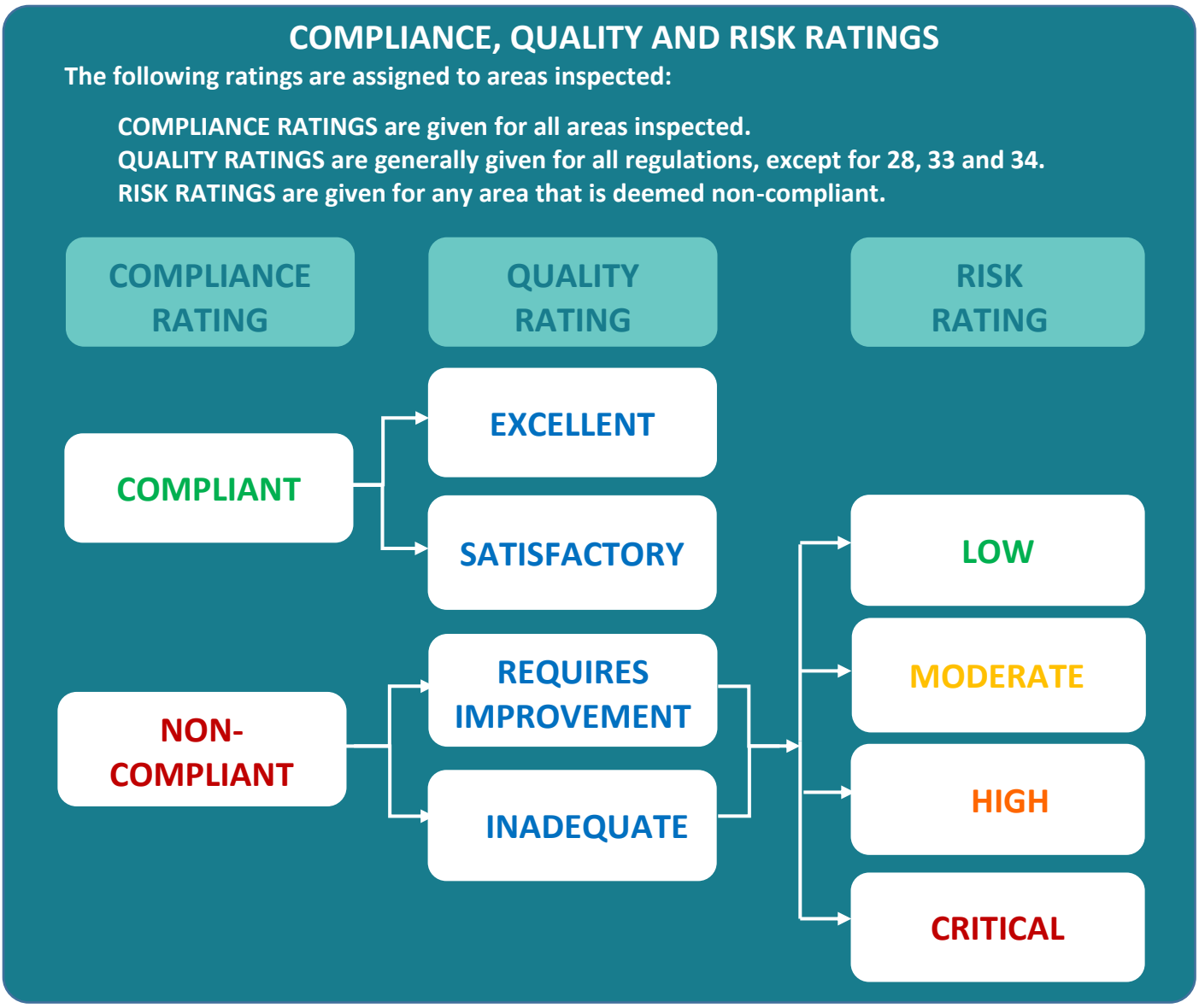
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

The approved centre was a Child and Adolescent Mental Health Service (CAMHS) in-patient unit located on the grounds of University Hospital, Merlin Park, Galway. It provided care and treatment to young people from age 12 to 18, inclusive, with mental illness.

Two multi-disciplinary teams were responsible for the treatment and care of the young people admitted to the approved centre. The residence was split into two units – the Willows, which was a 14-bed unit with three single bedrooms in a special care area, and Woodsend, which was a 6-bed unit. The special care area, due to its size and layout, was not suitable. A dedicated new school on site was fully commissioned on the 1st September 2018. There was also a "parent flat", which allowed a family to stay overnight when they had travelled to see one of the young residents.

The approved centre has demonstrated excellent improvement in compliance with Regulations, Rules and Codes of Practice, from 62% in 2016, 66% in 2017, to 88% in 2018. There were nine compliances quality rated as excellent. There were no conditions attached to the registration of the approved centre.

Safety in the approved centre

Each young person had two personal identifiers for the purpose of providing individual treatment. Food safety was audited regularly and the kitchen areas were clean. Ligature anchor points were minimised and associated risks mitigated with appropriate observation levels. Medication was ordered, prescribed, administered and stored in a safe manner.

Not all staff had up-to-date mandatory training in fire safety and the Professional Management of Violence or Aggression, Children First and in the Mental Health Act 2001.

The approved centre was non-compliant with the regulation on Risk Management because management were unable to ensure resident or staff safety due to the demands of one resident's clinical needs and the structural environment. This was rated critical.

Appropriate care and treatment of residents

A number of initiatives were in place for the treatment of eating disorders. A new clinical nurse specialist in eating disorders and a full-time dietitian for eating disorders had been employed. The approved centre was the first CAMHS in-patient unit nationally to introduce nasogastric tube feeding for a young person with anorexia in an approved centre.

Each young person had a multi-disciplinary individual care plan that included input from the young person and their parents or guardian. There was an appropriate array of therapeutic services and programmes which were based on needs assessments. Physical health was monitored and there was access to medical treatment if necessary. The approved centre was compliant with the Code of Practice relating to admission, transfer and discharge.

Respect for residents' privacy, dignity and autonomy

CAMHS (Galway) had the first national pilot advocacy group in the HSE for the young person. This process enables the young person to voice their views and concerns, explore their options and rights, gives information to enable the young person to make informed decisions, contact relevant people or contacts, and accompany the young person to meetings and appointments.

The seclusion room was small and not adequately ventilated. At the time of the inspection, the seclusion door was compromised as the reinforcement bars were damaged and they could not be locked. This did not ensure respect for residents' privacy and dignity. The seclusion room was designed with a hard floor fitting, which posed a risk to patient safety. In one seclusion episode, the seclusion order was not recorded in the clinical file. All uses of seclusion were recorded on the seclusion register. The approved centre was compliant with the Code of Practice on Physical Restraint.

Responsiveness to residents' needs

Young people were able to meet their visitors in private. Access to communication was determined by the individual care plan and parental consent. There was an excellent range of recreational activities, both indoor and outdoor and during weekdays and weekends. Information provided to the young people was informative and appropriate. Complaints were handled in accordance with HSE policy.

The external structure of the main administration building was dark and worn. The external and internal grounds looked overgrown and weeds were emerging through the tiled areas. In comparison, the internal areas were filled with artwork and bright furniture, and bedrooms were personalised by the young residents.

Governance of the approved centre

The approved centre was part of Community Healthcare Organisation (CHO) 2. Local governance of the CAMHS in-patient unit at the time of this inspection appeared well balanced with a very strong focus on resident centred approach to care. It was clear at local level that communication pathways were positive, open, and clear between all disciplines.

Management noted that staffing was an ongoing challenge. Many nursing staff were on special duties leading to an increase demand on nursing staff. To address this shortfall, nurses were working overtime and

agency staff had been rostered to ensure adequate amounts of staff were on duty at all times. Due to an ongoing safety concern, the approved centre had to close to all admissions. At the time of inspection, the approved centre had nine extra nurses on special duties. There was an increase of nursing staff off duty due to sick leave and work related injuries.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. CAMHS (Galway) had the first national pilot advocacy group in the HSE for the young person. This process enables the young person to voice their views and concerns. It helps them to explore their options and rights, gives information to enable the young person to make informed decisions, contact relevant people or contacts and will accompany the young person to meetings and appointments.

2. The first CAMHS in-patient unit nationally to introduce nasogastric tube feeding for a young person with anorexia in an approved centre.

3. The introduction of a new individual care plan on a pilot basis with the use of computer inputting.

4. The introduction of twice-weekly yoga classes on an ongoing basis.

5. The development of a new missing persons' information sheet.

6. Introduction of two trainee family therapists working with families with young persons diagnosed with eating disorders.

7. The introduction of Body Why's 4 week programme- Pillar Programme working with parents of young persons with eating disorders.

8. Development of a new group evaluation folder.

9. The development of a new clinical nurse specialist role in eating disorders.

10. Employment of a full-time dietitian for eating disorders.

11. Employment of a new candidate advanced nurse practitioner in family therapy.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was a Child and Adolescent Mental Health Service (CAMHS) in-patient unit located on the grounds of Merlin Park Regional Hospital, Galway. There was a large wooden front to the main building, which housed a reception area, offices, conference rooms, a large gym, an occupational therapy kitchen, activity and therapy rooms, and a dining room where the young people ate their meals. Two multi-disciplinary teams were responsible for the treatment and care of the young people admitted to the approved centre and were based in this building. The residence was split into two units – the Willows, which was a 14-bed unit comprising two double bedrooms, seven single bedrooms, and three single bedrooms in a special care area, and Woodsend, which was a 6-bed unit comprising one double bedroom and four single bedrooms. A dedicated new school on site was fully commissioned on the 1st September this year. This comprised of four spacious classrooms. There was a large enclosed courtyard between the main building and the two units. There was also a "parent flat", which allowed a family to stay overnight when they had travelled to see one of the young residents.

The external structure of the main administration building was dark and worn. The external and internal grounds looked overgrown and weeds were emerging through the tiled areas. In comparison, the internal areas were filled with artwork and bright furniture, and bedrooms were personalised by the young residents. The approved centre provided care and treatment to young people from age 12 to 18, inclusive, with mental illness.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**11**
Number of detained patients	2
Number of wards of court	2
Number of children	11 (4 of which were on leave)
Number of residents in the approved centre for more than 6 months	2
Number of patients on Section 26 leave for more than 2 weeks	N/A

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre was part of Community Healthcare Organisation (CHO) 2. The overall Governance of the Galway/Roscommon area within the CHO was well established and had representation from all disciplines. Local governance of the CAMHS in-patient unit at the time of this inspection appeared well balanced with a very strong focus on resident centred approach to care. It was clear at local level that communication pathways were positive, open, and clear between all disciplines.

A number of operational committees functioned to ensure continuity and a high standard of care. These included the overarching clinical governance team meeting process, business meetings, nurse manager/consultant meetings, and the Health and Safety Committee. The minutes of these various committees were made available to the inspection team. Agendas appeared robust in nature with clear evidence of on-going quality improvement.

Management noted that staffing was an ongoing challenge. Many nursing staff were on special duties leading to an increase demand on nursing staff. To address this shortfall nurses were working overtime and agency staff had been rostered to ensure adequate amounts of staff were on duty at all times. The main objective of management was to maintain the health, safety and welfare of residents and staff. Due to circumstances pertaining at the time of inspection, the approved centre had to close to all admissions for the first time since its official opening. At the time of inspection, the approved centre had nine extra nurses on special duties. There was an increase of nursing staff off duty due to sick leave and work related injuries.

There were two psychologists (combined 1.8 WTE) and two social workers based in the approved centre – one on each of the two consultant-led teams. There were no ongoing challenges noted by management with regard to providing psychology or social work interventions to in-patients of Merlin Park. There was one occupational therapist (OT) within the approved centre. It was noted by management that working across two teams was impacting key performance indicators and the OT's ability to respond to all identified needs, in addition to completing assessments and summary reports. A dietitian 0.8 WTE was spread across two teams; however, an appointment of a full-time dietitian for young persons diagnosed with an eating disorder was being processed.

Each person with management responsibility had good knowledge of operational aspects of the approved centre as appropriate to their role. There was a shared understanding of each other's roles and a shared goal for the approved centre, which influenced cohesion and transparency within the service whereby issues could be discussed openly and appropriately.

4.5 Use of restrictive practices

The doors to the Willows and Woodsend units were secured with access via swipe card. The rationale for this restrictive practice was to ensure the safety and welfare of the residents. There were no other restrictive practices identified during the inspection process.

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 22: Premises	✗	Moderate	✗	High	✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate
Regulation 32: Risk Management	✗	Moderate	✗	High	✗	Critical
Rules Governing the Use of Seclusion	✗	High	✗	Low	✗	High

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 4: Identification of Residents
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 13: Searches
Regulation 17: Children's Education
Regulation 18: Transfer of Residents
Regulation 20: Provision of Information to Residents
Regulation 25: Use of Closed Circuit Television
Regulation 29: Operating Policies and Procedures

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation 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.
Rules Governing the Use of ECT	As the approved centre does not use ECT as a treatment this rule in N/A
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable
Code of Practice 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.
- The Area Lead from the HSE Mental Health Engagement Office was contacted.

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.

Young people preferred to meet the inspectors together; two residents spoke to the inspectors for approximately 30 minutes on their experience in the approved centre. Two questionnaires were completed.

Residents suggested that a new pathway needed to be put in place on the way to the new school, as they had to walk through the grass. They suggested the staff at times could be more sensitive to their needs. They commented that the floors in the approved centre could be cleaned more often and that the grass in the enclosed garden could be cut more often. They voiced that when they looked out of their window there was a lot of weeds and that this could look bleak.

They also expressed many positives, such as the residents knew their key worker. They stated that they were reviewed regularly by their treating consultant psychiatrist and were very much a part of devising their care plan with the team. They were happy with the level of activities in the approved centre. They liked the swings in the garden and found them very relaxing. They also stated the food in the approved centre was satisfactory.

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:

- Acting Executive Director
- Acting Area Director of Nursing
- Assistant Director of Nursing
- Three Consultant Psychiatrists
- Occupational Therapy Manager
- Senior Occupational Therapist
- Acting General Manager
- Acting Dietician Manager
- Senior Dietician
- Senior Dietician Linn Dara CAMHS
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Acting Clinical Nurse Manager

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. These are included in the body of the 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 **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in March 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 the identification of residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that clinical files contained appropriate resident identifiers. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. The approved centre used name, photograph, and date of birth of each resident as identifiers. The identifiers were person-specific and appropriate to the residents' communication abilities. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate alerts were used to assist staff in telling the difference between residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **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 March 2017. 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 policies. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policies.

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: The approved centre's menus were approved monthly by a part-time dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Residents had two choices for main meals. Hot meals were served daily. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly. Fresh water was available in easily accessible locations in the approved centre.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The approved centre was in the process of introducing an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements, but it was not yet implemented at the time of the inspection. Residents' special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

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

Regulation 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 June 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not 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 for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety/hygiene commensurate with their role. Staff training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendation. A temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: The storage facilities for dry goods were limited and required improvement. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

Appropriate hand-washing areas were provided for catering services. Food was prepared off-site and transported to the approved centre. Catering areas and associated catering and food safety equipment was not appropriately cleaned. The floor in the main kitchen was in a low standard of cleanliness and it was in need of a deep clean. 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 training and education and evidence of implementation pillars.

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 June 2017. 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 on residents' clothing. 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 monitored on an ongoing basis. A record of residents wearing nightclothes during the day, as indicated by their individual care plan, was not maintained and monitored.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents had an adequate supply of individualised 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 **Satisfactory**

(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 policy in relation to residents' personal property and possessions, which was last reviewed in March 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 policies. Relevant staff were able to articulate the processes for residents' personal property and possessions, as set out in the policies.

Monitoring: Personal property logs were not monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept distinct from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre's policy.

Secure facilities were provided for the safekeeping of the residents' monies, valuables, personal property, and possessions. Most of each residents' possessions were sent home. Each resident was provided with a drawer in a filing cabinet where runners and hoodies were kept. They could access these items under supervision.

Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

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 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in July 2017. 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 policies. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policies.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a record of resident uptake and attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Accessible and suitable information on the activities available to residents was provided in the information booklet that each resident received on admission. The timetable for activities in the Willlows and Woodsend units including the school timetable was displayed on noticeboards.

Recreational activities were appropriately resourced. A budget was available for financing away trips and recreational materials for day-to-day use. Opportunities were available for indoor and outdoor exercise and physical activity. Activities and recreational spaces included a large gym, outdoor activities, a chill out room, sitting room, and an activities room.

Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at events were maintained in-group records or in the clinical files.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 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 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 and supported within the approved centre. Residents had access to multi-faith chaplains, if required. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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 and procedures in relation to visits, which was last reviewed in June 2017. 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: There were no restrictions on residents' rights to receive visitors. Analysis was not completed to identify improvement.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting room areas were suitable for children.

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 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

(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 and procedures in relation to resident communication, which was last reviewed in June 2017. 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 policies. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policies.

Monitoring: Resident communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, telephone, and the internet but only under supervision. Residents did not have access to personal mobiles. Any phone calls made were limited to specified numbers and could only be made under staff supervision.

Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. A senior staff member only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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 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 and procedures in relation to the implementation of resident searches, which was last reviewed in July 2017. 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 processes for searches, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had been completed to identify opportunities for improvement of search processes.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches. The clinical file for one resident who was searched was inspected. Risk had been assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. The resident's consent was sought and documented, prior to the search taking place.

The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

The search was implemented with due regard to the resident's dignity, privacy, and gender. At least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

A written record of every search of a resident, every environmental search, and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

The 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 and protocols in relation to care of the dying, which was last reviewed in June 2018. The policy included the 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 had been transferred elsewhere (e.g. for general health care services).

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 end of life care, as set out in the policy.

As there had been no deaths in the approved centre since the last inspection, the approved centre was only assessed under the two pillars of processes and training and education for this regulation.

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 March 2016. 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 received training in individual care planning.

Monitoring: Residents' ICPs were not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: There were seven residents under the age of 18 in the approved centre at the time of the inspection. Each had an ICP and all seven ICPs were inspected. A key worker was identified to ensure continuity in the implementation of a resident's ICP. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Residents had been assessed at admission and an initial ICP was completed by the admitting clinician to address the immediate needs of the resident. All residents received an evidenced-based assessment within seven days of admission, but their communication abilities were not assessed. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, and next of kin, as appropriate. Family were involved in residents' ICPs with residents' consent.

The ICPs identified residents' assessed needs, defined appropriate goals, and identified the care and treatment required to meet the identified goals. The ICP identified the resources required to provide the care and treatment identified. The ICP included a risk management plan. However, one ICP inspected did not have a preliminary discharge plan documented.

The ICP was reviewed by the MDT in consultation with the resident regularly. Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews. All residents were asked to sign their ICP.

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 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 July 2017. The policy included the requirements of the *Judgement Support Framework* with the exception of the facilities available for the provision of therapeutic services and programmes.

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 therapeutic activities and programmes, as set out in the policies.

Monitoring: The range of services and programmes provided in the approved centre were 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 range of therapeutic services and programmes available in the approved centre was appropriate for the assessed needs of residents. There were two consultant-led teams, and each had its own range of allied health and social care professionals, including nursing, psychology, occupational therapy, social work, school teachers, and an activities nurse. Each team also had access to dietetics.

The therapeutic services and programmes provided were evidence-based and directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A list of services and programmes provided in the approved centre was available to residents, and these included the following: mindfulness, life skills, anxiety management, decider skills training, Dialectical Behaviour Therapy, a Wellness Recovery Action Plan group, first episode psychosis group, gardening, and therapeutic art.

Adequate and appropriate resources and facilities were available in the approved centre for the delivery of therapeutic services and programmes, including spaces for one-to-one and group work. Where residents required therapeutic services or programmes that were not provided internally, arrangements were in place for services to be provided by an approved, qualified health professional in a suitable location. A record was maintained of resident participation and engagement in and outcomes achieved in therapeutic services or programmes.

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 children's education, which was last reviewed in July 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Individual providers of educational services on behalf of the approved centre were 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 resident attendance at internal and external educational services.

Evidence of Implementation: Residents were assessed in terms of their individual education requirements, with consideration of individual needs and age on admission, as indicated by their individual care plans. They were initially assessed by the multi-disciplinary team (MDT) and teachers attended the MDT meetings. Where appropriate, the approved centre liaised with educational authorities and local education providers to ensure that each resident was appropriately assessed in relation to education needs. Where appropriate to the needs and age of the resident, the education provided by the approved centre was reflective of the required educational curriculum.

Appropriate facilities and sufficient numbers of personnel were available for the provision of education to child residents. The educational provisions available within the approved centre were effectively communicated to residents and their representatives. A daily activity timetable was developed in line with residents' individual needs. Attendance by residents at educational services within the approved centre and outside was documented, including reasons for non-attendance. The approved centre maintained comprehensive records of residents' educational history.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents, which was last reviewed in July 2017. 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 maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was examined. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the other facility. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This communication included the reasons for transfer, the resident's care and treatment plan, including needs and risks, and the resident's accompaniment requirements on transfer.

The resident was assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident's needs. Relevant documentation was issued as part of the transfer, with copies retained, including a letter of referral with a list of current medications and a resident transfer form. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident's clinical file.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(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 two separate 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 March 2017. The medical emergencies policy was last reviewed in March 2016. The policies combined included the requirements of the *Judgement Support Framework* with the following exceptions:

- The roles and responsibilities in relation to the provision of general health services to residents.
- The resource requirements for general health services, including equipment needs.

Training and Education: Not 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: The approved centre had an emergency bag and staff had access at all times to an Automated External Defibrillator. Emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, and each of the clinical files inspected evidenced that all residents had received a six-monthly general health assessment.

The six-monthly general health assessment documented a physical examination, family and personal history, body mass index, weight, waist circumference, blood pressure, smoking status, nutritional status, diet and physical activity including lifestyle, and a medication review. Ad hoc arrangements were in place for the provision of dental care.

Residents on antipsychotic medication received an annual assessment of glucose regulation, blood lipids, ECG, and prolactin levels, but one resident refused physical examination and biochemical testing. Refusals were documented. Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Records were available demonstrating residents'

completed general health checks and associated results, including records of any clinical testing. Residents had access to national screening programmes appropriate to age and gender.

National screening programmes did not apply to this resident cohort with the exception of retinal screening for diabetics; however, there was no resident with diabetes at the time of inspection. Residents had access to smoking-cessation programmes and supports. The approved centre had an individual based programme, which included nicotine replacement therapy and a therapeutic support package based on 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 processes, training and education, monitoring, and evidence of implementation pillars.

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents, which was last reviewed in June 2017. 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 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 monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with an information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team. The Youth Advocate Programmes Ireland was attached to the booklet for residents use.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident's diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to

the resident, including any possible side effects. Residents had access to interpretation and translation services as required.

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

Regulation 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 policy in relation to resident privacy, which was last reviewed in April 2017. The policy addressed 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 not been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were discreet when discussing residents' condition or treatment needs. Residents wore clothing that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. Locks had an override facility. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls. Residents could make and receive private phone calls to specified and pre-approved numbers. Residents were informed that calls would be monitored.

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in June 2017. 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 not completed a hygiene audit. A ligature audit was completed but it was undertaken with an audit tool, which was not validated. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit heated and ventilated. Residents had access to sufficient indoor and outdoor spaces to move about in. Natural and artificial lighting in the communal rooms suited the needs of residents and staff for reading and other activities. Appropriate signage and sensory aids were provided to support residents in not getting lost around the premises.

Hazards and ligature points were minimised. There was a cleaning schedule implemented but only when the multi-task assistant was available. The approved centre was not clean and hygienic throughout. The main kitchen floor was not kept in a clean state. While there was a programme of general maintenance, decorative maintenance, and repair of assistive equipment, and records were maintained, it was uncertain at the inspection time whether this programme was implemented in accordance with the schedule.

The approved centre was not kept in a good state of repair inside and outside. A number of doors in the special care unit had been damaged and required replacement. The external garden areas were poorly maintained. The garden was overgrown and weeds were in abundance.

Resident bedrooms were appropriately sized to address the resident needs. Most bedrooms were single with en suite facilities. Rooms were centrally heated, and the heating system in place was underfloor heating. Heating was not adjustable on an individual room basis, in compliance with health and safety guidance and building regulations.

Suitable furnishings were provided to support resident independence and comfort. There was a sufficient number of toilets and showers for residents in the approved centre. Back-up power was available in the approved centre through a hospital backup generator. Remote or isolated areas of the approved centre were monitored by CCTV, which was used to monitor the external public areas of the campus.

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

a) **The premises, especially parts of the external areas were not maintained in good decorative condition 22, 1 (a).**
b) **The premises were not kept clean 22, 1 (a).**
c) **Doors within the special care unit had been damaged and required replacement, 22, 1 (a).**

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 development and review of operating policies and procedures required by the regulations, which was last reviewed in July 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: All nursing, pharmacy, and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing, medical, and 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. Nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had 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: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's MPAR. A record was kept when medication was refused by the resident.

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. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration; and expired medications were not administered. All medicines were administered by a registered nurse or registered medical practitioner, and any advice provided by the resident's pharmacist regarding the appropriate use of the product was adhered too.

Medication was stored in the appropriate environment as indicated on the label or packaging, or as advised by the pharmacist. All medications were kept in a locked storage area within a locked room. Medication fridges were kept locked. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. An inventory of medications was conducted on a monthly basis by the pharmacy, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication. MDA drugs which were not in use, had not been returned to the pharmacy for disposal, and this was rectified during the inspection.

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

Regulation 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 operational policy and procedures in relation to the health and safety of residents, staff, and visitors, which was last reviewed in June 2016. The policy addressed the requirements of the *Judgement Support Framework* with the following exceptions:

- Falls prevention initiatives.
- Vehicle controls.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the health and safety 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 **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of CCTV, which was last reviewed in January 2017. 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 interviewed could articulate the processes relating to the use of CCTV, as set out in the policy.

Monitoring: The quality of CCTV images was checked regularly to ensure that the system was operating appropriately. Analysis had been completed to identify opportunities for improving the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. Residents were monitored solely for the purpose of ensuring their health, safety, and welfare. The Mental Health Commission had been informed about the approved centre's use of CCTV. CCTV cameras used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

(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 a written policy and procedures in relation to its staffing requirements, which was last reviewed in July 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 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: The organisational chart in place identified the leadership and management structure and the lines of authority and accountability of the approved centre's staff. Staff were recruited and selected in accordance with the approved centre's policy and procedures for recruitment, selection, and appointment.

Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. 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. An appropriately qualified staff member was on duty and in charge at all times.

The number and skill mix of staffing were sufficient to meet resident needs. A written staffing plan was available within the approved centre. Staff were not trained in manual handling, infection control and prevention, care for residents with an intellectual disability, resident rights, risk management and treatment, incident reporting, recovery-centred approaches to mental health care and treatment, and recovery-centred approaches to mental health care and treatment.

Staff were trained in Basic Life Support, but not all health care staff were trained in the following:

- Fire safety.
- The Professional Management of Violence and Aggression, (PMAV).
- The Mental Health Act 2001.
- Children First.

All staff training was documented and staff training logs were maintained. The following is a table of clinical staff assigned to the approved centre.

Ward or Unit	*Staff Grade*	*Day*	*Night*
	ADON (Across both units)	1	0 (On Call)
	CNM3 (Across both units)	1	0
	CNM2	1	1
	RPN	3	1
	MTA	2	1
The Willows	Occupational Therapist	0.5	
	Social Worker	1	
	Psychologist	1	
	Dietician	0.4	
	Night Porter	1	

Consultant Psychiatrist 1 WTE (covering both units)
Consultant Psychiatrist 0.5 WTE
Consultant Psychiatrist 0.5 WTE

Ward or Unit	*Staff Grade*	*Day*	*Night*
	CNM2	1	0
	RPN	2	2
	MTA	1	0
	Night Porter	1	
Woodsend	Occupational Therapist	0.5	
	Social Worker	1	
	Psychologist	0.8	
	Dietician	0.4	
	Night Porter	1	

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

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

a) **Not all staff had up-to-date mandatory training in fire safety and the Professional Management of Violence or Aggression, and Children First 26(4).**
b) **Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).**

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 a written policy and procedures in relation to the maintenance of records, which was last reviewed in March 2017. The policy addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. 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. Not all clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process insofar as was practicable. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Seven clinical files were inspected and all residents' records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Some files were too outsized and needed to be thinned out. Resident records were reflective of the residents' status at the time of inspection and the care and treatment being provided. Residents' access to their records was managed in accordance to the Data Protection Acts.

Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation. Only authorised staff made entries in residents' records, or specific sections therein. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Two entries on records did not include the date and time using the 24-hour clock.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

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 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 up-to-date, hard copy register of residents admitted. The register contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in July 2017. 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 timeframes. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service-users, as appropriate. Operating policies and procedures were communicated to all relevant staff.

The operating policies and procedures required by the regulations were all reviewed within the required three-year timeframe, were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines. The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Where generic policies were used, the approved centre had a written statement to this effect adopting the generic policy, which was reviewed at least every three years.

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

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 a written operational policy and procedures in relation to the management of complaints, which was last reviewed in June 2017. The policy and procedures addressed all of the 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. 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 processes for making, handling, and investigating complaints, as set out in the policy.

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

Evidence of Implementation: There was a nominated individual with responsibility for dealing with all complaints, the complaints officer, who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives.

There was no evidence to indicate that the any resident who made a compliant received diminished care and treatment as a result. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. All complaints were documented and dealt with by the local nominated complaints officer. Details of complaints and of subsequent investigations and outcomes were fully recorded and kept distinct from residents' individual care plans.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003.

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 monitoring pillars.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating CRITICAL

(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 comprehensive risk management written policy in place, which was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework* and all of the policy-related requirements.

Training and Education: All staff had signed a log to indicate that they had read and understood the risk management policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. Relevant staff were trained in the identification, assessment, and management of risk. Staff were trained in health and safety risk management. Clinical staff were trained in individual risk management processes. Management staff were trained in organisational risk management. All staff were trained in incident reporting and documentation. All training was documented.

Monitoring: The risk register was audited on a quarterly basis to determine compliance with the approved centre's risk management policy. All incidents in the approved centre were recorded and risk-rated. Analysis of incident reports was completed to identify opportunities for improvement of risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk management procedures did not actively reduce identified risks to the lowest level of risk, in particular in relation to one resident who was inappropriately placed in the approved centre. The approved centre was unable to provide an appropriate structural or therapeutic environment to meet the complex needs of this young person.

Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to and during physical restraint, mechanical restraint, at admission, transfer, and discharge.

Structural risks and ligature points were not removed and were not effectively mitigated. Due to the lack of adjacent toilet and shower facilities in the seclusion area, the seclusion area remained high risk of injury to the patient and staff.

The seclusion area was off a main corridor, which was an administrative area. When a patient in seclusion needed to use the toilet facilities, the area was sectioned off, leaving a very confined area whereby two nurses and the young person enter before the toilet facility**.** This area was so confined that if the young person attempted to assault the staff there was no room to deflect contact, leaving the risk of injury much higher for both parties.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their weekly meeting. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level.

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

The approved centre was non-compliant with this regulation because management were unable to ensure resident's or staff safety due to the demands of one resident's clinical needs and their appropriate structural environment needs, 32, 2 (b & c).

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, which was prominently displayed.

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

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually, which was last reviewed in June 2018. The policy included all of the guidance criteria of this code pursuant to Section 69 of the Mental Health Act 2001, including who may implement seclusion, the provision of information about seclusion to the resident, and ways of reducing rates of seclusion use.

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

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

Evidence of Implementation: Patients in seclusion did not have access to adequate toilet and washing facilities. To access the shower facilities patients had to walk through a corridor, which was used by staff to get to the washing facilities.

The seclusion room was small and was not adequately ventilated. At the time of the inspection, the seclusion door was compromised as the reinforcement bars were damaged and they could not be locked. This did not ensure respect for residents' privacy and dignity.

The seclusion room was designed with a hard floor fitting, which posed a risk to patient safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified on the use of seclusion within the appropriate time frame.

The clinical files of two patients who had been in seclusion were inspected. Of the three seclusion episodes inspected, two episodes were a continuation of a seclusion order. In all episodes, seclusion was only implemented in the resident's best interests and in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. Cultural awareness and gender sensitivity were demonstrated. Residents were informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. Each resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter.

In one seclusion episode, the seclusion order was not recorded in the clinical file. All uses of seclusion were recorded on the seclusion register. A copy of seclusion was placed in the clinical file in all cases.

Each episode of seclusion was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode of seclusion.

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

a) **Residents in seclusion did not have access to adequate and private toilet and washing facilities, 8.1.**
b) **The seclusion room was too small and it was poorly ventilated. The seclusion door was compromised as the reinforcement bars were damaged and they could not be locked. This indicated that the seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, 8.2.**
c) **The seclusion room was designed with a hard floor fitting which posed a risk to patient safety, 8.3.**

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to the approved centre at the time of this inspection. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

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: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in June 2018. The policy addressed the following:

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

Training and Education: The approved centre maintained a written record to indicate that all staff involved in physical restraint had read and understood the policy.

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

Evidence of Implementation: Three physical restraint episodes in relation to two residents were inspected. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour. In all cases, the restraint order lasted for a maximum of 30 minutes.

The registered medical practitioner completed a physical examination of each resident within three hours after the start of an episode of physical restraint. All residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. In all three episodes, the resident's next of kin was informed about the physical restraint. In all episodes of physical restraint, a same sex staff member was present during the physical restraint episode.

Each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode. All uses of physical restraint were clearly recorded in the clinical practice forms detailed and recorded within clinical files.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. All policies were last reviewed in March 2016. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:
Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The decision to admit was made by the registered medical practitioner or Consultant Psychiatrist. The resident was assigned a key-worker. The resident's family member, carer, or 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, and any other relevant information, such as 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 clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team, and the resident's family. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to the appropriate health professional, within three days. A comprehensive discharge summary was issued within 14 days, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan Template – CAMHS Merlin Park - 2018 Inspection Report

Regulation 22: Premises

Report reference: Pages 40 & 41

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. The premises, especially parts of the external areas were not maintained in good decorative condition, 22(1)(a).	*Reoccurring*	Corrective Action(s): • Put in place a maintenance schedule to highlight the areas of maintenance that require maintenance (quarterly, bi-annually, annually). • Met with the maintenance heads and made a plan to implement the schedule ASAP • Contracted in Radharc LTD to attend on a regular basis to tend to gardens and footpaths and weeds • Contracted in Higgins painters to attend quarterly to paint all internal areas Post-Holder(s) responsible: Mr John Canny Business Manager	Quarterly meetings between management and maintenance to ensure actions as identified in the Corrective actions are being addressed.	No identified barriers	In process- maintenance is a re-occuring event. All areas identified in inspection report are being addressed and continue to be addressed.
		Preventative Action(s): Post-Holder(s) responsible:	As above	No identified barriers	As above
2. The premises were not kept clean, 22(1)(a).	*Reoccurring*	Corrective Action(s): Contract cleaners undertook a deep clean of the entire Unit which was completed by Friday the 28th of September 2018. We have put forward a business case for contract cleaners to attend the unit x 2 days per weeks, as we are currently short staffed on MTA's. Daily Checklists in place for Multi task attendants to oversee cleanliness of unit.	Regular contact with the business manager requesting updates on progression of business case. Nurse managers to sign off on a daily basis.	Funding	In Process Completed

		Recuritment of additional Multi task attendants to cover long term sick leave and vacancies is currently being progressed. Post-Holder(s) responsible: John Canny Business Manager	Regular contact between Management,HR and NRS in relation to recruitment.		Inprocess
		Preventative Action(s): Post-Holder(s) responsible:	As above	Completed	Completed
3. Doors within the special care unit had been damaged and required replacement, 22(1)(a).	New	Corrective Action(s): Origional doors were repaired immediately and reinstalled as an interim solution. Areas have been measured and bespoke new doors are being made. Update from carpenter is that the new doors should be ready for installation in one months time. Post-Holder(s) responsible: Brian O'Malley Assistant Director of Nursing	Regular contact between management and carpenter.	No identified barriers	1 month
		Preventative Action(s): Post-Holder(s) responsible:	As above	No identified barriers	1 month

Regulation 26: Staffing

Report reference: Pages 46 & 47

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
4. Not all staff had up-to-date mandatory training in fire safety and the Professional Management of Violence or Aggression, and Children First 26(4).	*Reoccurring*	Corrective Action(s): Management have put together a 1 day mandatory training day for all staff to attend, it includes TMV, Manual Handling and BLS, Other mandatory training can be completed on-line. A greater emphasis this year put on training by Management Post-Holder(s) responsible: Maurice Maloney CNM2	Assign nurse manager Maurice Moloney to oversee and monitor training Register to highlight attendance of mandatory training .	Shortage of staff to be released for training . General business of the unit. Training being cancelled due to instructors being asked to return to work on the units.	9 months
		Preventative Action(s): Post-Holder(s) responsible:			
5. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).	*Reoccurring*	Corrective Action(s): CNM2 Maurice Moloney will be overseeing the mandatory training register. All staff that have not completed, or are not up to date on Mental Health Act Traininig will be informed that they must complete the training. Post-Holder(s) responsible: Maurice Maloney CNM2	CNM2 Maurice Moloney will be overseeing the mandatory training register. All staff that have not completed, or are not up to date on Mental Health Act Traininig will be informed that they must complete the training.	Training is easy to access, it is both on line and training can be easily arranged by the NPPC Achievable	9 Months
		Preventative Action(s): Post-Holder(s) responsible:	As above	Achievable	9 months

Regulation 32: Risk Management Procedures

Report reference: Page 54 & 55

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
6. Management were unable to ensure resident's or staff safety due to the demands of one resident's clinical need's and their appropriate structural environment needs, 32, 2 (b & c).	New	Corrective Action(s): 3.We have reduced our inpatient capacity. 4.We avoid admitting aggressive patients who require special care or seclusion. Three high risk patients who impacted on our ability to deliver care in a safe environment have now been discharged We hired agency staff to complement our staffing numbers . Post-Holder(s) responsible: Brian O'Malley Assistant Director of Nursing	2.Regular contact between management and carpenter for updates of doors. 4.Consultants oversee all referrals, to ensure appropriate admissions.	No barriers identified	1 month
		Preventative Action(s): Post-Holder(s) responsible:	As above	No barriers identified	1 month

Section 69: The Use of Seclusion

Report reference: Pages 59 & 60

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
7. Residents in seclusion did not have access to adequate and private toilet and washing facilities, 8.1.	New	Corrective Action(s): There are structural elements to the seclusion room which require addressing. This has been ongoing, there are plans in place for building works for a new seclusion room with the appropriate requirements , unfortunately securing capital funding remains an issue. Post-Holder(s) responsible: Mr Charlie Meehan Head of Mental Health	This has been escalated on the Risk Register Remains a standing item on our business eating agenda.	1.2 million funding requirement	2-5 years
		Preventative Action(s): Post-Holder(s) responsible:	As above	As above	2-5years
8. The seclusion room was too small and it was poorly ventilated. The seclusion door was compromised as the reinforcement bars were damaged and they could be locked. This indicated that the seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, 8.2. 9. The seclusion room was designed with a hard floor fitting which posed a risk to patient safety, 8.3.	New	Corrective Action(s): There are structural elements to the seclusion room which require addressing. This has been ongoing; there are plans in place for building works for a new seclusion room with the appropriate requirements ie non hard floor, appropriate ventilation, appropriate size. Unfortunately, release of capital funds is an issue. In relation to the seclusion door, there will dead locks placed in the door to replace the old reinforcement bars. Post-Holder(s) responsible:	This has been escalated on the Risk Register Remains a standing item on our business eating agenda.	1.2 million funding requirement	2-5 years 1 Month
		Preventative Action(s): Post-Holder(s) responsible:	As above	1.2million funding requirement	2-5 years