# Eist Linn Child & Adolescent In-patient Unit

**ID Number:** AC0082

## 2017 Approved Centre Inspection Report (Mental Health Act 2001)

Eist Linn Child & Adolescent In-patient Unit
Bessborough
Blackrock
Cork

**Approved Centre Type:**
Child & Adolescent Mental Health Care

**Most Recent Registration Date:**
22 December 2016

**Conditions Attached:**
None

**Registered Proprietor:**
HSE

**Registered Proprietor Nominee:**
Ms Sinéad Glennon

**Inspection Team:**
Leon Donovan, Lead Inspector
Donal O'Gorman
Barbara Morrissey

**Inspection Date:**
2 – 5 May 2017

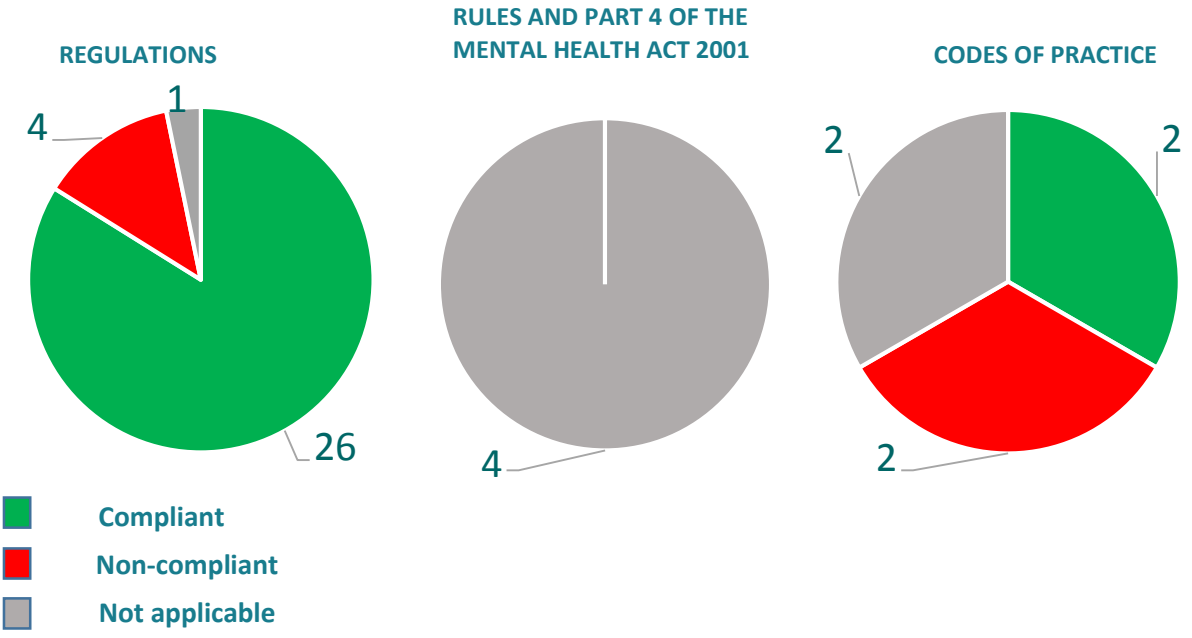
**Inspection Type:**
Unannounced Annual Inspection

**Previous Inspection Date:**
25 – 28 October 2016

**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Date of Publication:**
28th September 2017

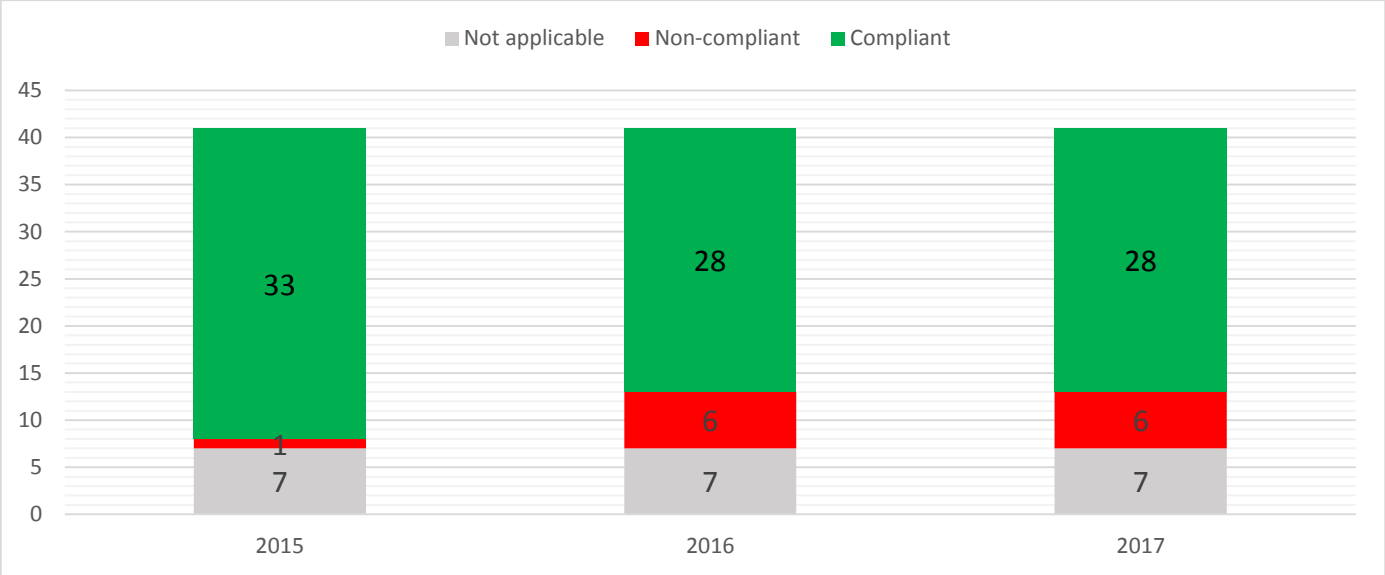
## COMPLIANCE RATINGS 2017



# RATINGS SUMMARY 2015 – 2017

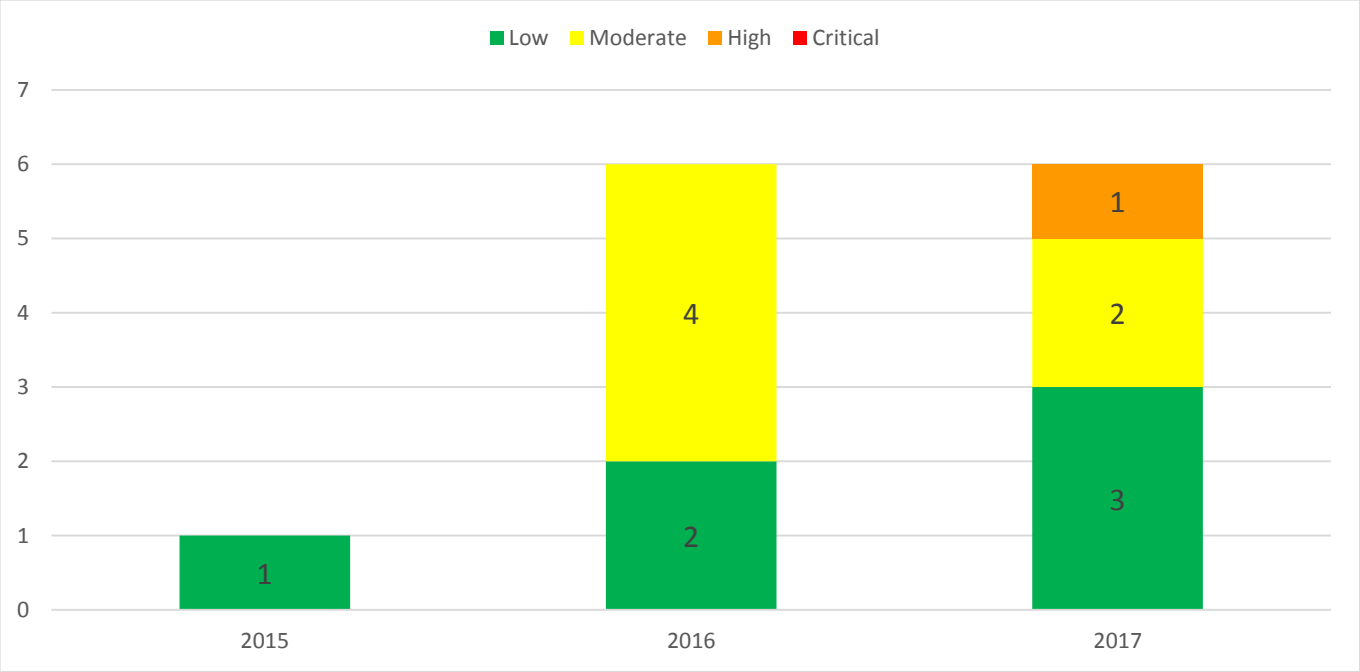
Compliance ratings across all 41 areas of inspection are summarised in the chart below.

**Chart 1 – Comparison of overall compliance ratings 2015 – 2017**




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 2015 – 2017**



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# 1.0 Introduction to the Inspection Process

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

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

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

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

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

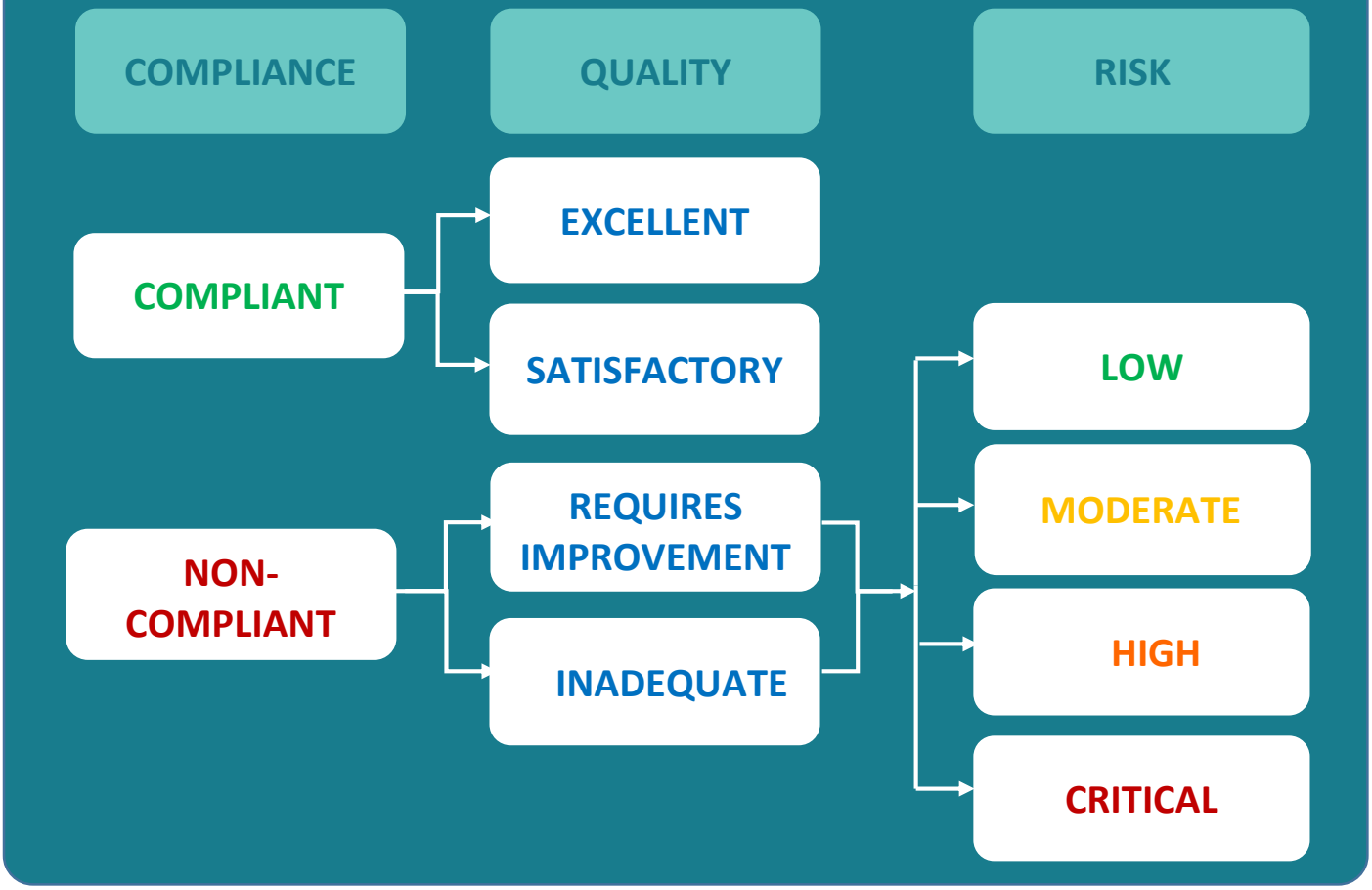
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

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

## COMPLIANCE, QUALITY AND RISK RATINGS

**The following ratings are assigned to areas inspected. COMPLIANCE RATINGS are given for all areas inspected. QUALITY RATINGS are given for all regulations, except for 28, 33 and 34. RISK RATINGS are given for any area that is deemed non-compliant.**




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

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

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

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

# 2.0 Inspector of Mental Health Services – Summary of Findings

## Inspector of Mental Health Services — Dr Susan Finnerty

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

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

## Safety in the approved centre

There was a written policy in relation to the health and safety of residents, staff, and visitors. An associated safety statement was in place. There were a number of written policies in relation to risk management and incident management processes, and individual risk assessments were carried out. Structural risks, including ligature points, were effectively mitigated. Three appropriate resident identifiers were used before the administering of medications, undertaking of medical investigations, and provision of other health care services. Food safety audits were periodically undertaken, and a documented analysis was completed to identify opportunities to improve food safety processes. Hygiene was maintained to support food safety requirements.

The storage and prescription of medication was satisfactory. However, there were a number of errors in the documenting of administration of medication. Not all health care professionals were trained in fire safety, Basic Life Support (BLS), management of violence and aggression, and the Mental Health Act 2001.

**AREAS REFERRED TO**
**Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.**

## Appropriate care and treatment of residents

Each resident had a multi-disciplinary individual care plan (ICP). All ICPs identified appropriate goals, appropriate care and treatment, interventions, and specified the resources required to provide the care and treatment identified. All residents had access to their ICPs and were kept informed of any changes. The majority of residents confirmed that they knew who their multi-disciplinary team were, but some reported that they were never involved in goal setting for their individual care plan. Eist Linn's menus were reviewed by a dietician every three weeks to ensure nutritional adequacy in accordance with the residents' dietary needs. A dietician reviewed the needs of residents identified as having special nutritional requirements once a week or twice weekly where a resident had an eating disorder.

The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, and met the needs of the residents, as documented in their individual care plans (ICPs).

Therapeutic services and programmes were provided in a separate, dedicated room. There was no occupational therapist assigned to the approved centre, however, this post was in the process of being filled, with an appointment expected imminently. As a result, no functional assessments of residents had been completed in relation to occupational therapy services. Some residents reported that there were not enough activities to occupy them during the day. There was a three-teacher school on the grounds of the approved centre. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. The approved centre was compliant with the Code of Practice on admission of children.

Not all clinical files were in good order and contained loose pages. There were deficits in the admission, transfer and discharge policies.

**AREAS REFERRED TO**
**Regulations 5, 14, 15, 16, 17, 18, 19, 23, 25, 27, Part 4 of the Mental Health Act 2001, Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Rule Governing the Use of ECT, Code of Practice on Physical Restraint, Code of Practice on the Admission of Children, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, Code of Practice on Admission, Transfer and Discharge, service user experience, and interviews with staff.**

## Respect for residents' privacy and dignity

No resident was wearing night clothing during daytime hours over the course of the inspection, and residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans. Secure facilities were provided for the safe-keeping of resident monies, valuables, personal property and possessions, as necessary. Residents' personal property was either kept in their own bedrooms or in the main property store room, depending on the outcome of a risk assessment of items. The resident search policy and procedures were communicated to all residents. Resident consent was sought and documented prior to all searches. Searches were implemented with due regard to the resident's dignity, privacy and gender. All residents' bedrooms were large, single en-suites. Residents dignity and requirements for privacy were respected. The use of CCTV was advertised, non-recording and viewed only by healthcare professionals. Physical restraint was only implemented in a resident's best interests and in rare and exceptional circumstances, where a resident posed an immediate threat of serious harm to self or others. Cultural awareness and gender sensitivity were demonstrated by the presence of a same sex staff member during the period of physical restraint.

**AREAS REFERRED TO**
**Regulations 7, 8, 13, 14, 21, 25, Rule Governing the Use of Seclusion, Code of Practice on Physical Restraint, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.**

## Responsiveness to residents' needs

Residents were provided with a variety of wholesome and nutritious food choices and with hot meals daily, at breakfast, dinner, and tea. Residents had access to their own snacks and hot and cold drinks at night. Recreational activities programmes were developed, implemented, and maintained with the involvement of residents. Residents had access to a wide range of appropriate recreational activities. Activities took place indoors and outdoors and communal areas in the approved centre were suitable for recreational activities. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes. Several visitor rooms or visiting areas were provided where residents could meet visitors in private.

Eist Linn provided a self-contained bedroom, bathroom, and kitchenette to facilitate parents of residents to stay overnight if they lived long distances away from the approved centre. Residents had access to mail, telephone, and supervised Internet. Eist Linn did not allow the use of personal mobile phones but did provide access to landline phones. Senior staff only examined incoming resident communication if it came from an individual not named on a resident's communication list, in which case the mail was only opened in the presence of one of the resident's parents.

Residents were provided with an information handbook at admission, and it included all necessary information on housekeeping arrangements. Residents were not provided with details of relevant advocacy agencies as currently, there are no child advocacy services available in Ireland. Specific information about medications and diagnoses was provided.

Eist Linn was adequately lit, heated, and ventilated. It was clean and was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was a robust complaints procedure in place, which was well advertised.

**AREAS REFERRED TO**
**Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.**

## Governance of the approved centre

The approved centre was a regional child and adolescent in-patient unit for HSE South, including Community Health Organisation (CHO) Area 4; Kerry, North Cork, North Lee, South Lee, West Cork and CHO Area 5; South Tipperary, Carlow/Kilkenny, Waterford, Wexford.

Eist Linn business team meetings were scheduled to take place monthly. A policy review group meeting took place every month, and was attended by clinical, allied health professional, and management staff. Operating policies and procedures were communicated to all relevant staff. All operating policies and procedures required by the regulations were reviewed within three years. A risk management meeting was scheduled to take place monthly. However, the last meeting took place in November 2016.

There was evidence of clear lines of responsibility and reporting in each discipline. There was an awareness throughout all disciplines of the issue of reduced operational capacity within the approved centre and this

was attributed to the difficulty in recruiting an adequate number of consultants and non-consultant hospital doctors (NCHDs) for Child and Adolescent Mental Health Services in the region. One head of discipline also expressed difficulty in replacing staff currently on extended leave. At the time of the inspection, the approved centre had access to 1.4 whole time equivalent (WTE) consultants and 0.8 WTE NCHDs. In order to run at full capacity, the service indicated that it required 2.0 WTE consultants and 2.0 WTE NCHDs.

**AREAS REFERRED TO**
**Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.**

# 3.0 Quality Initiatives

## The following quality initiatives were identified on this inspection

- An audit team had been established.
- Staff had completed training in Cognitive Remediation Therapy for eating disorders.
- Two training days on eating disorders and psychosis for nursing staff took place in March.
- Staff were sent educational resources on eating disorder awareness every week for the month of February and were encouraged to take time weekly for eating disorder continuing professional development.
- A new catering committee meeting and a new menu cycle were introduced.
- Art projects were ongoing and artwork created by residents was displayed.
- A staff member had begun art therapy training.
- The approved centre had begun liaising with Cork Arts and Health Programme to investigate implementing a pilot music group.
- “Sportsercise”, which is a structured group physical activity and movement session, had been added to the group activity programme and nursing staff had completed a fitness instruction programme to facilitate this.
- A staff member had completed training on the religion/spiritual needs of service users and a spiritual care folder had been developed for staff to reference.
- The unit had recently been repainted, the TV room was being refurbished, and the frieze on the glass in the upstairs atrium had been replaced.

# 4.0 Overview of the Approved Centre

## 4.1 Description of approved centre

Located on the grounds of the Bessborough Centre in the Cork suburb of Blackrock, the approved centre was a Child and Adolescent Mental Health Services (CAMHS) in-patient unit that catered for young people under 18 years of age. The building, which opened in March 2011 after extensive refurbishment and renovation, was situated adjacent to a large green space, and residents had access to a large outdoor garden as well as enclosed internal garden areas. The approved centre was bright and spacious, with high ceilings and some of the internal walls were partially decorated with artwork created by the residents. All bedrooms were single, en suite rooms. There was a school on the premises with two classrooms as well as a large art room, an occupational therapy kitchen, a small gym, and a large gym hall. The hall, which was a converted church, was equipped to accommodate basketball and other indoor sporting activities.

The 20-bed in-patient service provided assessment and treatment for young people referred by community child and adolescent teams in the HSE South area (Carlow/Kilkenny/Tipperary/Waterford/Cork and Kerry); however, at the time of the inspection the approved centre was operating with a reduced capacity of 11 beds.

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 | 0 |
| Number of Wards of Court | 0 |
| Number of children | 10 |
| Number of residents in the approved centre for more than 6 months | 1 |

## 4.2 Conditions to registration

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

## 4.3 Reporting on the National Clinical Guidelines

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

## 4.4 Governance

The approved centre was a regional child and adolescent in-patient unit for HSE South, including Community Health Organisation (CHO) Area 4; Kerry, North Cork, North Lee, South Lee, West Cork and CHO Area 5; South Tipperary, Carlow/Kilkenny, Waterford, Wexford.

The minutes of the last four Cork Mental Health Management Team meetings were provided to the inspection team. These meetings, which were held monthly, documented the attendance by heads of discipline and discussed matters concerning CHO Area 4, including risk management and recruitment issues. They also addressed specific issues pertinent to the approved centre, including implementation of the Children First policy, Child and Adolescent Mental Health Service vacancies, and review of the risk register.

Eist Linn business team meetings were scheduled to take place monthly. The minutes for one meeting, held in September 2016, were provided to the inspection team. This was attended by a mix of clinical, allied health professional, administrative, and management staff from the approved centre. Issues such as staffing, training, communication, service user involvement, clinical audit, clinical effectiveness, and building infrastructure were discussed.

A policy review group meeting took place every month, and minutes for meetings dating back to the previous inspection were provided. The meetings, where policy issues as well as audits were discussed, was attended by clinical, allied health professional, and management staff.

A risk management meeting was scheduled to take place monthly. However, the last meeting took place in November 2016. Minutes for this and the previous meeting were provided and these detailed discussions surrounding staff training, the local risk register, and incidents.

# 5.0 Compliance

## 5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 25-28 October 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

| Regulation/Rule/Act/Code | 2017 Inspection Findings |
|---|---|
| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines | Non-Compliant |
| Regulation 26: Staffing | Non-Compliant |
| Regulation 27: Maintenance of Records | Non-Compliant |
| Code of Practice on the Use of Physical Restraint in Approved Centres | Non-Compliant |
| Code of Practice on Notification of Deaths and Incident Reporting | Compliant |
| Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre | Non-Compliant |

## 5.2 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 2016 and 2015:

| Regulation/Rule/Act/Code | 2015 Compliance | 2016 Compliance | 2017 Compliance |
|---|---|---|---|
| Regulation 23: Ordering, Prescribing, Storing & Administration of Medicines | ✗ | ✗ | ✗ |
| Regulation 26: Staffing | ✓ | ✗ | ✗ |
| Regulation 27: Maintenance of Records | ✓ | ✗ | ✗ |
| Regulation 28: Register of Residents | ✓ | ✓ | ✗ |
| Code of Practice on the Use of Physical Restraint in Approved Centres | ✓ | ✗ | ✗ |
| Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre | ✓ | ✗ | ✗ |

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

## 5.3 Areas of compliance rated Excellent on this inspection

The following areas of compliance were rated excellent on this inspection:

| Regulation |
| --- |
| Regulation 5: Food and Nutrition |
| Regulation 8: Residents' Personal Property and Possessions |

# 6.0 Service-user Experience

Members of the inspection team informally approached residents and sought their views on the approved centre. In addition, posters and leaflets were displayed in the approved centre inviting residents to talk to the inspection team. Residents were also invited to complete a service user experience questionnaire and submit it in confidence to the inspection team.

Six service users were engaged during a group discussion and one resident met the inspection team in private. Residents expressed satisfaction with the food choice and no issues of concern were raised.

Nine questionnaires were completed by residents and returned to the inspection team. The majority of respondents confirmed that they knew who their multi-disciplinary team were, but some reported that they were never involved in goal setting for their individual care plan. Some also reported that there were not enough activities to occupy them during the day.

# 7.0 Interviews with Heads of Discipline

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following individuals:

- Head of Nursing
- Executive Clinical Director
- Occupational Therapy Manager
- Head of Social Work

The Head of Psychology was unable to meet with the inspection team but was interviewed by telephone.

Except for nursing, heads of discipline were not based in the approved centre. Each visited the centre from between every six weeks to as when they were needed. There was evidence of clear lines of responsibility and reporting in each discipline.

There was an awareness throughout all disciplines of the issue of reduced operational capacity within the approved centre and this was attributed to the difficulty in recruiting an adequate number of consultants and non-consultant hospital doctors (NCHDs) for Child and Adolescent Mental Health Services in the region. One head of discipline also expressed difficulty in replacing staff currently on extended leave.

# 8.0 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:

- Consultant Child and Adolescent Psychiatrist x 2
- Clinical Nurse Specialist
- Acting Clinical Nurse Manager 2
- Acting Assistant Director of Nursing
- Interim Area Social Work Manager
- Head of Service
- Interim Area Principal Psychology Manager
- Area Occupational Therapy Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The Acting Clinical Nurse Manager highlighted that the Medication Prescription and Administration Records were a work in progress and that many of the *Judgement Support Framework* elements were in the process of being implemented.

# 9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

## Regulation 4: Identification of Residents

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a policy dated January 2017 on the identification of residents. The policy included requirements of the *Judgement Support Framework,* with the exception of the required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on the identification of residents. Relevant staff interviewed articulated the processes for identifying residents, as set out in the policy.

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

**Evidence of Implementation:** A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. The identifiers were detailed within the residents' clinical files.

Three appropriate resident identifiers were used before the administering of medications, undertaking of medical investigations, and provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

Eist Linn Child and Adolescent Mental Health Service (CAMHS) used photograph, name, and patient medical record number of each resident as identifiers. The identifiers used were appropriate to the residents' communication abilities.

The identifiers used were person-specific and did not include room number or physical location. There was an alert system in place for same- and similar-name residents.

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

## Regulation 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 policy on food and nutrition, dated February 2017. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on food and nutrition. Relevant staff interviewed articulated the processes relating to food and nutrition, as set out in the policy.

**Monitoring:** A systematic review of menu plans was conducted to ensure residents were provided with wholesome and nutritious food in line with their needs. A documented analysis was completed by the head of catering using resident feedback and dietetic input to enhance the food and nutrition processes. Changes to the menus were introduced on foot of the analysis.

**Evidence of Implementation:** Eist Linn's menus were reviewed by a dietician every three weeks to ensure nutritional adequacy in accordance with the residents' dietary needs. Residents were provided with a variety of wholesome and nutritious food choices and with hot meals daily, at breakfast, dinner, and tea. Both hot and cold drinks were offered twice daily. In addition, residents had access to their own snacks and hot and cold drinks at night. Residents had adequate supplies of safe and fresh drinking water in easily accessible locations throughout the approved centre.

The needs of residents identified as having special nutritional requirements were reviewed by a dietician once a week or twice weekly where a resident had an eating disorder. An evidence-based nutritional assessment tool, the St. Andrew's Nutrition Screening Instrument, was used for residents with special dietary needs. Nutritional and dietary needs were assessed, where necessary, and addressed and documented in residents' individual care plans.

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

## Regulation 6: Food Safety

**COMPLIANT**

**Quality Rating** **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a policy in place on food safety, dated February 2017. The policy included one of the four requirements of the *Judgement Support Framework,* which was adhering to the relevant food safety legislative requirements.

It did not include

- The roles and responsibilities in relation to food safety within the approved centre.
- Food preparation, handling, storage, distribution, and disposal controls.
- The management of catering and food safety equipment.

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on food safety. Relevant staff interviewed articulated the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). The training was documented twice, and these records were stored in two separate locations.

**Monitoring:** Food temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored by kitchen staff. Food safety audits were periodically undertaken, and a documented analysis was completed to identify opportunities to improve food safety processes.

**Evidence of Implementation:** There was appropriate and sufficient catering equipment, crockery, and cutlery to meet the needs of the residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

**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 the criteria of the *Judgement Support Framework* under the processes pillar.**

## Regulation 7: Clothing

**COMPLIANT**

**Quality Rating** **Satisfactory**

The registered proprietor shall ensure that:

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy, dated January 2017, in relation to residents' clothing. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on residents' clothing. Relevant staff interviewed articulated the processes relating to residents' clothing, as set out in the policy.

**Monitoring:** A record of residents wearing nightclothes during the day was kept and monitored. However, there was no documented evidence that the availability of an emergency supply of clothing for residents was monitored on an ongoing basis.

**Evidence of Implementation:** No resident was wearing night clothing during daytime hours over the course of the inspection, and residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans.

Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs. They had an adequate supply of individualised clothing.

Residents were provided with an ample supply of appropriate emergency personal clothing, which considered their preferences, dignity, bodily integrity, and religious and cultural practices. There were new t-shirts, jumpers, and pyjamas in two emergency clothing containers, one for female residents and one for male residents.

**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 the criteria of the *Judgement Support Framework* under the monitoring pillar.**

## Regulation 8: Residents' Personal Property and Possessions

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy dated January 2017 relating to residents' personal property and possessions. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on residents' personal property and possessions. Relevant staff interviewed articulated the processes for residents' personal property and possessions, as set out in the policy.

**Monitoring:** Personal property logs were maintained, audited, and monitored in the approved centre. A documented analysis was completed to identify opportunities to improve the processes for managing residents' personal property and possessions.

**Evidence of Implementation:** Secure facilities were provided for the safe-keeping of resident monies, valuables, personal property and possessions, as necessary. Residents were discouraged from bringing money into Eist Linn, but a safe was available to store residents' monies. Residents' personal property was either kept in their own bedrooms or in the main property store room, depending on the outcome of a risk assessment of items.

Eist Linn CAMHS maintained a signed property checklist, contained within a property folder, and it detailed each resident's personal property and possessions. The property checklist was kept distinct from the resident's individual care plan (ICP). Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

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

## Regulation 9: Recreational Activities

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy dated January 2017 in relation to the provision of recreational activities. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Not all relevant staff had signed a log to indicate that they had read and understood the policy on recreational activities. Relevant staff interviewed articulated the processes for residents' recreational activities as set out in the policy.

**Monitoring:** There was a record of the occurrence of planned recreational activities, including a record of resident uptake and attendance. A documented recreational survey, audit, and analysis had been completed to identify opportunities to improve the processes for recreational activity.

**Evidence of Implementation:** The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. A weekly schedule of recreational activities was available to residents; however, there was no timetable for weekend activities. Individual risk assessments were completed for residents, where necessary, in relation to the selection of appropriate activities.

Recreational activities programmes were developed, implemented, and maintained with the involvement of residents. Residents had access to a wide range of appropriate recreational activities. Activities took place indoors and outdoors and included morning walks in parks, shopping, wildlife photography, cinema and a film review group, sports, and quizzes. There was a large gym with sports equipment and a large garden.

Communal areas in the approved centre were suitable for recreational activities. There were two large television rooms with plasma screens, comfortable furnishings, and a selection of DVDs. Residents' decisions to participate, or not, in activities were respected and documented, as appropriate. Documented records of attendance at recreational activities were retained in group records or within the resident's clinical file, as appropriate.

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

## Regulation 10: Religion

**COMPLIANT**

**Quality Rating** **Satisfactory**

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 policy dated February 2017 on the facilitation of religious practices. The policy included requirements of the *Judgement Support Framework,* with the exception of the specific staff roles and responsibilities in relation to the support of residents' religious practices.

**Training and Education:** Not all relevant staff had signed a log to indicate that they had read and understood the policy on religion. Relevant staff interviewed articulated 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 had not been reviewed to ensure that it reflected the identified needs of the residents.

**Evidence of Implementation:** Residents' rights to practice religion were facilitated insofar as was practicable. Eist Linn did not have a chapel, but there were a number of quiet spaces where residents could retreat to for contemplation and prayer, if desired.

Residents had access to off-site multi-faith chaplains following risk assessment. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes. The care and services provided within the approved centre were respectful of the residents' religious beliefs and values.

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

## Regulation 11: Visits

**COMPLIANT**

**Quality Rating** **Satisfactory**

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

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

### INSPECTION FINDINGS

**Processes:** There was a written operational policy, dated January 2017, in relation to visits. It included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on visits. Relevant staff interviewed articulated 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. Analysis had not been completed to identify opportunities to improve visiting processes.

**Evidence of Implementation:** Visiting times were publicly displayed at the entrance to Eist Linn CAMHS, and were appropriate, reasonable, and flexible.

Several visitor rooms or visiting areas were provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Eist Linn provided a self-contained bedroom, bathroom, and kitchenette to facilitate parents of residents to stay overnight if they lived long distances away from the approved centre.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Visitors were required to sign a visitors' book before entering the unit and to meet with a member of the clinical staff in order to gain entry.

Children could visit, if accompanied by an adult and supervised at all times. The visiting rooms, spaces, and facilities available were suitable for visiting children.

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

## Regulation 12: Communication

**COMPLIANT**

**Quality Rating** **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 dated January 2017 in relation to communication. The policy included requirements of the *Judgement Support Framework,* with the exception of the following:

- The assessment of resident communication needs.
- The individual risk assessment requirements in relation to limiting resident communication activities.

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on communication. Relevant staff interviewed articulated the processes for communication, as set out in the policy.

**Monitoring:** Residents' communication needs and restrictions on communication were monitored on an ongoing basis. Analysis had not been completed in order to identify opportunities to improve communication processes.

**Evidence of Implementation:** The approved centre completed individual resident risk assessments, when necessary, in relation to any risks associated with residents' external communications; these were documented in each resident's individual care plan.

Residents had access to mail, telephone, and supervised Internet. Eist Linn did not allow the use of personal mobile phones but did provide access to landline phones. Residents with an assessed communication issue were provided with speech and language therapy input.

Relevant senior staff only examined incoming resident communication if it came from an individual not named on a resident's communication list, in which case the mail was only opened in the presence of one of the resident's parents.

**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 the criteria of the *Judgement Support Framework* under the processes and monitoring pillars.**

## 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:** There was a written policy dated January 2017 available in relation to the searching of a resident, his or her belongings, and the environment in which he or she was accommodated. The policy included all of the requirements of the *Judgement Support Framework,* including

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

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on searches. Relevant staff interviewed articulated the searching processes, as set out in the policy.

**Monitoring:** A log of searches was maintained and each search record was systematically reviewed to ensure compliance with the requirements of the regulation. A documented analysis was not completed to identify opportunities for improvement of the search processes.

**Evidence of Implementation:** The resident search policy and procedures were communicated to all residents. Eist Linn CAMHS conducted environmental searches daily, as part of the unit's safety checks, and general written consent from each resident and their parents/guardians was sought for this. Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought and documented prior to all searches and refusal was documented in a 'search consent refusal form'.

Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted.

Searches were implemented with due regard to the resident's dignity, privacy and gender; at least one of the staff members conducting a search was the same gender as the resident being searched.

A written record of every search of a resident, every property search, and all environmental searches was available (i.e. a record of the reason for the search, the names of both staff members who undertook the search and details of who was in attendance for the search).

**The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring 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, dated January 2017, in relation to care of the dying. The policy included requirements of the *Judgement Support Framework,* with the exception of the following:

- The staff roles and responsibilities for care of the dying.
- Advance directives in relation to end of life care, Do Not Attempt Resuscitation orders, and residents' religious and cultural end of life preferences.
- The required communication with the resident and their representatives, family, next of kin, and friends during end of life care.
- 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 a log to indicate they had read and understood the policy and protocols on care of the dying. Relevant staff interviewed articulated the processes for end of life care, as set out in the policy.

As no resident had died within the approved centre since the last inspection and no current resident was receiving end of life care, this regulation was assessed under the processes and training and education pillars for this regulation only.

**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:** There was a policy on individual care plans (ICPs) dated February 2017. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Not all clinical staff had signed a log to indicate that they had read and understood the policy on individual care planning. All clinical staff interviewed articulated the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members were trained in individual care planning.

**Monitoring:** ICPs were audited on a quarterly basis to assess compliance with the regulation. A documented analysis was completed to identify opportunities to improve the individual care planning process.

**Evidence of Implementation:** Each resident had an ICP, and 11 ICPs were inspected. The ICPs were a composite set of documentation and included; goals, treatment, care, and resources required. Reviews were included. The documentation was stored within each resident's clinical file, was identifiable, uninterrupted, and was not amalgamated with progress notes.

Each resident had been assessed at admission by the admitting clinician and an ICP was established. The ICPs were then developed by the MDT following a comprehensive assessment, as soon as was possible but within seven days of admission. Evidence-based assessments were used.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family and next of kin, as appropriate. All ICPs identified appropriate goals, appropriate care and treatment, interventions, and specified the resources required to provide the care and treatment identified.

There was no preliminary discharge plan in any of the ICPs inspected. The MDTs reviewed ICPs weekly, at a minimum. The ICPs were updated following the review, as indicated by the residents' changing needs, condition, circumstances, and goals; this was documented.

All residents had access to their ICPs and were kept informed of any changes. Each resident was offered a copy of their ICP, including any reviews, and this was documented. However, when a resident declined or refused a copy of their ICP, this was not recorded, nor was the reason, if given.

All ICPs of child residents included broad educational requirements, which were not unique and specific to each child resident's educational requirements.

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

## Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to therapeutic services and programmes, dated January 2017. The policy included requirements of the *Judgement Support Framework* with one exception, the consideration of risk when assessing residents as to the appropriateness of services and programmes.

**Training and Education:** Not all clinical staff had signed a log to indicate that they had read and understood the policy on therapeutic services and programmes. All clinical staff interviewed articulated the processes for therapeutic activities and programmes, as set out in the policy.

**Monitoring:** There was evidence of ongoing monitoring of the range of services and programmes provided to ensure that they met the assessed needs of residents. A documented analysis had been completed to improve the processes relating to therapeutic services and programmes.

**Evidence of Implementation:** The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, and met the needs of the residents, as documented in their individual care plans (ICPs).

The programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. These included Dialectical Behaviour Therapy, Cognitive Behavioural Therapy, psychology, yoga, a food group, clay arts, relaxation, an art room, speech and language therapy, and a “My Space” group.

Where a resident required a therapeutic service or programme that was not provided internally, Eist Linn CAMHS arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Therapeutic services and programmes were provided in a separate, dedicated room. Adequate and appropriate resources and facilities were not available to provide therapeutic services and programmes. There was no occupational therapist assigned to the approved centre, however, this post was in the process of being filled, with an appointment expected imminently. As a result no functional assessments of residents had been completed in relation to occupational therapy services.

A record was maintained of residents’ participation, engagement, and outcomes achieved in therapeutic services or programmes, within their clinical files.

**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 the criteria of the *Judgement Support Framework* under the processes, training and education, and evidence of implementation pillars.**

## Regulation 17: Children's Education

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

### INSPECTION FINDINGS

**Processes:** There was a written policy dated February 2017 in relation to the provision of education to child residents in the approved centre. The policy included one element of the *Judgement Support Framework* in relation to the facilities and resources available to support education of child residents internally. It did not reference

- Support for child residents who access external educational services.
- The roles and responsibilities relating to the provision of educational services for child residents by the approved centre.
- The planning, provision, documentation, and review of educational provisions to child residents.
- The assessment of the educational needs of child residents.
- The information provided to child residents and their representatives on the educational services available.
- The methods for assessing child residents' progress within the educational provisions of the approved centre.
- The management of the transition of child residents between educational services.

**Training and Education:** Individual providers of educational services on behalf of the approved centre were qualified in line with their role and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs.

**Monitoring:** A daily record was kept of the child residents' attendance at internal and external educational services.

**Evidence of Implementation:** Child residents were assessed in terms of their individual educational requirements, with consideration of their needs and age on admission. Where appropriate to the needs and age of the child, the education provided by the approved centre was reflective of the required educational curriculum. There was a three-teacher school on the grounds of the approved centre. Nine residents attended the on-site school and one resident was transitioning back to school by attending an external school daily.

**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 the criteria of the *Judgement Support Framework* under the processes pillar.**

## Regulation 18: Transfer of Residents

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy dated January 2017 in relation to the transfer of residents. The policy included requirements of the *Judgement Support Framework,* with the exception of the following:

- The criteria for transfer.
- The process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- The process for managing the transfer of involuntary patients.

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on transfers. Relevant staff interviewed articulated the processes for the transfer of residents, as set out in the policy.

**Monitoring:** A log of transfers was maintained. Each transfer record was systematically reviewed to ensure that all relevant information was provided to the receiving facility. A documented analysis was completed to identify opportunities to improve information provision during transfers.

**Evidence of Implementation:** The clinical files of two residents who had been transferred from the approved centre were examined. One resident was transferred in an emergency. In both cases, communication records with the receiving facility were documented, including the reason for the transfer and the residents' care and treatment plan (including needs and risk).

Each resident was risk assessed prior to the transfer, and documented consent of the resident to the transfer was available. Full and complete information was issued as part of the transfer, including a letter of referral, the resident transfer form, and a list of the required medication for the resident during the transfer process. In the case of the emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the residents' clinical files.

**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 the criteria of the *Judgement Support Framework* under the processes pillar.**

## 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 a written operational policy for responding to medical emergencies and a policy in relation to general health, both of which were dated February 2017. The policies, combined, included requirements of the *Judgement Support Framework,* with the exception of the following:

- The management of emergency response equipment, including the resuscitation trolley and Automated External Defibrillator (AED).
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The incorporation of general health needs into the resident individual care plan (ICP).
- The documentation requirements in relation to general health assessments.

**Training and Education:** Not all clinical staff had signed a log to indicate that they had read the policies on the provision of general health services and for responding to medical emergencies. All clinical staff interviewed articulated the processes for the provision of general health services and for responding to medical emergencies, as detailed in the policies.

**Monitoring:** Resident take-up of national screening programmes was not applicable to Eist Linn CAMHS as the young residents did not come within the remit of current national screening programmes. A systematic review to ensure six-monthly reviews of general health needs, did not take place. A documented analysis was not completed to identify opportunities to improve general health processes.

**Evidence of Implementation:** The approved centre had an emergency trolley, and staff had access at all times to an AED, both of which were located in the clinical room. Records were available of any medical emergency that occurred within the approved centre and the care implemented.

Residents received appropriate general health care interventions in line with their ICPs. Registered medical practitioners assessed residents' general health needs at admission and completed a physical examination for all residents at admission.

Since the previous inspection, two residents had been in the approved centre for more than six months and both received a six-monthly physical exam.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents usually attended their own GP with their family. It was

possible for staff to organise for residents to see a local GP. Referrals could be arranged to Cork University Hospital or the Mercy Hospital.

**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 the criteria of the *Judgement Support Framework* under processes, training and education, and monitoring pillars.**

## Regulation 20: Provision of Information to Residents

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy, dated January 2017, and procedures available in relation to the provision of information to residents. Combined, the policies included requirements of the *Judgement Support Framework,* with the exception of

- The process for identifying the residents' preferred ways of giving and receiving information.
- The methods for providing information to residents with specific communication needs.

**Training and Education:** Not all staff had signed a log to indicate that they had read and understood the policy on the provision of information to residents. Staff interviewed articulated the processes for providing information to residents, as set out in the policy.

**Monitoring:** The provision of information to residents was not monitored on an ongoing basis. A documented analysis was not completed to identify opportunities to improve the processes for providing information to residents.

**Evidence of Implementation:** Residents were provided with an information handbook at admission, and it included all necessary information on housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, and residents' rights. In addition, the information booklet contained details of residents' multi-disciplinary team (MDT). Resident were not provided with details of relevant advocacy agencies as currently, there are no child advocacy services available in Ireland.

Diagnosis-specific information about medications, including potential side-effects, was provided to each resident. Medication information sheets, as well as verbal information, were provided to residents in a format that was compatible with their needs. The content of medication information sheets addressed indications for use of all medications to be administered to the resident, including any possible side-effects.

Residents were provided with written and verbal information regarding their diagnosis unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition. This information was provided to residents' parents by the treating psychiatrist, the psychologist, or the clinical nurse specialists. Diagnosis information was documented in the residents' clinical files.

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

## Regulation 21: Privacy

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a policy dated January 2017 in relation to privacy. The policy included requirements of the *Judgement Support Framework,* with the exception of

- The method for identifying and ensuring, where possible, the resident's privacy and dignity expectations and preferences.
- The process applied where resident privacy and dignity were not respected by staff.

**Training and Education:** Not all staff had signed a log to indicate that they had read and understood the policy relating to resident privacy. Staff interviewed articulated the processes for ensuring resident privacy and dignity, as set out in the policy.

**Monitoring:** An annual review of the implementation of the policy had taken place and was documented. A formal analysis had not been completed to identify opportunities to improve the processes relating to residents' privacy and dignity. A resident satisfaction questionnaire was used as a forum to highlight and inform improvements.

**Evidence of Implementation:** The general demeanour of staff and the way in which staff addressed and communicated with residents was calm, courteous, and respectful. Residents were dressed appropriately to ensure their privacy and dignity and wore day clothes and not nightclothes throughout each day of the inspection.

Eist Linn CAMHS was located in a private area surrounded by trees and greenery. All residents' bedrooms were large, single en-suites. All bathrooms, showers, toilets, and bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

Resident bedrooms were located on the second floor and rooms were not overlooked by public areas. Observation panels on bedroom and treatment room doors were fitted with opaque glass or blinds to maintain privacy. Noticeboards did not display any identifiable resident information.

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

## Regulation 22: Premises

**COMPLIANT**

**Quality Rating** **Satisfactory**

(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 an up-to-date policy in place dated February 2017 in relation to the premises. The policy included requirements of the *Judgement Support Framework,* with the exception of

- The approved centre's cleaning programme.
- The identification of hazards and ligature points in the premises.

**Training and Education:** Not all relevant staff had read and understood the premises policy. Relevant staff interviewed articulated the processes relating to the maintenance of the premises, as set out in the policy.

**Monitoring:** There was documented evidence that a hygiene audit had been completed. A ligature audit was completed and documented. There was no documented analysis that identified opportunities for improving the premises.

**Evidence of Implementation:** Accommodation for each resident in Eist Linn assured their comfort and privacy and met their assessed needs. There was a sufficient number of toilets and showers for residents. All bedrooms were appropriately sized to meet residents' needs. They were large, single en suites, with a toilet and shower. All fixtures and fittings were anti-ligature. Each bedroom had a wardrobe, chair and desk, locker space, and a whiteboard.

Residents had access to personal space and adequate communal space, including indoor and outdoor spaces. There was a basketball court and a gym area. The unit was large and spacious, with two outside enclosed garden areas, two large television rooms, large brightly lit corridors, comfortable couches in each television room, a recreational room with a pool table, a computer room, and a large dining room.

Eist Linn was adequately lit, heated, and ventilated. It was clean, hygienic, and free from offensive odours. There was suitable and sufficient heating, which could be safely controlled in each resident's bedroom, in compliance with health and safety guidance and building regulations.

Rooms were ventilated and all bedrooms had air vents, but some residents reported that bedrooms could get too warm and stuffy. Windows, which were anti-ligature, were fitted with safety keys and could be opened for ventilation.

The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities. The signage and sensory aids provided did not always support resident orientation needs. For example, behind the front desk in the reception area, the filing room was signposted as the personal property room.

Hazards, including large open spaces, steps and stairs, slippery floor, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised and monitored; and a ligature audit was made available to the inspection team following the inspection.

Eist Linn CAMHS was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained. Remote or isolated areas of the approved centre, such as the car park, were monitored via CCTV.

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

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

**NON-COMPLIANT**

**Quality Rating** Requires Improvement
**Risk Rating** HIGH

(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 operational policy dated January 2017 on the ordering, prescribing, storing and administration of medicines. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Not all nursing, medical, and pharmacy staff, where applicable, had signed a log to indicate that they had read and understood the policy. Staff interviewed articulated the processes for ordering, prescribing, storing and administering medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Not all nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

**Monitoring:** Quarterly audits had been conducted on Medication Prescription and Administration Records (MPARs). Incident reports were recorded for medication errors and near misses. Analysis had not been completed to identify opportunities for improvement of medication management processes.

**Evidence of Implementation:** Each resident had an MPAR and 11 of these were inspected. All MPARs evidenced the use of two appropriate resident identifiers and a record of any allergies or sensitivities to medications, including if the resident had no allergies. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication was included on each MPAR.

There was a notes section at the back of each MPAR where staff had logged the non-administration and, in some cases, the administration of drugs. This practice resulted in a number of issues:

- One MPAR did not clearly record the administration route for the medication, which was detailed in the notes section at the back.
- Four MPARs did not clearly record or indicate what was administered to the resident.
- One MPAR documented the administration of a drug on the notes page but not on the prescription page.
- One MPAR documented staff initials against a drug, implying that it had been administered, although the notes page indicated that the drug was withheld because it was not in stock. An appropriate code was not used to indicate that the drug was withheld.
- One MPAR contained staff initials, which were circled, against a number of prescriptions. The notes page indicated that many of these were refusals, but the date of refusal was not always noted. An appropriate code was not used in the MPAR to indicate that the drug was refused.

All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members prior to administration.

Appropriate resident identifiers, good hand-hygiene practices, and cross-infection control techniques were used. Medication arriving from the pharmacist was verified against the order by two staff members to ensure it was correct and was accompanied by appropriate directions for use. Medication was stored in the appropriate environment.

**The approved centre was not compliant with this regulation for the following reasons:**

a) **One MPAR did not clearly record the administration route for the medication**
b) **Four MPARs did not clearly record or indicate what was administered to the resident.**
c) **One MPAR did not clearly record the administration of medication on the prescription page.**
d) **One MPAR did not record an appropriate code where medication was withheld.**
e) **One MPAR did not record an appropriate code where medication had been refused.**

## 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:** There was a written policy dated March 2017 in relation to the health and safety of residents, staff, and visitors. An associated safety statement was in place. The policy and safety statement included requirements of the *Judgement Support Framework,* with the exception of infection control measures relating to linen handling and the availability of staff vaccinations and immunisation.

**Training and Education:** Not all staff had signed a log to indicate that they had read and understood the health and safety policy. All staff interviewed articulated the processes relating to health and safety, as set out in the policy.

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

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

**The approved centre was compliant with this regulation.**

## Regulation 25: Use of Closed Circuit Television

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** There was a policy in place dated February 2017 on the use of CCTV. The policy included requirements of the *Judgement Support Framework,* with the following exceptions:

- The roles and responsibilities for the use of CCTV within the approved centre.
- The maintenance of CCTV cameras by the approved centre.
- The disclosure of the existence and usage of CCTV or other monitoring devices 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.
- The process to cease monitoring a resident using CCTV in certain circumstances.

**Training and Education:** Not all relevant staff had signed a log to indicate that they had read and understood the policy on CCTV. Relevant staff interviewed articulated the processes relating to the use of CCTV, as set out in the policy.

**Monitoring:** The quality of CCTV images was not checked regularly to ensure they were operating appropriately. An audit and analysis was not completed to identify opportunities for the improvement of the use of CCTV.

**Evidence of Implementation:** There were small signs conveying where CCTV cameras were located throughout Eist Linn CAMHS. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare.

The Mental Health Commission had been informed about the approved centre's usage of CCTV on inspection. Cameras were incapable of recording or storing a resident's image in any format.

CCTV cameras used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. The monitor was located in the corner of the nurses' station and was not accessible or visible to residents, only to clinical staff.

**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 of the criteria of the *Judgement Support Framework* under processes, training and education, and monitoring pillars.**

## Regulation 26: Staffing

**NON-COMPLIANT**

**Quality Rating** Requires Improvement
**Risk Rating** LOW

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

### INSPECTION FINDINGS

**Processes:** There was a staffing policy dated January 2017 available in relation to recruitment, selection, and vetting of staff. The policy included the requirements of the *Judgement Support Framework*, with the exception of

- The staff performance and evaluation requirements.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

**Training and Education:** Not all relevant staff had signed a log to indicate that they had read and understood the staffing policies. Relevant staff interviewed articulated the processes, as set out in the policy.

**Monitoring:** The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The number and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis was completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

**Evidence of Implementation:** Staff were recruited and selected in accordance with the approved centre's policy and procedures for recruitment, selection and appointment. They had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any time during the day and night, was maintained in Eist Linn CAMHS. An appropriately qualified staff member was on duty and in charge at all times, and this was documented.

At the time of the inspection the approved centre had access to 1.4 whole time equivalent (WTE) consultants and 0.8 WTE NCHDs. In order to run at full capacity the service indicated that it required 2.0 WTE consultants and 2.0 WTE NCHDs.

The number and skill mix of staffing did not meet residents' needs. While there were six nurses, one clinical nurse manager 2, and one assistant director of nursing on the unit during the day, for 11 residents, there was no occupational therapist. However, the approved centre was in the process of finalising an appointment to this role. There was no written staffing plan available within the approved centre.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile.

Not all allied health professionals were trained in the following:

- Fire safety.
- Basic Life Support (BLS).
- Management of violence and aggression {e.g. Therapeutic Crisis Intervention (TCI) /Professional Management of Aggression and Violence (PMAV)}.
- The Mental Health Act 2001.

Many staff members had received training in manual handling and hand hygiene, but there was no evidence that staff had been trained in incident reporting.

All staff training was documented with staff training logs maintained.

The Mental Health Act 2001 and Mental Health Commission rules and codes and all other Mental Health Commission documentation and guidance were made available to staff and were stored in the area director of nursing's office and in the nurses' station.

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

| *Ward or Unit* | *Staff Grade* | *Day* | *Night* | *Twilight (12pm-12am)* |
|---|---|---|---|---|
| Eist Linn | A/ADON | 1 | 0 | 0 |
| | CNM 2 | 1 | 0 | 0 |
| | RPN | 6 | 3 | 1 |
| | HCA | 1 (3 days/week) | 0 | 0 |
| | MTA | 1 | 0 | 0 |
| | CNS | 3 | 0 | 0 |

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

*Clinical Nurse Specialist (CNS), Multi Task Attendant (MTA), Acting Assistant Director of Nursing (A/ADON)*

Area Director of Nursing x 1

**The approved centre was not compliant with this regulation for the following reasons:**

**a) The number and skill mix of staff were not appropriate to the assessed needs of residents. There was no occupational therapist dedicated to the approved centre, 26(2).**

**b) Not all allied health professionals had up-to-date required training in fire safety, BLS, the management of violence and aggression, and the Mental Health Act 2001, 26(4).**

## 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 operational policy dated January 2017 in relation to the maintenance of records. The policy included requirements of the *Judgement Support Framework,* with the exception of

- The required resident record creation and content.
- Record review requirements.
- The roles and responsibilities for the creation of, access to, retention of and destruction of records.
- Privacy and confidentiality of resident record and content.

**Training and Education:** Not all clinical staff and other relevant staff had signed a log to indicate that they had read and understood the policy relating to the maintenance of records. All clinical staff and other relevant staff interviewed articulated the processes for the creation of, access to, retention of, and destruction of records, as outlined in the policy. Not all clinical staff were trained in best-practice record keeping.

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

**Evidence of Implementation:** Eleven resident records were inspected. Although the files were developed and maintained in a logical sequence, six records were not in good order with a number of loose pages observed.

Resident records were reflective of the residents' current status and the care and treatment being provided. Entries were factual, consistent, and accurate. However, each entry did not record the date and time using the 24-hour clock.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Residents' access to their records was managed in accordance to the Data Protection Acts.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

**The approved centre was not compliant with this regulation because residents' records were not in good order, contrary to 27(1).**

## Regulation 28: Register of Residents

**NON-COMPLIANT**

**Quality Rating** Requires Improvement
**Risk Rating** LOW

(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 register of residents which consisted of a folder of registration forms, with details of each resident. The folder contained an individual form for every resident registered to the approved centre. The entries relating to ten residents and one discharged resident were inspected, however, all forms were not fully complete and did not contain all of the information specified in Schedule 1 to the Mental Health Act 2001. Diagnosis on admission was not recorded in four cases. Next of kin/representative(s) were not listed in one case. Diagnosis on discharge was not listed in one case.

**The approved centre was non-compliant with this regulation because not all of the entries in the register of residents listed diagnosis on admission, diagnosis on discharge, and next of kin/representative details, contrary to 28(2).**

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy, dated February 2017, in relation to the development, management, and review of operating policies and procedures. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log to indicate they had read and understood the policy on developing and reviewing operating policies. Relevant staff interviewed articulated the processes for developing and reviewing operational policies, as set out in the policy. Relevant staff were not trained on approved operational policies and procedures.

**Monitoring:** Quarterly reviews took place to determine compliance with review time frames. Analysis of operating policies and procedures was not conducted to identify opportunities to improve the processes for developing and reviewing policies.

**Evidence of Implementation:** Eist Linn CAMHS's operating policies and procedures were specific to the approved centre and were not generic. Policies 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. All operating policies and procedures required by the regulations were reviewed within three years. The format of policies and procedures did not reference the document owner or the reviewers.

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

## Regulation 30: Mental Health Tribunals

NOT APPLICABLE

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

### INSPECTION FINDINGS

As Mental Health Tribunals did not take place in Eist Linn CAMHS, this regulation was not applicable.

## 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 dated February 2017 in relation to the management of complaints. It included the requirements of the *Judgement Support Framework,* with the exception of the confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.

**Training and Education:** Relevant staff were trained in the complaints management processes during their induction. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed articulated the processes for making, handling, and investigating complaints, as set out in the policy.

**Monitoring:** No audits of the complaints log and related records had been completed. No documented analysis of complaints data was presented to the inspection team.

**Evidence of Implementation:** There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The overall complaints officer was the area director of nursing. Eist Linn CAMHS's management of complaints processes was well publicised and accessible to residents and their representatives. All complaints were investigated promptly. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. The complainant's satisfaction or dissatisfaction with the investigation findings was not documented in all cases.

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

## Regulation 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 number of written policies in relation to risk management and incident management processes: a risk management procedures policy dated January 2017, a safety statement dated March 2017, a policy on levels of supervision, policy on risk assessment, a policy on reporting serious incidents, and a medical emergency response policy. The policies, combined, were comprehensive and included requirements of the *Judgement Support Framework,* such as

- The roles and responsibilities for risk management and the implementation of the risk management policy.
- The methods in place for controlling specified risks – residents absent without leave, suicide and self-harm, and assault and accidental injury to residents or staff.
- Arrangements for identifying, recording, investigating, and learning from incidents involving residents.
- The process for responding to specific emergencies.
- The process for notifying the Mental Health Commission (MHC) about incidents involving residents of the approved centre.
- The person responsible for the completion the of six-monthly incident summary reports required by the MHC.
- A process for identifying structural risks, including ligature points.
- The process for protecting children and vunerable adults in the care of the centre.

The policies did not include

- The responsibilties of the registered proprietor.
- The process for the identifcation and assessment of organisational risks.
- Capacity risks relating to the number of residents in the approved centre.
- Risks to the resident group during the provision of general care and services.
- Risks to individual residents during the delivery of individualised care.
- The record keeping requirement for risk management.
- The process for recording and reporting incidents.
- The process for investigating incidents.
- The process for learning from incidents.

**Training and Education:** Relevant staff were trained in the identification, assessment, and management of risk. Staff were trained in health and safety risk management. Clinical staff were trained in individual risk management processes. All staff were trained in incident reporting and documentation. All staff interviewed articulated the risk management processes, as set out in the policy.

Management staff were not trained in organisational risk management, not all staff had read and understood the risk management policy, and not all training was documented.

**Monitoring:** The risk register was not audited at least quarterly to determine compliance with the approved centre's risk management policy. The local risk register was populated daily and discussed at weekly MDT meetings. All incidents in the approved centre were recorded and risk-rated.

**Evidence of Implementation:** The approved centre's risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Structural risks, including ligature points, were effectively mitigated. The person with responsibility for risk was not identified and known by all staff.

Incidents were recorded and risk-rated in a standardised format. The person with responsibility for risk management did not review incidents for any trends or patterns occurring in the services. The National Incident Management System (NIMS) was analysed for trends at a high level but not locally. There was functionality within the NIMS online system to conduct analysis, but this was not in place.

The approved centre provided a six-monthly summary report of all incidents to the MHC in line with the Code of Practice on the Notification of Deaths and Incident Reporting. 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.

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

## Regulation 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 had up-to-date insurance. It covered 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

There was an up-to-date certificate of registration displayed in a prominent position, in the reception area of Eist Linn.

**The approved centre was compliant with this regulation.**

# 10.0 Inspection Findings – Rules

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

NOT APPLICABLE

## Section 59: The Use of Electro-Convulsive Therapy

Section 59

(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –

(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or

(b) where the patient is unable to give such consent –

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

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

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

### INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this rule was not applicable.

## Section 69: The Use of Seclusion

NOT APPLICABLE

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

### INSPECTION FINDINGS

As the approved centre did not use seclusion, this rule was not applicable.

## Section 69: The Use Mechanical Restraint

NOT APPLICABLE

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

### INSPECTION FINDINGS

As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

# 11.0 Inspection Findings – Mental Health Act 2001

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

## Part 4 Consent to Treatment

NOT APPLICABLE

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.

(2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

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

### INSPECTION FINDINGS

As there were no involuntary patients in the approved centre for longer than three months, Part 4 of the Mental Health Act 2001: Consent to Treatment, was not applicable.

# 12.0 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

**NON-COMPLIANT**

**Risk Rating** **LOW**

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

### INSPECTION FINDINGS

**Processes:** There was a written policy in relation to the use of physical restraint and a separate written policy and procedure for training staff. The policies, combined, included all relevant elements of the code of practice.

**Training and Education:** Eist Linn CAMHS did not maintain a written record to indicate that all staff involved in physical restraint had read and understood the policy. A record of training was maintained.

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

**Evidence of Implementation:** Two clinical files of residents who had been physically restrained were inspected. Eist Linn CAMHS complied with all of sections 1 and 5 of the code of practice on physical restraint across the two episodes.

Physical restraint was only implemented in a resident's best interests and in rare and exceptional circumstances, where a resident posed an immediate threat of serious harm to self or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident's unsafe behaviour. Physical restraint was not prolonged beyond the period necessary to prevent immediate and serious harm to self or others. Cultural awareness and gender sensitivity were demonstrated by the presence of a same sex staff member during the period of physical restraint.

Physical restraint was initiated by a member of the multi-disciplinary team (MDT). A designated staff member was lead. The consultant psychiatrist was notified as soon as was practicable and this was recorded in the clinical file. The resident was informed of the reasons, likely duration, and circumstances that would lead to discontinuation of physical restraint.

The clinical practitioner form was signed by the clinical practitioner within 24 hours. The next of kin were informed and the resident was given the opportunity to discuss the episode with members of the MDT. All uses of physical restraint were recorded in the clinical file and the clinical practice form in accordance with section 5.7.

**The approved centre was not compliant with this code of practice because it did not maintain a written record to indicate that all staff involved in physical restraint had read and understood the policy, 9.2.**

## Admission of Children

**COMPLIANT**

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

### INSPECTION FINDINGS

**Processes:** Eist Linn CAMHS had policies and protocols in place in relation to the admission of a child.

**Training and Education:** All staff had received training relating to the care of children.

**Evidence of Implementation:** The approved centre was a Child and Adolescent Mental Health Service (CAMHS) unit and complied in full with this code of practice. Age-appropriate facilities and a programme of activities appropriate to age and ability were provided. All children were given information on their rights and were provided with the "Headspace Toolkit" information booklet.

The children did not have access to age-appropriate advocacy services, as there were no child advocacy services available nationally.

In relation to child protection issues, staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated and included segregation according to age and gender such as sleeping arrangements and bathroom areas. Staff were gender sensitive. The educational needs of each child were met.

Appropriate visiting times for families, including children, were available. Consent for treatment was obtained from at least one parent.

**The approved centre was compliant with this code of practice.**

## Notification of Deaths and Incident Reporting

**COMPLIANT**

Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

### INSPECTION FINDINGS

**Processes:** There was a care of the dying policy, management of sudden death policy, and a risk management policy, which covered the notification of deaths and incident reporting to the Mental Health Commission (MHC). While not designating a specific risk manager, the risk management policy did identify the patient risk and safety advisor and specified the risk management group as having responsibility for the identification and assessment of risks throughout the approved centre. The policies, combined, included all of the elements of this code of practice.

**Training and Education:** There was no documented evidence that staff had read and understood the policies on the notification of deaths and incidents. Staff interviewed articulated the policy requirements.

**Monitoring:** Deaths and incidents were reviewed weekly by the multi-disciplinary team to identify and correct any problems and to improve the quality of processes. There had been no deaths in the approved centre since the last inspection.

**Evidence of Implementation:** The approved centre was compliant with Regulation 32: Risk Management Procedures. There was an incident reporting system in place, the National Incident Management System (NIMS), and the standardised NIMS report form was made available to inspectors. A six-monthly summary of all incidents was provided to the MHC.

**The approved centre was compliant with this code of practice.**

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

NOT APPLICABLE

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

### INSPECTION FINDINGS

As there were no residents in the approved centre who were diagnosed with an intellectual disability, this code of practice was not applicable.

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

NOT APPLICABLE

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

### INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.

## Admission, Transfer and Discharge

**NON-COMPLIANT**

**Risk Rating** MODERATE

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

### INSPECTION FINDINGS

**Processes:** There were written and up-to-date admission, transfer, and discharge policies in place.

**Admission:** The admission policy, dated January 2017, included all items of this code of practice, with the exception of the following:

- The procedure for involuntary admission.
- The protocol for planned admission with reference to pre-admission assessments, eligibility for admission and referral letters.
- The protocol for individuals who self-present.
- The protocol for the timely communication with primary care and CMHTs.

**Transfer:** The transfer policy, dated 2017, included all elements of this code of practice, with the exception of the procedure for involuntary transfer.

**Discharge:** The discharge policy, dated 2017, included elements of this code of practice, with the exception of the following:

- The procedure for discharge of involuntary patients.
- Reference to prescriptions and supply of medication on discharge.
- The protocol for discharging homeless persons.

**Training and Education:** Not all staff had read and understood the policy on admission and discharge. Not all health professionals had read and understood the policy on transfer.

**Monitoring:** An audit was not undertaken to monitor the admission and discharge processes.

**Evidence of Implementation**:

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

The clinical files of two residents were inspected in relation to the admission process. Each resident was assigned a key worker. The admission assessment was comprehensive in each case. All assessments and examinations were documented within clinical files inspected. The family/carer/advocate was involved in the admission process (with the resident's consent).

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical files of two residents were inspected. In both cases, the resident was transferred to another approved centre

to receive specialised treatment, the registered medical practitioner made the decision to transfer, the decision to transfer was agreed with the receiving facility, an assessment and a risk assessment were completed. The residents' families were informed and consent was obtained from them. A copy of the referral letter was present in each resident's clinical file.

**Discharge:** The clinical file of one resident who had been discharged was inspected. The decision to discharge was made by a registered medical practitioner. A discharge plan was in place and documented as part of the resident's individual care plan. The resident underwent a comprehensive assessment prior to being discharged. A comprehensive discharge summary was sent to the general practitioner/primary care team/community mental health services within 14 days.

**The approved centre was not compliant with this code of practice for the following reasons:**

a) **The admission process did not comply with Regulation 27: Maintenance of Records, 22.6.**
b) **The admission policy did not include the following elements under section 4 of the code of practice:**
   - **The procedure for involuntary admission, 4.2.**
   - **The protocol for planned admission with reference to pre-admission assessments, eligibility for admission, and referral letters, 4.3.**
   - **The protocol for individuals who self-present, 4.5.**
   - **The protocol for the timely communication with primary care and community mental health teams, 4.9.**
c) **The transfer policy did not include the procedure for involuntary transfer, 4.2.**
d) **The discharge policy did not include the following:**
   - **The procedure for discharge of involuntary patients, 4.2.**
   - **Reference to prescriptions and supply of medication on discharge, 4.10.**
   - **The protocol for discharging homeless persons, 4.12.**
e) **Not all staff had signed a log to indicate that they had read and understood the policy on admissions and discharge, 9.1.**
f) **Not all health professionals had read and understood the policy on transfer, 9.1.**
g) **An audit was not undertaken to monitor the admission and discharge processes, 4.19.**

## Appendix 1 – Corrective and Preventative Action Plans

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

*Report reference: page 43-44*

| **Area(s) of non-compliance** | | **Specific** | **Measureable** | **Achievable / Realistic** | **Time-bound** |
|---|---|---|---|---|---|
| *Taken from the inspection report* | *Reoccurring or New area of non-compliance* | *Provide corrective and preventative action(s) to address the area of non-compliance* | *Provide the method of monitoring the implementation of the action(s)* | *Provide details of any barriers to the implementation of the action(s)* | *Provide the timeframe of the completion of the action(s)* |
| 1. One MPAR not clearly record the administration route for the medication.<br>2. Four MPARs did not clearly record or indicate what was administered to the resident.<br>3. One MPAR did not clearly record the administration of medication on the prescription page.<br>4. One MPAR did not record an appropriate code where medication was withheld.<br>5. One MPAR did not record an appropriate code where medication had been refused. | Reoccurring non-compliance with MPAR records since 2016 | Corrective Action(s):<br>MPAR's were immediately remedied (points 2 & 3).<br>A new MPAR has been designed and implemented into practice. This new record will show any medication refused and withheld by code on the prescription page.<br>Post-Holder(s) responsible:<br>Dr. Maura Delaney (CAMHS Consultant)<br>Dr. Sara McDevitt (CAMHS Consultant)<br>Marie-Therese Keating (CNM2) | New MPAR implemented June 2017 Policy Review Group Meeting.<br>Weekly and six monthly audit of MPAR will check for compliance | Achievable and realistic.<br>No barriers | Completed August 2017 |
| | | Preventative Action(s):<br>All nursing and medical staff will be inducted on new MPAR as part of induction and within ongoing in house training.<br>Post-Holder(s) responsible:<br>Marie-Therese Keating (CNM2) | A log will be maintained to record staffs; attendance and that staff have read and understood the policy. | Achievable and realistic.<br>No barriers | September 2017 |

# Regulation 26: Staffing

*Report reference: page 48-49*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| *Taken from the inspection report* | *Reoccurring or New area of non-compliance* | *Provide corrective and preventative action(s) to address the area of non-compliance* | *Provide the method of monitoring the implementation of the action(s)* | *Provide details of any barriers to the implementation of the action(s)* | *Provide the timeframe of the completion of the action(s)* |
| 6. The number and skill mix of staff were not appropriate to the assessed needs of residents. There was no occupational therapist dedicated to the approved centre. | New | Corrective Action(s):<br>Occupational Therapist (full-time) has been filled and due to start in November 2017. While waiting for processing, one OT (part-time) is employed one day a week.<br>Post-Holder(s) responsible:<br>James Creasey (Occupational Thearpy Manager) | Area Management Team Meetings | Achievable and realistic.<br><br>Funding<br>Recruitment process NRS | November 2017 |
| 7. Not all health care professionals had up-to-date required training in fire safety, BLS, the management of violence and aggression, and the Mental Health Act 2001. | Reoccurring since 2016 | <u>Update on 2016 CAPA Plan</u>:<br>All staff continue to be reminded on a monthly basis regarding training. Recent audit on staff training has been submitted. | | | |
| | | Corrective action(s):<br>Any staff member who has not completed mandatory training or who has not recorded their training will do so. Staff will be reminded to update their training records so they are readily available to the MHC on inspection. Amended Policy attached.<br>Staff will be requested to undertake MHA Training on HSeland.<br>Post-holder(s):<br>Dr Sara McDevitt (CAMHS Consultant)<br>Dr Maura Delaney (CAMHS Consultant)<br>Marie-Therese Keating (CNM2) | • The Clinical Nurse Specialist who coordinates mandatory training will email staff on a monthly basis to request they update the common training folder.<br>• Completed training record will be uploaded to commom training folder.<br>• Updates to training folder will be audited monthly | Achievable and realistic.<br><br>Barrier will be the availability of training courses in PMAV & BLS.<br><br>Fire Safety Course already booked for Oct 2017 | November 2017 |

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| | | Preventative Action(s):<br>Each discipline line manager will oversee compliance for the staff that report to them<br>Post-holder(s):<br>Dr Sara McDevitt (CAMHS Consultant)<br>Dr Maura Delaney (CAMHS Consultant)<br>Marie-Therese Keating (CNM2)<br>Prof. Marcellino Smyth (ECD Cork Mental Health Services)<br>Mr David Hughes (Interim Social Work Manager)<br>Mr James Creasey (Occupational Therapy Manager)<br>Mr Daniel Flynn (Principal Psychology Manager)<br>Ms Vivienne Foley (Speech & Language Therapy Manager) | Staff training will be discussed as an agenda item at Area Management Team meeting. | Achievable and realistic.<br>No barriers | |

# Regulation 27: Maintenance of Records

*Report reference: page 50-51*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| *Taken from the inspection report* | *Reoccurring or New area of non-compliance* | *Provide corrective and preventative action(s) to address the area of non-compliance* | *Provide the method of monitoring the implementation of the action(s)* | *Provide details of any barriers to the implementation of the action(s)* | *Provide the timeframe of the completion of the action(s)* |
| 8. Residents' records were not in good order. | Reoccurring since 2016 | <u>Update on 2016 preventative action plan</u>: Business case sent to Area Management Team | | | |
| | | Corrective Action(s):<br>All staff have a responsibly in maintaining records in good order/condition.<br>Post-Holder(s) responsible:<br>All staff in Eist Linn | This information will be circulated to all staff via email. | Achievable and realistic.<br>No barriers | Completed<br>August 2017 |
| | | Preventative Action(s):<br>Business case made to Head of Mental Health and Area Administrator for additional administrative support / ward clerk.<br>Post-holder(s):<br>Dr Sara McDevitt (CAMHS Consultant)<br>Dr Maura Delaney (CAMHS Consultant)<br>Mr Michael O'Sullivan (Area Director of Nursing)<br>Ms Naranjan McCormack (Acting Area Director of Nursing | | Funding and WTE Barriers | September 2017 |

# Regulation 28: Register of Residents

*Report reference: page 52*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| *Taken from the inspection report* | *Reoccurring or New area of non-compliance* | *Provide corrective and preventative action(s) to address the area of non-compliance* | *Provide the method of monitoring the implementation of the action(s)* | *Provide details of any barriers to the implementation of the action(s)* | *Provide the timeframe of the completion of the action(s)* |
| 9. Not all of the entries in the register of residents listed diagnosis on admission, diagnosis on discharge, and next of kin/representative details. | New | Corrective Action(s):<br>Update admission and discharge check lists. For nursing and medical team to jointly complete the register of residents form regarding diagnosis on admission and discharge.<br>Amendments to policy.<br>Post-Holder(s) responsible:<br>Dr. Maura Delaney (CAMHS Consultant)<br>Dr. Sara McDevitt (CAMHS Consultant)<br>Kevin Leen (CNS) | Clinical Nurse Specialist will complete a monthly audit to check for compliance. | Achievable and realistic.<br>No barriers. | Completed<br>August 2017 |
| | | Preventative Action(s):<br>In house training and induction to staff will be used to inform staff of this new practice.<br>Post-Holder(s) responsible:<br>Kevin Leen (CNS) | A log will be maintained to record staffs; attendance and that staff have read and understood the policy. | Achievable and realistic.<br>No barriers. | September 2017 |

# Code of Practice: Use of Physical Restraint

*Report reference: page 67*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| *Taken from the inspection report* | *Reoccurring or New area of non-compliance* | *Provide corrective and preventative action(s) to address the area of non-compliance* | *Provide the method of monitoring the implementation of the action(s)* | *Provide details of any barriers to the implementation of the action(s)* | *Provide the timeframe of the completion of the action(s)* |
| 10. Did not maintain a written record to indicate that all staff involved in physical restraint had read and understood the policy. | New | Corrective Action(s):<br>All training is logged in the training register on the common folder. | Monthly audit will check for compliance | Barrier will be the availability of PMAV training courses. | Completed August 2017 |
| | | Email all staff to read physical restraint policy and sign log as proof of reading policy.<br>Post-Holder(s) responsible:<br>Marie-Therese Keating (CNM2)<br>Kevin Leen (CNS) | An email will be sent to all staff to read and sign policy. | No Barrier | September 2017 |
| | | Preventative Action(s):<br>In house training and induction of staff will be used to inform staff of policy.<br>Post-Holder(s) responsible:<br>Kevin Leen (CNS) | A log will be maintained to record staffs; attendance and that staff have read and understood the policy. | No barriers | September 2017 |

# Code of Practice: Admission, Transfer and Discharge

*Report reference: page 72-73*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| *Taken from the inspection report* | *Reoccurring or New area of non-compliance* | *Provide corrective and preventative action(s) to address the area of non-compliance* | *Provide the method of monitoring the implementation of the action(s)* | *Provide details of any barriers to the implementation of the action(s)* | *Provide the timeframe of the completion of the action(s)* |
| 11. The admission policy did not include the following elements under section 4 of the code of practice:<br>– The procedure for involuntary admission,<br>– The protocol for planned admission with reference to pre-admission assessments, eligibility for admission, and referral letters,<br>– The protocol for individuals who self-present,<br>– The protocol for the timely communication with primary care and community mental health teams.<br>12. The transfer policy did not include the procedure for involuntary transfer.<br>13. The discharge policy did not include the following:<br>– The procedure for discharge of involuntary patients,<br>– Reference to prescriptions and supply of medication on discharge,<br>– The protocol for discharging homeless persons. | Reoccurring non-compliance with policy requirements since 2016 | Corrective Action(s):<br>Amendments to Admission, Transfer and Discharge policies have been made accordingly from the points highlighted 11-13.<br>Post-Holder(s) responsible:<br>Dr. Maura Delaney (CAMHS Consutlant)<br>Marie-Therese Keating (CNM2)<br>Kevin Leen (CNS) | Policy Review Meeting | Achievable and realistic.<br>No barriers. | Completed<br>August 2017 |
| | | Preventative Action(s):<br>In house training and induction of staff will be used to inform staff of changes to policies.<br>An email will be circulated to all staff informing them of change to policies (Admission, Transfer and Discharge)<br>Post-Holder(s) responsible:<br>Kevin Leen (CNS) | A log will be maintained to record staffs; attendance and that staff have read and understood the policy. | Achievable and realistic.<br>No barriers. | September 2017 |

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 14. Not all staff had signed a log to indicate that they had read and understood the policy on admissions and discharge.<br>15. Not all health professionals had read and understood the policy on transfer. | New | Corrective Action(s):<br>All staff will be emailed regarding changes to the Admission, Transfer and Discharge polices.<br>Post-Holder(s) responsible:<br>Marie-Therese Keating (CNM2) | A training slot on the Admission, Transfer and Discharge policies will be rolled out for all staff to attend<br>A log will be maintained to record staff have read and understood the policy. | Achievable and realistic.<br>No barriers. | September 2017 |
| | | Preventative Action(s):<br>In house training and induction of staff will be used to inform staff of the Admission, Transfer and Discharge policies.<br>Post-Holder(s) responsible:<br>Kevin Leen (CNS0 | A training slot will be rolled out for all staff to attend and understand the Transfer policy.<br>A log will be maintained to record staffs; attendance and that staff have read and understood the policy. | Achievable and realistic.<br>No barriers. | September 2017 |
| 16. An audit was not undertaken to monitor the admission and discharge processes. | New | Corrective Action(s):<br>The team will carry out an annual audit on admission and discharge process.<br>Amendments to policies<br>Post-Holder(s) responsible:<br>Dr. Maura Delaney (CAMHS Consultant)<br>Marie-Therese Keating (CNM2) | An annual audit will check for compliance. | Achievable and realistic.<br>No barriers. | September 2017 |