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

ID Number: AC0081

2019 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, CHO 2 - Mental Health Services

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
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Inspection Date:
26 – 29 March 2019

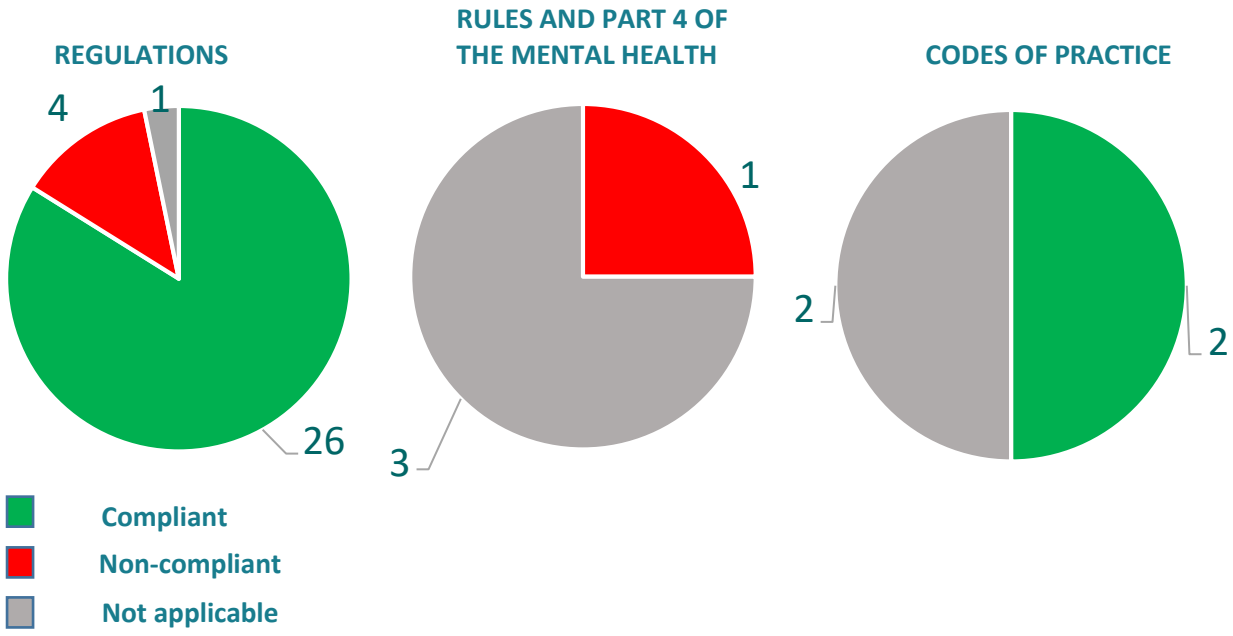
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
18 – 21 September 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 26 September 2019

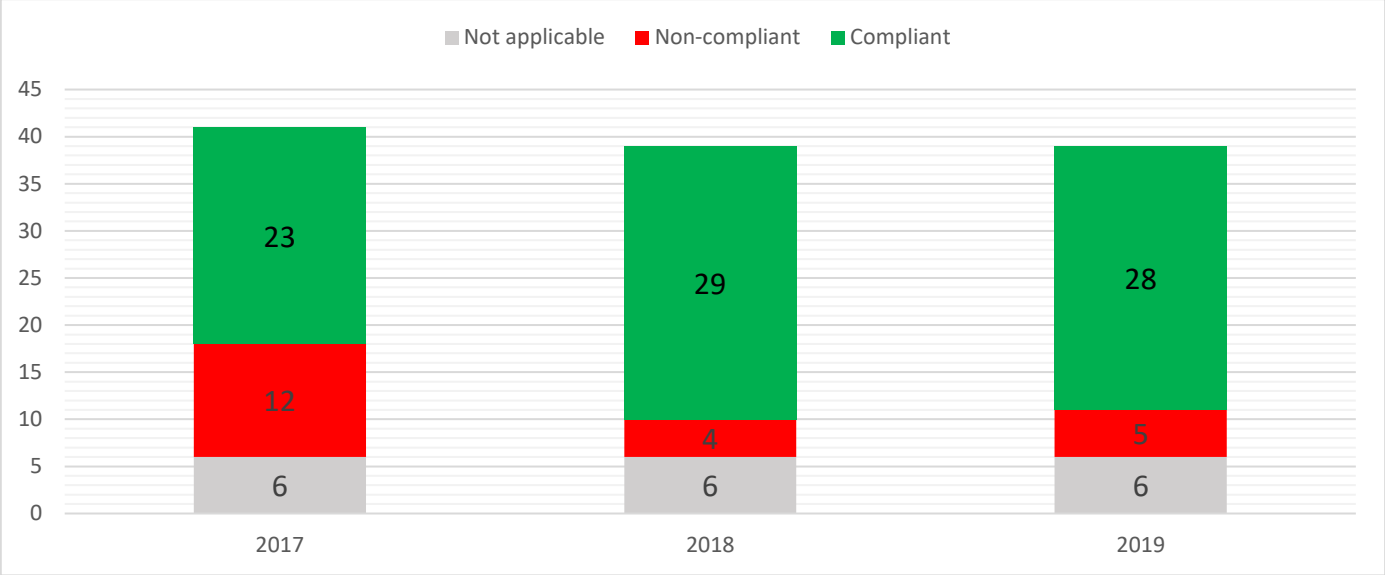
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

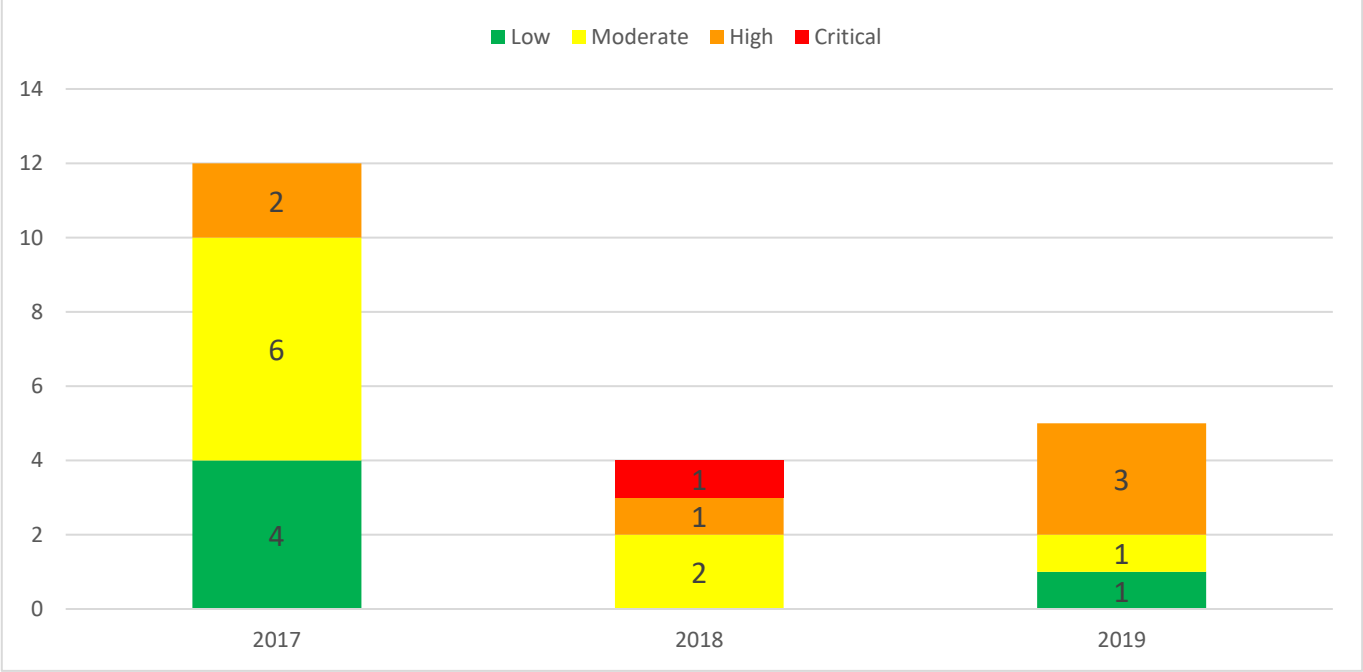
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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 2017 – 2019



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

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. The approved centre 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 and were based in this building. The residence was split into two units, the Willows, which was a 14-bed unit, and Woodsend, which was a 6-bed unit comprising one double bedroom and four single bedrooms. The approved centre had a dedicated school on site. There was also a "parent flat", which allowed a family to stay overnight when they had travelled to see one of the young people.

The approved centre had maintained its improvement in compliance with regulations, rules and codes of practice since 2017 when compliance was 66%. In 2019, compliance was 85%. There were 14 compliances with regulations rated as excellent.

Conditions to registration

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

Safety in the approved centre

- The ordering, prescription, storage and administration of medication was excellent.
- Ligature points were minimised to their lowest practicable level, based on risk assessment.

However:

- Food safety was not maintained. The main kitchen did not have enough dry storage facilities, and dry food was stored on open countertops. Catering areas and associated catering and food safety equipment were not appropriately cleaned. There was no backsplash in the main kitchen. Walls were splashed with food markings and chipped paint was observed on the counter tops surrounding walls in the main kitchen where food was prepared and stored. Floors were stained and dirt was ingrained within the lino.
- Not all staff had up-to-date mandatory training in fire safety, Basic Life Support, the management of violence and aggression, the Mental Health Act 2001, and Children First.

Appropriate care and treatment of residents

- For residents with special dietary requirements, an evidence-based nutrition assessment tool was used. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. The approved centre had employed a clinical dietetic specialist to work solely with residents with eating disorders.
- Individual care plans (ICPs) were developed by the multi-disciplinary team (MDT) and were discussed, agreed and drawn up with the participation of the resident and their representative, family and next-of-kin, as appropriate. All ICPs identified the care and treatment required to meet the goals and the resources required to provide the care and treatment identified. All ICPs were reviewed by the MDT in consultation with the resident at least weekly. Residents were invited to submit "My Weekly Care Plan Review" forms and attend ICP meetings towards the end of the meeting. All ICPs of residents included their educational requirements.
- The therapeutic services and programmes provided by the approved centre were appropriate and met the addressed needs of the residents. These included a life skills assessment group, psycho-education, family support group sessions, Cognitive Behavioural Therapy and Dialectical Behaviour Therapy.
- Residents received appropriate general health care interventions in line with their individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.
- Admission, transfer and discharge procedures were satisfactory.

However:

- A keyworker was not specified within the ICP documents reviewed; a keyworker system was piloted in 2018 for several months but was not in place at the time of inspection.

Respect for residents' privacy, dignity and autonomy

- Visiting times were appropriate and reasonable. A separate visitor room was provided where residents could meet visitors in private.
- Resident consent was sought prior to all searches. Consent for routine and random searches was sought from parents/guardians on admission. There was a minimum of two clinical staff in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to the resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair both externally and internally.
- Clear signs were in prominent positions where CCTV cameras or other monitoring systems were located in the approved centre. CCTV cameras used to observe residents were incapable of recording

or storing a resident's image. CCTV cameras used to observe residents did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.
- The approved centre was compliant with the Code of Practice on Physical Restraint.

However:

- The approved centre was not clean, hygienic, and free from offensive odours. The breakfast room in the Woodsend unit was observed to have a strong odour. The outside area of Woodsend was not clean when the inspection team arrived; the main kitchen area did not have the required wall tiles to maintain cleanliness in the kitchen. Despite efforts of staff to clean the lino on the kitchen floor, this remained stained and appeared to be dirty. There was poor maintenance of the garden areas including the widespread presence of weeds.
- The location of the seclusion room within the approved centre meant that residents were required to go outside the building to access it, compromising their privacy and dignity.
- Residents in seclusion did not have access to adequate toilet and washing facilities. The seclusion room had been designed with a hard floor fitting, which posed a risk to resident safety. There was graffiti on the walls at the time of inspection.
- The temperature of the seclusion room was uncomfortably warm. Staff informed the inspection team that it was not possible to adjust the heating within the approved centre, as maintenance had to be contacted to do this. Once the maintenance team was contacted and the temperature changed, it could take one to two days for the temperature to adjust.

Responsiveness to residents' needs

- For all residents, approved centre menus were provided by a dietitian to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups. Modified consistency diets were presented in a manner that was attractive and appealing.
- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and weekends. Recreational activities included TV, board games, gymnasium, badminton, basketball, football, air hockey, walks, swings, and baking. On weekends, residents had access to walks, board games, TV, movies, and other such activities. There was a gymnasium and six of the staff were qualified gym instructors.
- Provision of information about the approved centre, diagnoses and medications was excellent.

Governance of the approved centre

- 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 a 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.
- Clinical governance team meeting agenda items included health and safety, drugs and therapeutics, policies and procedures, audit and quality improvement, complex care needs, and clinical complaints.
- There was a strong ethos of staff supervision in all of the departments and clear lines of responsibility and reporting in place.
- Processes for risk escalation from the local risk register were in place. Actions to manage risks were identified and the risk register recorded timeframes for the completion of these actions.
- Annual staff training plans were completed to identify required training. A variety of training courses was also available to staff.
- The approved centre had a robust programme of cyclical audit. Clinical audits were undertaken by senior nursing management and other members of the MDT.
- Resident and carer involvement in service improvement was principally achieved via community meetings and feedback obtained by 'Your Service Your Say' surveys. Issues arising from minor complaints were resolved by staff in a timely and effective manner. Formal complaints and compliments were reviewed at the management meetings and escalated where appropriate.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had introduced a clinical dietetic specialist to the team to meet the increasing needs of residents with eating disorders.

2. Nursing staff had been trained in the use of a nutritional screening tool to identify residents at risk.

3. The approved centre had developed a new admission programme for residents who require crisis admission.

4. The approved centre was the first CAMHS in-patient unit nationally to employ a candidate Advanced Nurse Practitioner to provide intensive treatment and early discharge for residents with personality disorders.

5. A Family Talk Group has been introduced. This service was offered to families when a parent of a resident had a mental illness.

6. The approved centre had introduced weekly clinical review meetings. The aim of these meetings was to connect with the community mental health teams.

3.0 Overview of the Approved Centre

3.1 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. The main building 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. All bedrooms had an en suite. The location of the seclusion room within the approved centre meant that residents could be required to go outside the building to access it, compromising their privacy and dignity. The approved centre was not at full capacity at the time of inspection; residents were accommodated in the Willows Unit.

The approved centre has a dedicated school on site. The school 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 people. At the time of inspection, the garden areas particularly in the Woodend were in need of maintenance. The exterior walls required cleaning; this was rectified during the inspection.

Internally the Willows and Woodsend units were bright and spacious 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	**10**
Number of detained patients	3
Number of wards of court	1
Number of children	10
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was 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 a 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, clinical review meetings and a Quality and Safety Committee (QPS). Clinical governance team meeting agenda items included health and safety, drugs and therapeutics, policies and procedures, audit and quality improvement, complex care needs, and clinical complaints. Meeting minutes were provided to the inspection team; however, in spite of repeated requests, only one copy of a QPS monthly meeting was provided. Agendas appeared robust in nature with clear evidence of on-going quality improvement.

There was a strong ethos of staff supervision in all of the departments and clear lines of responsibility and reporting in place. Low staffing levels were identified as an operational risk for the nursing, medical, occupational therapy, social work and psychology departments. Issues with regard to the approved centre's seclusion room not being fit for purpose were identified, as had issues regarding transfer of residents between the Willows and Woodsend units; a link corridor had been requested. These risks had been escalated to senior management. Actions to manage risks were identified and the risk register recorded timeframes for the completion of these actions. Processes for risk escalation from the local risk register were in place.

At the time of inspection, the approved centre was not at full capacity and nursing staffing levels were easy to maintain. Annual staff training plans were completed to identify required training; however, records indicated that not all health professionals had up-to-date mandatory training. A variety of non-mandatory training courses was also available to staff, and management facilitated and encouraged staff members to engage in higher education programmes as relevant.

The approved centre had a robust programme of cyclical audit, and these audits were made available to the inspection team. Clinical audits were undertaken by senior nursing management and other members of the MDT.

Resident and carer involvement in service improvement was principally achieved via community meetings and feedback obtained by 'Your Service, Your Say' surveys. Issues arising from minor complaints were resolved by staff in a timely and effective manner. Formal complaints and compliments were reviewed at the management meetings and escalated where appropriate.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 6: Food Safety	✓		✓		✗	Low
Regulation 22: Premises	✗	High	✗	Moderate	✗	High
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	High
Regulation 27: Maintenance of Records	✗	Low	✓		✗	Moderate
Rules Governing the Use of Seclusion	✗	Low	✗	High	✗	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.

4.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 16: Therapeutic Services and Programmes
Regulation 17: Children's Education
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines
Regulation 25: Use of CCTV
Regulation 29: Operating Policies and Procedures

4.3 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 Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As this was a child and adolescent facility, this Code of Practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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

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

With the residents' permission, their experience was fed back to the senior management team. The inspection team met with one young person. This resident suggested that they would like access to a computer, so they could listen to music. Feedback suggested that the food was good and there was a variety to choose from. The resident was offered a copy of their individual care plan. The inspection team did not receive any completed service user experience questionnaires.

6.0 Feedback Meeting

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

- Assistant Director of Nursing (ADON)
- Acting Clinical Director
- General Manager
- Occupational Manager
- Senior Social Worker
- Senior Dietitian (Acting Clinical Specialist)
- Clinical Nurse Manager 3 (CNM3)
- CNM2
- Acting CNM2
- Multitask Attendant
- Consultant Psychiatrist
- Deputy School Principal

Apologies:

- Clinical Director
- Area Director of Nursing

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. There were discussions regarding the approved centre's intensive treatment for early discharge, the new Candidate Advanced Nurse Practitioner post for Galway/Mayo and the electronic individual care plans.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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 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 identifying residents, as set out in the policy.

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

Evidence of Implementation: There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Name and date of birth were used as well as a photograph. The preferred identifiers used for each resident were detailed within residents' clinical files. Identifiers were person-specific, ensuring that residents could be identified easily. Identifiers were appropriate to the residents' communication abilities. Two appropriate resident group findings were used before administering medications, undertaking medical investigations, and providing other health care services.

An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for residents with the same or a similar name; there was a process of a coloured sticker alert system in place.

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 **Excellent**

(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 policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

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

Evidence of Implementation: For all residents, approved centre menus were provided by a dietitian to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups. Modified consistency diets were presented in a manner that was attractive and appealing. A source of safe, fresh drinking water was available to residents at all times through water coolers along the main corridors and small kitchens on both units.

For residents with special dietary requirements, an evidence-based nutrition assessment tool was used. Weight charts were implemented, monitored, and acted upon for residents. Residents, their representatives, family, and next of kin were educated about residents' diets, where appropriate, specifically in relation to any contraindications with medication. Nutritional and dietary needs were assessed and addressed in residents' individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents. The approved centre had employed a clinical dietetic specialist to work solely with residents with eating disorders.

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 6: Food Safety

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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

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

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. There was suitable and sufficient catering equipment. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre did not ensure that there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. The main kitchen did not have enough dry storage facilities, and dry food was stored on open countertops. Catering areas and associated catering and food safety equipment were not appropriately cleaned. There was no backsplash in the main kitchen. Walls were splashed with food markings and chipped paint was observed on the counter tops surrounding walls in the main kitchen where food was prepared and stored. Floors were stained and dirt was ingrained within the lino.

The approved centre was non-compliant with this regulation because a high standard of hygiene was not maintained in relation to the storage, preparation, and disposal of food and related refuse, 1 (c).

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

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. 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. This was documented. A record of residents wearing nightclothes during the day was maintained and monitored. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents' clothing was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. A large selection of emergency clothing was available. Residents changed out of nightclothes during daytime hours. Residents had an adequate supply of individualised clothing.

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 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in February 2019. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the residents' monies, valuables, personal property and possessions, as necessary. A record of each resident's property was maintained by the approved centre, which was stored separately from their individual care plan. Residents were entitled to bring personal possessions with them into the approved centre, in line with admission procedures. Where any money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained. Where possible, this was counter-signed by the resident or their representative.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **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 policy. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log 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 weekends. Recreational activities included TV, board games, gymnasium, badminton, basketball, football, air hockey, walks, swings, and baking. On weekends, residents had access to walks, board games, TV, movies, and other such activities.

The approved centre had a gymnasium and six of the staff were qualified gym instructors. Communal areas were provided in both units. Records of attendance were documented in the resident's individual care plans.

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 within the approved centre insofar as was practicable. Any specific religious requirements relating to the provision of services, care and treatment were clearly documented within residents' admission assessment and individual care plans. Residents were facilitated to observe or abstain from religious practice in accordance 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 **Excellent**

(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 policy in relation to visits. The policy were 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: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate and reasonable. A separate visitor room was provided where residents could meet visitors in private, unless there was an identified risk to the resident or to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Visits for young children were facilitated off the unit within therapy rooms where appropriate. The visiting area was suitable for visiting children.

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 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 in relation to resident communication. The policy 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 communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were 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, fax, email, internet, and telephone unless otherwise risk assessed with due regard to the residents' wellbeing, safety and health. There was a computer in the nurse's station that residents could use under supervision in both units. The senior staff member designated by the Clinical Director only examined incoming and outgoing resident communication if there was reasonable cause to believe that 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 **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in June 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 searching processes, as set out in the policy.

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

Evidence of Implementation: The registered proprietor ensured that searches were only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre. Resident consent was sought prior to all searches. The request and the received consent was documented for every search of a resident and every property search. Consent for routine and random searches was sought from parents/guardians on admission. General written consent was sought for routine environmental searches. Where consent was not received, this was documented and the process relating to searches without consent was implemented. Search consent forms and clinical notes did not reflect a risk assessment prior to searches. The resident search policy and procedure was

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

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 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 February 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the roles and responsibilities relating to individual care planning.

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

Evidence of Implementation: Ten ICPs were inspected. The ICPs were a composite set of documents which included sections for goals, treatment, care, resources required and reviews, and were stored within the clinical files. They were identifiable and uninterrupted, and were not amalgamated with progress notes. Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address the immediate needs of the resident. The assessment did not include the residents' communication needs. The ICPs were developed by the MDT following a comprehensive assessment within seven days of admission.

The ICPs were discussed, agreed and drawn up with the participation of the resident and their representative, family and next-of-kin, as appropriate. All ICPs identified the care and treatment required to meet the goals, including the frequency and responsibilities for implementing the care and treatment. ICPs identified the resources required to provide the care and treatment identified. All ICPs were reviewed by the MDT in consultation with the resident at least weekly. Residents were invited to submit "My Weekly Care Plan Review" forms and attend ICP meetings towards the end of the meeting. It was documented if it was not suitable or a resident refused. All ICPs of child residents included their educational requirements.

A key-worker was not specified within the ICP documents reviewed; a key-worker system was piloted in 2018 for several months but was not in place at the time of 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 processes and evidence of implementation pillars.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

(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 November 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the addressed needs of the residents, as documented in residents' individual care plans. A list of services and programmes in the approved centre was available to the residents, and these included the following: life skills assessment group, psycho education, family support group sessions, Cognitive Behavioural Therapy and Dialectical Behaviour Therapy. The therapeutic services and programmes provided by the approved centre were evidence-based. The therapeutic services and programmes provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

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 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of education to child residents, which was last reviewed in June 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Child residents were assessed regarding their individual educational requirements with consideration of their individual needs and age on admission. Where appropriate to the needs and age of the resident, the education provided by the approved centre was reflective of the required educational curriculum. The approved centre linked in with educational authorities and local education providers to ensure that each resident was appropriately assessed in relation to educational needs. Appropriate facilities were available for the provision of education to residents, as well as sufficient personnel resources, which were also used for residents to access external educational services. In addition, such educational provisions were effectively communicated to residents and their representatives, and a daily activity timetable for schooling was available. Attendance of educational services by residents in both the approved centre and through external services was documented. There were comprehensive records of each resident's educational history, such as schools attended, reports obtained, and certificated awarded. Where there was an educational transition of a resident, such as changing school, they were given additional support and assistance by the approved centre, as deemed appropriate in the specific circumstances.

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

(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. The policy was last reviewed in July 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

As there had been no transfers 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 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 written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. Both policies were last reviewed in March 2017. The policies and procedures addressed 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 trolley and staff had access at all times to an Automated External Defibrillator (AED).

Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with their individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The general health assessment documented the following: a physical examination, family/personal history, Body Mass Index (BMI), weight and waist circumference, blood pressure, smoking status, nutritional status, medication review and dental health.

Records were available demonstrating the residents' completed general health checks and the associated results. Smoking was assessed on admission and smoking cessation was offered. The approved centre was a no smoking campus.

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 training and education 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 in relation to the provision of information to residents. The policy 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 policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

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: The approved centre had an information booklet, which included information regarding housekeeping arrangements, arrangements for personal property and mealtimes, visiting times, and details of relevant advocacy and voluntary agencies. Residents were provided with the details of their multi-disciplinary team. Residents were also provided with written and verbal information regarding their 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 their clinical file.

The residents had access to medication information sheets which included information on 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 **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in April 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 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 been undertaken to ensure that the policy was being respected and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: There was evidence relating to resident privacy and dignity being respected throughout the approved centre. This included residents being called by their preferred name, the general demeanour of staff, and the manner in which staff addressed and communicated with residents. There was staff discretion when discussing the residents' condition or treatment needs. In addition, staff sought the residents' permission before entering their rooms, as appropriate. All residents wore clothes that respected their privacy and dignity.

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to the resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

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 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Appropriate sized communal rooms were provided. Private and communal areas were suitably sized and furnished. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces were minimised in the approved centre. Ligature points were minimised to their lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair both externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records of such were maintained. There was a sufficient number of toilets and showers for residents in the approved centre. All resident bedrooms were appropriately sized to address the resident needs.

The temperature of the seclusion room was uncomfortably warm. Staff informed the inspection team that it was not possible to adjust the heating within the approved centre, as maintenance had to be contacted

to do this. Once the maintenance team was contacted and the temperature changed, it could take one to two days for the temperature to adjust.

The approved centre was not clean, hygienic, and free from offensive odours. The breakfast room in the Woodsend unit was observed to have a strong odour. The outside area of Woodsend was not clean when the inspection team arrived; power hosing was completed during the inspection which cleaned this dirt. The main kitchen area did not have the required wall tiles to maintain cleanliness in the kitchen. Despite efforts of staff to clean the lino on the kitchen floor, this remained stained and appeared to be dirty. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43C. Heating could not be safely controlled in the resident's own room.

The location of the seclusion room within the approved centre meant that residents were required to go outside the building to access the seclusion room, compromising their privacy and dignity. There was poor maintenance of the garden areas including the widespread presence of weeds. This meant that the approved centre was not maintained with due regard to the specific needs of the residents.

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

a) **The outside area of the Woodsend unit was not clean and maintained in good order on inspection, 22 (1)(a).**
b) **The breakfast room in the Woodsend unit was not clean, and was observed to have a strong odour, 22 (1)(a).**
c) **The temperature in the seclusion room was uncomfortably warm, 22 (1)(b).**

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

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in July 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten MPARs were inspected. All entries on the MPARs were legible and written in black indelible ink. Each MPAR evidenced a record of medication management practices, including records of all medications administered, and details of routes, dosages and frequency of medication. Medication was reviewed and re-written 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. A prescription was not altered where a change was required. Where there was any alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with directions of the prescriber, and any advice provided by that resident's pharmacist regarding the appropriate use of the product.

The expiration date of the medication was checked prior to administration, and expired medications were not administered. Schedule two controlled drugs were checked by two staff members, against the delivery form and details were entered on the controlled drug book. Direction to crush medication was only accepted from the resident's medical practitioner. The medical practitioner gave a documented reason why the medication was to be crushed. The pharmacist was consulted about the type of preparation to be used. The medical practitioner documented within the MPAR that the medication was to be crushed.

Medication was stored in the appropriate environment as indicated on the label or packaging of the medication, or as advised by the pharmacist. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage. Food and drink were not stored in areas used for the storage of medication. Medication dispensed or supplied to the resident was stored

securely in a locked storage unit, with the exception of medication which was recommended to be stored elsewhere (e.g. refrigerator). The medication trolley remained locked at all times and secured in a locked room. Schedule two and three controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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 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 written operational policies and procedures in relation to the health and safety of residents, staff and visitors. The policies were last reviewed in March 2017 (Health and Safety Policy) and November 2018 (Safety Statement).

The policies and safety statement addressed 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 policy. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy.

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

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 and protocols in relation to the use of CCTV. The policy was last reviewed in January 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre.

Training and Education: All relevant 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 relating to the use of CCTV, as set out in the policy.

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

Evidence of Implementation: Clear signs were in prominent positions where CCTV cameras or other monitoring systems were located in the approved centre. There was one CCTV camera used in the seclusion room. Images from this camera were transmitted to the screen outside the seclusion room, and not in the nurse's station. This was for the purpose of maintaining the dignity of the resident while in the seclusion room.

Residents were monitored solely for the purposes of ensuring the health, safety and welfare of that resident. The use of CCTV had been disclosed to the Mental Health Commission. CCTV cameras used to observe residents were incapable of recording or storing a resident's image. CCTV cameras used to observe residents did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.

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 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 in relation to its staffing requirements. The policy was last reviewed in July 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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.

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing	88	%	94	%	86	%	72	%	94	%
Medical	100	%	67	%	100	%	67	%	67	%
Occupational Therapist	100	%	100	%	100	%	100	%	100	%
Social Worker	100	%	50	%	100	%	100	%	100	%
Psychologist	100	%	100	%	100	%	100	%	100	%

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

Not all staff had up-to-date mandatory training in the following: fire safety; Basic Life Support; the Management of Violence and Aggression, the Mental Health Act 2001; and Children First.

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

Ward or Unit	Staff Grade	Day	Night
	ADON	1	On call
	CNM3	1	0
	CNM2	1	1
	RPN	6	4
The Willows			
	Occupational Therapist	1	0
	Social Worker	2	0
	Psychologist	1.8	0
	Dietitian	1	0

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 Basic Life Support, fire safety, Children First or PMAV, 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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 in relation to the maintenance of records. The policy was last reviewed in March 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents' records.
- Record retention periods.
- The destruction of records.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the 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 policy. All clinical staff had been trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Resident records were reflective of the residents' status at the time of inspection and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Records were written legibly in black, indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Each entry included a date. Each entry was followed by a signature. The approved centre also maintained a record of all signatures used in the resident record. All entries made by student nurses were countersigned by a supervisor.

Correction fluid was not permitted on records in the approved centre. Two appropriate resident identifiers were recorded on all documentation. Where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title. Where information was given over the phone, this was documented as such by the member of staff who

took the call and the person giving the information and/or advice was clearly identified. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre. Ten clinical files were inspected. Two files were oversized making it difficult to handle them, and information was difficult to find. Both files had loose pages. Records were not maintained in good order. Not all entries in the progress notes included the time.

The approved centre was non-compliant with this regulation because two files were oversized making it difficult to handle them. Information was difficult to find and both files had loose pages, 27 (1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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 June 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 time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all 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 time frame, were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

The format of 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, and this was reviewed at least every three years. Any generic policies were appropriate to the approved centre and the resident group profile.

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 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 in relation to the management of complaints. The policy was last reviewed in June 2017. The policy 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. 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. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. This included the provision of information about the complaints procedure to the resident and their representative at admission, or soon thereafter. This information was provided within the resident information booklet. The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family and next-of-kin were informed of all methods by which a complaint could be made.

Complaints that could not be addressed locally were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan.

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 monitoring pillar.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in March 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical, health and safety, and corporate risks were identified, assessed, treated, reported and monitored and were documented in the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were completed prior to and during resident seclusion, physical restraint, admission, discharge and in conjunction with medication requirements or administration. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format.

The approved centre provided a six-monthly summary report of all incidents 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 staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

Multi-disciplinary teams (MDTs) were not involved in the development, implementation, and review of individual risk management processes. The Consultant Psychiatrist and the Clinical Nurse Managers met monthly to discuss risks within the unit. However, the other MDT members were not present at this meeting.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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 statutory rules were 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: Seclusion was initiated by a registered medical practitioner (RMP) and/or a registered nurse. The relevant consultant psychiatrist (CP) was notified as soon as practicable on the use of seclusion. When seclusion was initiated, it only occurred following a risk assessment, and this was recorded in the clinical file and seclusion register by the person initiating seclusion. The seclusion order was recorded in the clinical file and seclusion register by the RMP. The RMP indicated the duration of the seclusion order, which was to be no longer than eight hours. The seclusion register was signed by the responsible CP within 24 hours, and a medical review of the three patients took place no later than four hours after the commencement of the episode of seclusion.

Residents in seclusion did not have access to adequate toilet and washing facilities. The seclusion room had been designed with a hard floor fitting, which posed a risk to resident safety. Seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, as there was graffiti on the walls at the time of inspection.

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

a) **Residents in the seclusion room did not have access to adequate toilet or washing facilities, as there was no shower unit included in the nearby washroom. The washroom was not directly accessible to residents from the seclusion room, 8.1.**
b) **The seclusion room was not maintained with due regard to ensure respect for resident dignity as there was graffiti visible on the seclusion room wall, 8.2.**

c) **The fact that the floor of the seclusion room was of a hard fitting meant that it was not furnished so as not to endanger patient safety, 8.3.**

9.0 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: Consent to Treatment, was not applicable to this approved centre. Please see *Section 4.3 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

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

Training and Education: 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: The files of three residents who were physically retrained were reviewed on inspection. 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 at 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 2019. All policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:
Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident's family member, carer, 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: 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

Regulation 6: Food Safety					
Reason ID : 10000209		**A high standard of hygiene was not maintained in relation to the storage, preparation, and disposal of food and related refuse, 1 (c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1)There are structural elements to the Kitchen which require addressing.we are essentially a commercial kitchen working as a domestic kitchen This has been ongoing, there are plans in place for building works for a new and updated Kitchen with the appropriate requirements , unfortunately securing capital funding remains an issue. 2)MTA's made aware of this, and more vigilant of the importance of keeping a record on a daily basis.Liase with MTA's about the findings of the MHC. CNM's to complete regular checks on cleanliness of kitchen	1)Remains a standing item on our business eating agenda,Management will Continue to submit reminders to clinical governance meetings re importance of suitable kitchen and food area and outline risks involved 2)Checklist completed on a daily basis - regular audits by CNM's	Significant funding required,	31/12/2019	1)Mr Charlie Meehan Head of Mental Health and Joe Barrett Catering Manager 2)CNM's and MTA's
Preventative Action	1) As above 2)Unlikely to reoccur	As above	Achievable pending funding	31/12/2019	As above

Regulation 27: Maintenance of Records					
Reason ID : 10000210		**Two files were oversized making it difficult to handle them. Information was difficult to find and both files had loose pages, 27(1)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Since inspection Werd Clerk has been introduced whose duties include file maintainence Files have been agreed to be no more than 1 1/2 inches in thickness before a new file is created to avoid them being oversized New clinical progress sheets have been implemented in CAMHS, that have more durable spines to avoid tearing and multiple loose pages On going weekend duties for staff include file maintainence which incorporates file size, GDPR, and colour coded system for each individual section We have further updated the front section of the Health care record to include new sections to avoid any queries over correct filing of documentation/forms etc:	Audit of Files	Achievable	31/07/2020	CNM 3 CNM 2's Ward Clerk
Preventative Action	As Above	As Above	As Above	31/07/2020	As Above

Regulation 22: Premises

Reason ID : 10000211		The outside area of the Woodsend unit was not clean and maintained in good order on inspection, 22 (1)(a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• 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 1)We have now a contract cleaners to attend the unit x 2 days per weeks, as we are currently short staffed on MTA's. 2)Daily Checklists in place for Multi task attendants to oversee cleanliness of unit.	Quarterly meetings between management and maintenance to ensure actions as identified in the Corrective actions are being addressed. Nurse managers to sign off on a daily basis.	No identified barriers Funding 1& 2 is now completed	26/07/2019	Mr John Canny Business Manager
Preventative Action	As above	As above	No Identified barriers	26/07/2019	As above

Reason ID : 10000212		The breakfast room in the Woodsend unit was not clean, and was observed to have a strong odour, 22 (1)(a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Contract cleaners undertook a deep clean of the entire Unit Contract cleaners now 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. Recruitment of additional Multi task attendants to cover long term sick leave and vacancies is currently being progressed.	Regular contact with the business manager requesting updates on progression of business case. Nurse managers to sign off on a daily basis. Regular contact between Management,HR and NRS in relation to recruitment.	Funding	26/07/2019	John Canny Business Manager

Preventative Action	As above	As above	Some have ben completed others are ongoing	26/07/2019	As above
Reason ID : 10000213		**The temperature in the seclusion room was uncomfortably warm, 22 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• 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 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: appropriate ventilation,appropriate size. Unfortunately release of capital funds is an issue.	Quarterly meetings between management and maintenance to ensure actions as identified in the Corrective actions are being addressed. This has been escalated on the Risk Register Remains a standing item on our Business Meeting agenda.	No identified barriers 1.2 million funding requirement	30/07/2021	Mr John Canny Business Manager Mr Charlie Meehan Head of Mental Health
Preventative Action	As above	As above	No identified barriers 1.2million funding requirement	30/07/2021	As above
The Commission is engaging with the Approved Centre to finalise interim measures to address non-compliance. These were not available in time for publication.					

Regulation 26: Staffing					
Reason ID : 10000214		**Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, Children First or PMAV, 26(4). Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	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 requirements can be completed on-line. A greater emphasis this year put on training by Management 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.	Assign Nurse Manager Maurice Moloney to oversee and monitor training Register to highlight attendance of mandatory training 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 Training will be informed that they must complete the 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. Training is easy to access, it is both on line and training can be easily arranged by the NPPC	01/10/2019	Maurice Maloney CNM2
Preventative Action	As above	As above	Achievable	01/10/2019	As above

Rules Governing the Use of Seclusion

Reason ID : 10000206		Residents in the selcusion room did not have access to adequate toilet or washing faclities, as there was no shower unit included in the nearby washroom. The washroom was not directly accessible to residents from the seclusion room, 8.1.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	These 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.	This has been escalated on the Risk Register Remains a standing item on our Business Meeting agenda	1.2 million funding requirement	26/07/2024	Mr Charlie Meehan Head of Mental Health
Preventative Action	As above	As above	As above	26/07/2024	As above

The Commission is engaging with the Approved Centre to finalise interim measures to address non-compliance. These were not available in time for publication.

Reason ID : 10000207		The seclusion room was not maintained with due regard to ensure respect for resident dignity as there was graffitti visbile on the seclusion room wall, 8.2.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There are structural elements to the seclusion room which require addressing. However in relation to the grafitti, • 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 Higgins painters to attend quarterly to paint all internal areas,painting has since been completed	Quarterly meetings between management and maintenance to ensure actions as identified in the Corrective actions are being addressed.	No identified barriers	26/07/2019	Mr John Canny Business Manager
Preventative Action	As above	As above	No identified barriers	26/07/2019	As above

Reason ID : 10000208		The fact that the floor of the seclusion room was of a hard fitting meant that it was not furnished so as not to endanger patient safety, 8.3.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	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. Unfortunately release of capital funds is an issue. A temporary proposal was looked at to install Altro Acoustic flooring in the seclusion room, however this would not satisfy the needs of the care team, so unfortunately we will have to rely on the major capital submission to rectify this problem.	This has been escalated on the Risk Register Remains a standing item on our Business Meeting agenda.	1.2 million funding requirement	30/07/2021	Mr Charlie Meehan Head of Mental Health
Preventative Action	As above	As above	1.2million funding requirement	30/07/2021	As above
The Commission is engaging with the Approved Centre to finalise interim measures to address non-compliance. These were not available in time for publication.					

Appendix 2: Background to the inspection process

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

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

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

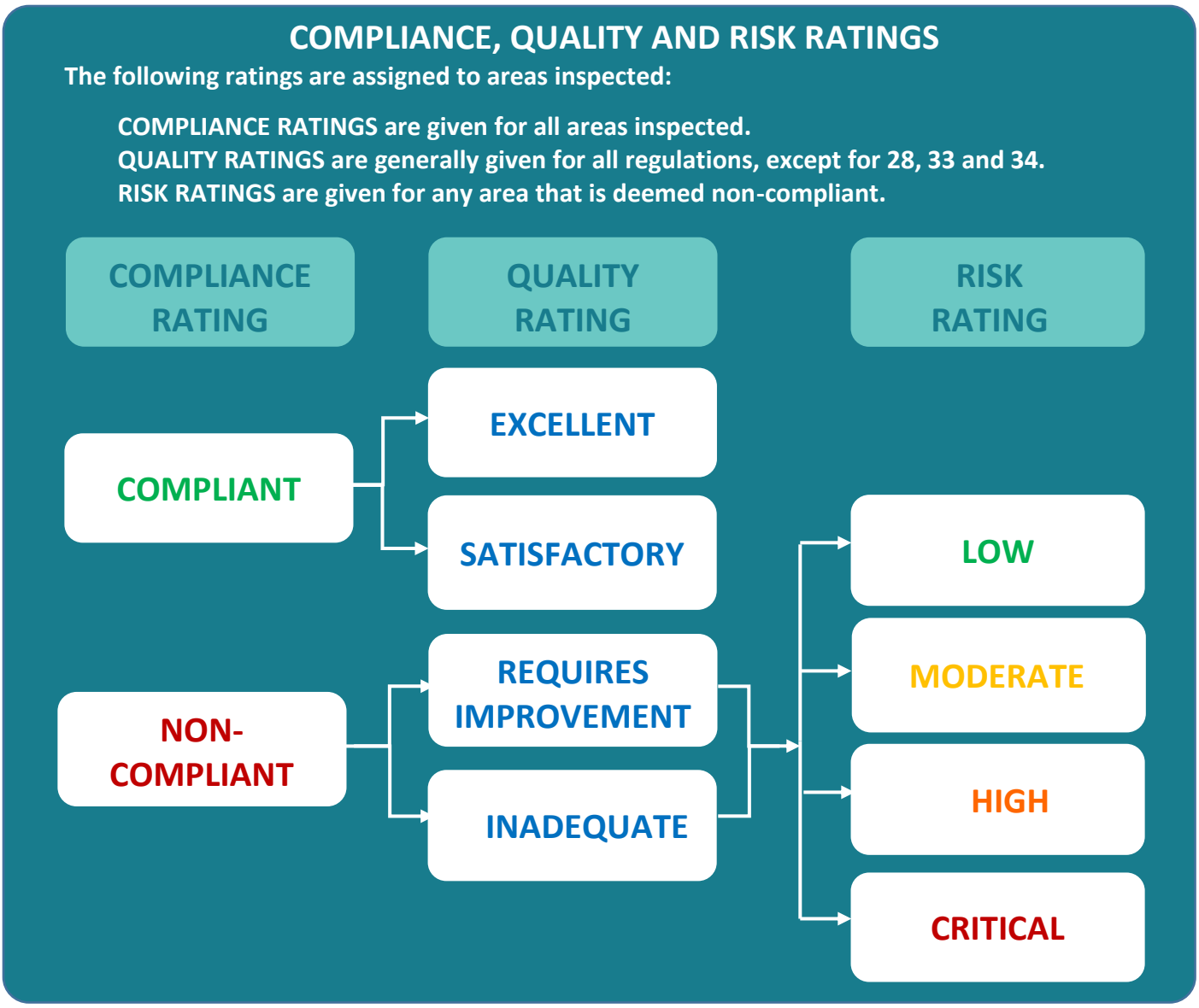
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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.