Eist Linn Child & Adolescent In-patient Unit

ID Number: AC0082

2018 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, Head of Mental Health Services - Cork & Kerry

Inspection Team:
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Inspection Date:
24 – 27 April 2018

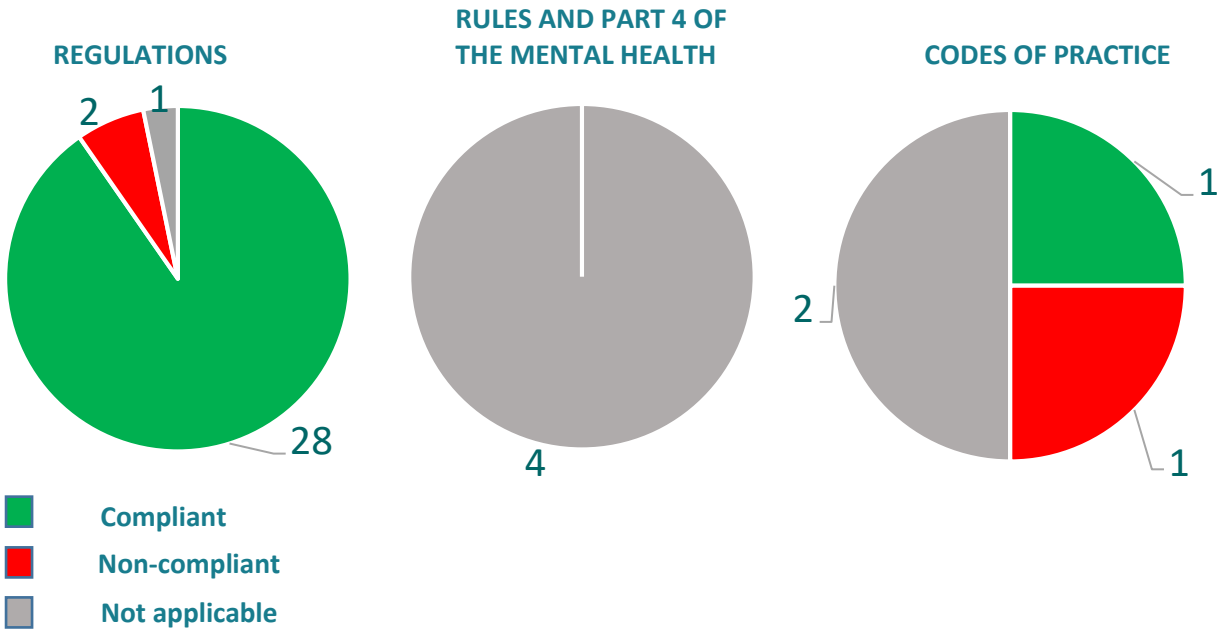
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
2 – 5 May 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
<<** – ** Month 2018>>

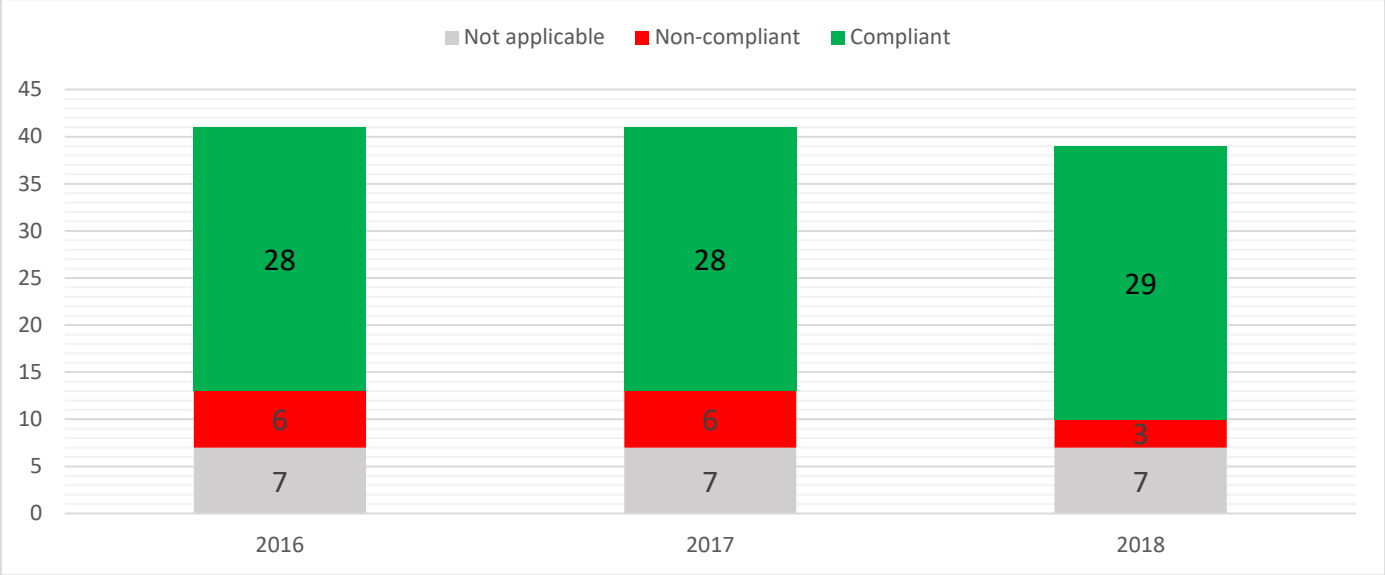
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

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

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018

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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".

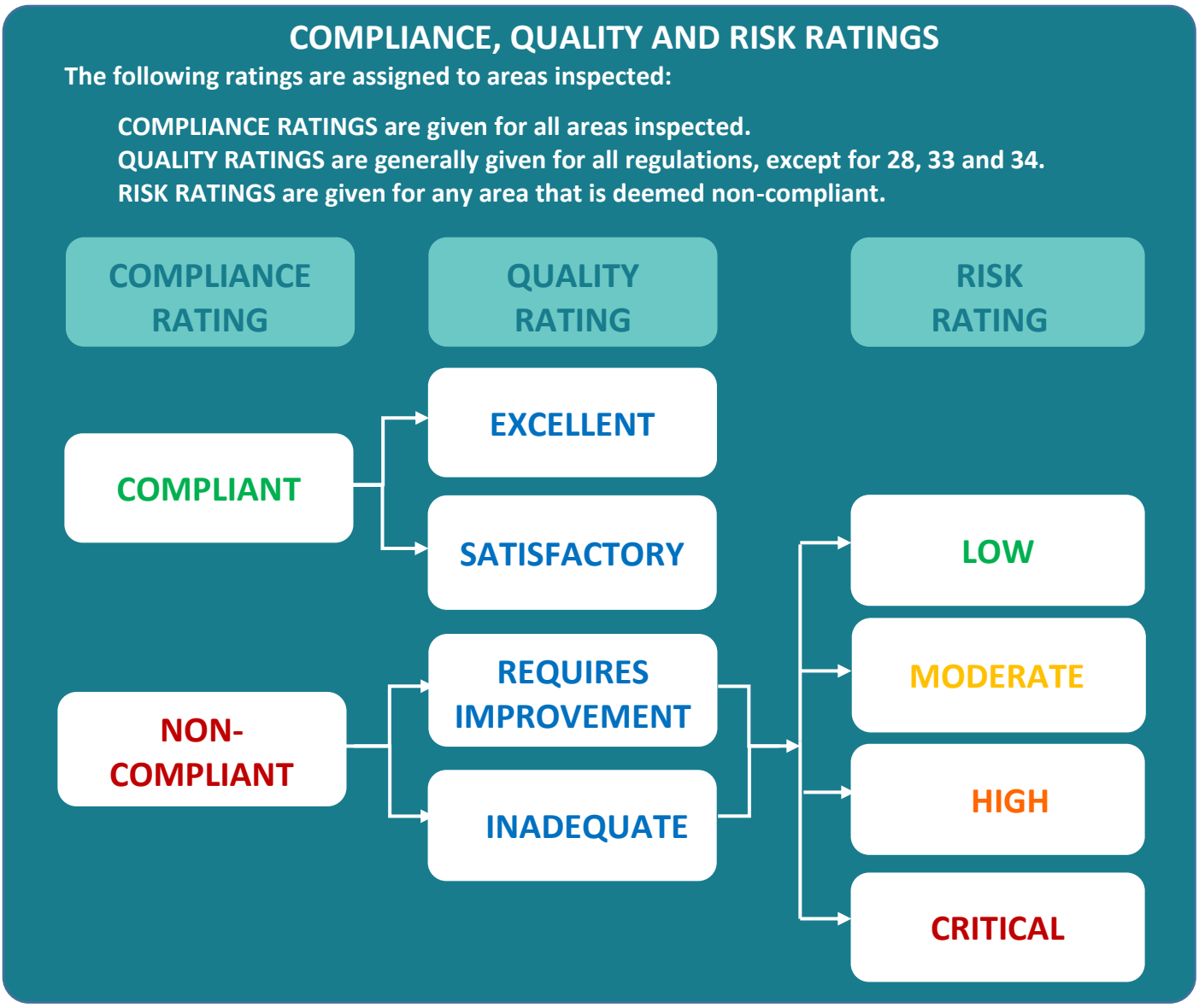
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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.



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

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

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

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

2.0 Inspector of Mental Health Services – 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.

In Brief

Eist Linn Child & Adolescent In-patient unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. It was one of four national in-patient child and adolescent services and served a population of approximately 1.2 million. Although registered for 20 beds, the approved centre was not operating at full capacity as vacant consultant psychiatrist and non-consultant hospital doctor positions had not been filled. The approved centre had never operated at full capacity due to on-going medical staff shortages. At the time of inspection, there were ten residents.

Compliance with regulations and codes of practice improved from 82% in 2017 to 91% in 2018 and there was evidence that the staff of the approved centre were focused on providing a good quality service. Eight compliances with regulations were rated excellent.

Safety in the approved centre

The approved centre had a written policy in relation to risk management and incident management procedures. The implementation of risk management procedures was satisfactory. Each resident had an individual risk assessment and management plan. Two appropriate resident identifiers, including the resident's name, date of birth and medical record number (MRN) were used when administering medication, undertaking medical investigations, and providing health-care services. Food safety audits had been completed periodically and kitchen areas were well equipped and clean. Ligature points had been minimised to the lowest practicable level through an audit undertaken within the last year, which had been actioned.

The ordering, prescribing, storage and administration of medication was excellent.

While the minimum numbers of nursing staff have been maintained, there have been occasions where the nursing management and clinical nurse specialist had reassigned duties to cover immediate resident needs. The approved centre completed training plans for all staff. Not all staff were trained in Fire Safety, Basic Life Support and the Management of Violence and Aggression (e.g. Therapeutic Crisis Intervention/Professional

Management of Aggression and Violence [PMAV]). All health care professionals were trained in The Mental Health Act (2001) and all staff were trained Children First.

Appropriate care and treatment of residents

Each resident had an individual care plan (ICP) which was drawn up with the participation of the resident and their family, and, as appropriate. The ICPs identified appropriate goals for the resident, the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICPs also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT in consultation with the resident on a weekly basis. The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their ICPs. The education provided by the approved centre reflected the required educational curriculum and appropriate education facilities were provided.

Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The approved centre was not co-located with a general hospital.

Admission, transfer and discharge procedures were compliant with the code of practice.

Respect for residents' privacy, dignity and autonomy

The door to the approved centre was locked on each day of the inspection. This was risk assessed and reviewed daily, and based on clinical need for the safety and wellbeing of all the child residents. Residents did not have access to their personal mobile phones but were facilitated to make personal calls to pre agreed numbers. This was in line the policy and procedures of the approved centre. Residents were supported to manage their own property and secure facilities were provided for safe-keeping of residents' property, as necessary. Resident consent was sought prior to all searches which were implemented with due regard to the residents' dignity, privacy, and gender.

Residents were accommodated in single occupancy bedrooms. All observation panels on doors of bedrooms and treatment rooms were appropriately covered and rooms in the approved centre were not overlooked by public areas. Residents were facilitated to make phone calls in private. The policy on privacy specified that bathroom doors will be lockable and simultaneously that they will not be lockable on safety grounds. Neither bedrooms nor en suite bathrooms could be locked by residents. Common bathrooms were lockable with an override mechanism.

CCTV was used in the approved centre. It was noted by the inspectors that the system was capable of recording. This was disabled by the approved centre following a request from the inspectors.

Seclusion was not used in the approved centre. Physical restraint had been used in rare and exceptional circumstances, after alternative interventions were considered and based on a risk assessment. It was carried out with due respect for a resident's safety and dignity.

Responsiveness to residents' needs

Menus at Eist Linn had been approved by a dietitian and residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals. Residents were provided with access to a variety of age appropriate recreational activities. on weekdays and during the weekends. Residents were involved in the design of the approved centre's recreational programme. Internal gym facilities were available, together with two external garden areas. The facilitation of some planned recreational activities were not always appropriately resourced.

There was a visitors' room provided where residents could meet with visitors in private. Accommodation was available for families visiting the approved centre. Residents had access to a phone, but not personal mobiles. They also had access the internet in line with the approved centre's procedure.

Information was provided to the residents by means of an information booklet and there was also information about diagnosis and medication. There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives.

The approved centre was generally well maintained and was clean, hygienic, and free from offensive odours and a cleaning schedule was implemented.

Governance of the approved centre

The Cork/Kerry Mental Health Management Team of Community Health Organisation (CHO) 4 was responsible for the overall management and governance of Eist Linn. Representation on the area management team from Eist Linn included the interim area director of nursing and the executive clinical director. Quality and Patient Safety was an agenda item on the area mental health management team. Minutes from the monthly meetings evidenced thorough and robust processes with identified actions and outcomes documented. While there was a strategic focus it was evident that particular matters specific to Eist Linn were considered. The approved centre was part of the national child and adolescent service, reporting to its national office.

Heads of discipline met with the staff from their departments on a frequent basis and there were clearly defined line management structures. No department had staff performance appraisals.

Recruitment of staff was a difficulty. All heads of discipline identified challenges relating to delayed discharges, as young people could not always discharge a resident to their community team. Another challenge identified by the heads of discipline was that the approved centre was not a specialised eating disorder unit or attached to a general hospital.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had been partially refurbished, a number of areas had been repainted, new sitting room furniture had been procured and purchased, and new frieze frame panelling had been installed in the second storey high dependency area.

2. Quarterly audit meetings had commenced in the approved centre and an audit log / folder was now maintained on the share drive. Pharmacy had commenced input into the medication audits. An audit on psychosis completed in Eist Linn had been presented at the College of Psychiatrists of Ireland Spring Conference 2018.

3. Along with access to parents' accommodation on site, the approved centre had acquired further parent accommodation at the Brú Columbanus Centre in Wilton.

4. Two staff from the approved centre were part of the Cork /Kerry Policy Standardisation Review Group (PSRG).

5. A family support group for families of residents in Eist Linn had commenced in 2018.

6. Training completed by staff since the previous inspection included; Growth Monitoring training, Resilience training and Structural Interview for Prodromal Syndrome (SIPs) training. Four staff nurses had completed post graduate diplomas, one on Child and Adolescent Mental Health. The approved centre had hosted an education training day on Self-Harm.

7. A Young Person and Parent Satisfaction Questionnaire had been devised, disseminated and completed in August 2017. A poster presentation highlighting the results was displayed in the reception area of the approved centre.

8. The Nutrition Care Process Model had been introduced in the approved centre. A Menu Analysis Report for Nutritional Adequacy of Standard Menu Choices in Inpatient CAMHS had been completed in October 2017.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Eist Linn Child & Adolescent In-patient unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. It was one of four national in-patient child and adolescent services. The approved centre served a population of approximately 1.2 million and included counties; Wexford, Waterford, Carlow, Kilkenny, Tipperary, Kerry and Cork. Seventeen community child and adolescent teams referred into the approved centre, ten of these from Cork or Kerry, and seven from the remaining counties. On the days of inspection there were 10 children in the approved centre and included children from Cork, Kerry, Kilkenny and Waterford. One child was detained in accordance with Section 25 of the Mental Health Act. One child had been in the approved centre longer than six months.

The service which had originated in 2009 with 5 beds located in St Stephen's Hospital, had opened in 2011 in its current location. It comprised of a purpose built, two storey unit of 18 single en suite bedrooms and one double en suite bedroom. These were located on the upper floor. The lower floor comprised of day activities, group rooms, television / sitting rooms, dining room with a servery kitchen and staff offices. There was a school located across an internal garden with two classrooms, an activity kitchen and an expansive gym hall. There was a parent's flat with sleeping accommodation available.

Although registered for 20 beds the approved centre was not operating at full capacity as vacant consultant psychiatrist and non-consultant hospital doctor positions had not been filled. The approved centre had never operated at full capacity due to on-going medical staff shortages.

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	1
Number of wards of court	0
Number of children	10
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	N/A

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The Cork/Kerry Mental Health Management Team of Community Health Organisation (CHO) 4 was responsible for the overall management and governance of Eist Linn. Encompassing five areas: Kerry, North Cork, North Lee, South Lee and West Cork, the local management team reported directly on any matters relating to Eist Linn. Representation on the area management team from Eist Linn included the interim area director of nursing and the executive clinical director. Quality and Patient Safety was an agenda item on the area mental health management team. Minutes from the monthly meetings evidenced thorough and robust processes with identified actions and outcomes documented. While there was a strategic focus it was evident that particular matters specific to Eist Linn were considered. The approved centre was part of the national child and adolescent service, reporting to its national office.

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

- Occupational Therapy Manager
- Principal Social Worker for Eist Linn
- Acting / Assistant Director of Nursing and representing the interim Area Director of Nursing
- Principal Psychology Specialist in CAMHs and also representing the Psychology Manager
- Consultant Psychiatrist for Eist Linn

The inspection team also conducted telephone interviews with the executive clinical director and the social work manager.

With the exception of nursing and the staff based in Eist Linn, heads of discipline reported that they visited the approved centre on a regular basis, and at least two monthly.

Heads of discipline met with the staff from their departments on a frequent basis and there were clearly defined line management structures. No department had staff performance appraisals but all stated that this process was informally facilitated or addressed through supervision. Supervision for nursing personnel was from the area director of nursing to clinical nurse manager 11 grade and was not available to registered psychiatric nurse grade. Support was provided for multi-disciplinary team (MDT) members working in Eist Linn. In-house training had been provided once weekly and once a month there had been a staff process group for the collective MDT. This was described as a form of reflective practice. However, staff interviewed stated that they would prefer a separate forum for front line staff and managers.

Operational risks were not identified by the allied health professional groups. Medical and nursing groups discussed recruitment and retention and while a significant number of staff remained in the approved centre, recruitment was a difficulty. Relating to this was the requirement for mandatory training, although the service had made significant improvements with this since the last inspection.

All groups identified challenges relating to delayed discharges. The heads of discipline stated that as community child and adolescent mental health services were not always adequately resourced, the approved centre could not always discharge a resident to their community team. Another challenge identified by the heads of discipline was that the approved centre was not a specialised eating disorder unit or attached to a general hospital. Equally, staff reported that the unit was not a secure facility and these negatively affected the threshold for acceptance of some referrals. Another challenge identified related to the configuration of the unit, in particular the low stimulus area, which staff considered not suitable for more than one resident at time.

4.5 Use of restrictive practices

The door to the approved centre was locked on each day of the inspection. This was risk assessed and reviewed on a daily basis, and based on clinical need for the safety and wellbeing of all the child residents. Residents did not have access to their personal mobile phones but were facilitated to make personal calls to pre agreed numbers. This was in line the policy and procedures of the approved centre.

5.0 Compliance

5.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 25: Use of Closed Circuit Television	✓		✓		✗	High
Regulation 26: Staffing	✗	Low	✗	Low	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Moderate	✗	Low	✗	Low

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 13: Searches
Regulation 23: Ordering, Prescribing and Administration of Medicines
Regulation 27: Maintenance of Records
Regulation 32: Risk Management Procedures

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was not an adult centre this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Area Lead from the HSE Mental Health Engagement Office was contacted. However, they were unavailable on the days of inspection. It was understood that they were employed for the adult services and did not have a role in the management of this approved centre.

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

The inspectors met with four residents and spoke with two parents. Six completed service user experience questionnaires, which were returned.

Residents and their representatives described feeling safe in the approved centre, felt very well supported by staff and all knew who their key worker was. The processes associated with the Multi-Disciplinary Team (MDT) were well understood and the residents and their families were complimentary of the care from staff. In particular parents commented on the communication from the nursing, medical and allied health professionals to them, and how included they felt in the overall planning and care and treatment provided. The residents and families commented positively about their school experiences while in the approved centre. Three residents noted that they did not understand their care plan however they were involved in setting goals relating to their care plan and knew who the responsible MDT members were.

Residents stated that a number of planned groups had been cancelled over the previous two weeks. This also included outings that were on the scheduled timetable. The inspectors were informed that the planned outings had not occurred for the preceding four weeks. The residents said they were informed this was due to staff shortages. The residents felt that there was not enough to do, in particular at the weekends and that there could be more activities during the week also.

7.0 Feedback Meeting

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

- Consultant Psychiatrist and representing the Executive Clinical Director
- Business Manager and Acting Head of Service
- Principal Clinical Psychologist Specialist CAMHs and representing the Area Principal Psychology Manager
- Senior Clinical Psychologist
- Occupational Therapy Manager
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Acting Assistant Director of Nursing and representing the Interim Area Director of Nursing
- Principal Social Worker and representing the Area Social Work Manager
- Clinical Nurse Specialist x 2
- Teacher
- Staff Nurse

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. There was a discussion regarding the recording and monitoring of minor complaints which had been included as an agenda item at the resident meetings. There was also discussion about the reporting of planned group cancellations over the preceding weeks. Further items of clarification have been included in the respective section of the report.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs were used. The preferred identifiers for each resident had been detailed within their clinical files. Identifiers were person-specific and appropriate to the residents' communication abilities.

Two appropriate resident identifiers, including the resident's name, date of birth and medical record number (MRN) were used when administering medication, undertaking medical investigations, and providing health-care services. An appropriate identifier was used prior to the provision of therapeutic services and programmes. There was an alert system for identifying residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in September 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Menus at Eist Linn had been approved by a dietitian and residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals at dinner and tea time. Meals were attractive and appealing in presentation, and hot meals were provided on a daily basis. Hot and cold drinks were offered regularly to residents and a source of safe, fresh drinking water was available at all times.

For residents with special dietary requirements, an evidence-based nutrition assessment tool was used. Where appropriate, weight charts were implemented, monitored and acted upon. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian and addressed in the resident's individual care plans. Intake and output charts were maintained for residents where appropriate.

The residents, as well as their representatives, family, and next of kin were educated about resident's diets where deemed appropriate. An active process of meal coaching was undertaken with families to promote awareness of residents' dietary needs.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

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

Training and Education: Relevant staff had signed a signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). This training was documented, and evidence of certification was available.

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

Evidence of Implementation: There were hand-washing facilities, in the kitchen area, for catering services. Personal Protective Equipment (PPE) was used as appropriate during the catering process. Food came prepared from the general hospital twice daily, and there were proper facilities for the refrigeration, storage, preparation, cooking and serving of food in the approved centre.

Hygiene was maintained to support food safety requirements. The catering areas and associated equipment were appropriately cleaned. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Suitable and sufficient crockery and cutlery were provided to residents

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were wearing nightclothes during daytime hours at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents had individual laundry baskets and the approved centre had a washing machine and dryer on-site. Appropriate emergency clothes were available for male and female residents.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in January 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents were supported to manage their own property and secure facilities were provided for the safe-keeping of residents' property, as necessary. A safe was available to residents, however no money was stored in it. Residents were encouraged to keep money and valuables at home. A checklist was used to keep a record of residents' personal property and possessions. This was kept separately from the resident's individual care plan.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in January 2017. The policy addressed all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents were provided with access to a variety of age appropriate recreational activities. These were available on weekdays and during the weekends. Information, including frequency and type of recreational activities, was provided on the resident notice board and on the weekly activities schedule.

Residents were involved in the design of the approved centre's recreational programme. Individual risk assessments were completed for residents where deemed appropriate, in relation to the selection of appropriate recreational activities. Internal gym facilities were available, together with two external garden areas, which provided opportunities for outdoor exercise and physical activity. The facilitation of some planned recreational activities were not always appropriately resourced. Residents stated that planned outings had been cancelled in the weeks preceding the inspection.

There were a number of sitting rooms available on both levels of the approved centre. In this regard there was access to games, books, DVDs, and a television.

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 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 written policy in relation to the facilitation of religious practice by residents, which was last reviewed in May 2017. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation of the policy to support residents' religious practices was not reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents were facilitated in the practice of their religion. A *Faith Communities in Cork* listing was posted on the notice board, including the times and frequency of local services. There was a quiet room available to residents for reflective and religious practices. Listings and contact details of multi-faith chaplains were provided.

Care and services provided were respectful of residents' religious beliefs and values, and residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits. The policy was last reviewed in January 2017. The policy and procedures included the requirements of the *Judgement Support Framework,* with the exception of the required visitor identification methods.

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

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

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre. There was a visitors' room provided where residents could meet with visitors in private, unless there was an identified risk to the resident, others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visitors' room was suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in January 2017. The policy addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities for resident communication processes.
- The assessment of resident communication needs.

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

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

Evidence of Implementation: Residents had access to a phone, but not personal mobiles. They also had access to mail, and supervised internet use in line with the approved centre's procedure. Individual risk assessments were completed for residents in relation to any risks associated with their external communication and documented. A designated member of staff only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication could result in harm to the resident or to others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in October 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

Evidence of Implementation: Resident consent was sought prior to all searches. The request for consent, and received consent were documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. The resident search policy and procedure was communicated to all residents, which was outlined in the resident information booklet. Residents were informed by those implementing the search of what was happening during the search and why.

There were a minimum of two clinical staff in attendance at all times when searches were being conducted, in accordance with policy requirements. Searches were implemented with due regard to the

residents' dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched.

A written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. This was documented on the 'Personal Search Consent Form'. A written record was kept of all environmental searches.

Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, 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 in the approved centre since the last inspection and no current resident was receiving end of life care, this regulation was assessed under the two pillars of processes, and training and education 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: The approved centre had a written policy in relation to the development, use, and review of Individual Care Plans (ICPs), which was last reviewed in February 2017. The policy addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had read and understood the policy, and this was documented. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: The ICPs were a composite set of documents, which included allocated sections for goals, treatment, care, the resources required, and reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes. The ICPs were developed by the MDT following a comprehensive assessment within seven days of admission to the approved centre.

The ICPs were 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 for the resident, the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICPs also identified the resources required to provide the care and treatment identified.

The ICPs were reviewed by the MDT in consultation with the resident on a weekly basis. The ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. The residents' had access to their ICPs and were kept informed of any changes, however three resident's interviewed indicated that they did not understand their ICP. Residents were offered a copy of their ICP, including any reviews, and this was documented. A record was not documented of when a resident declined or refused a copy of their ICP, including the reason, if given. The ICPs included residents' 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 evidence of implementation pillar.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in January 2017. The policy addressed the requirements of the *Judgement Support Framework*, with the exception of the process for assessing residents as to the appropriateness of services and programmes, including risk.

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

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their ICPs. The interventions provided included Teen Life Skills, Psychotherapy Groups, individual Psychotherapy, Relaxation, Cognitive Behavioural Therapy (CBT), and Problem Solving Groups.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. In cases where a therapeutic service or programme was not provided internally, the approved centre sourced the intervention from an approved, qualified health professional in an appropriate location.

Adequate and appropriate resources and facilities were available to provide therapeutic services and activities, however residents reported that some groups had been cancelled in the weeks preceding the inspection.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes 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: The approved centre had a written policy in relation to the provision of education to child residents, which was last reviewed in May 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The facilities and resources available to support the education of child residents, including facilities and support for education provided by the approved centre and support for child residents who access external educational services.
- The methods for assessing child residents' progress within the educational provisions of the approved centre.

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

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

Evidence of Implementation: Child residents were assessed in relation to their educational requirements with consideration of their individual needs and age on admission. The education provided by the approved centre was reflective of the required educational curriculum, where appropriate to the needs and age of the child resident. Appropriate facilities were provided and the school was located in a separate building on the same grounds as the approved centre. All teachers were qualified secondary school teachers. There was no principal and the school was not a recognised exam centre. Provisions were being made to facilitate residents to undertake state examinations in a separate location, in close proximity to the approved centre.

A daily timetable for schooling was available to each child receiving educational services within the approved centre, and attendances were documented. Attendance by child residents at external educational services was also documented. The approved centre maintained a comprehensive record of each resident's educational history.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in August 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- 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.

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: An emergency transfer of a resident had been undertaken since the last inspection. Full and complete written information regarding the resident was transferred when he or she moved from the approved centre to the receiving facility. This information accompanied the resident and was passed onto medical staff in the receiving facility. Communications between the approved centre and receiving facility were documented and followed up with a written referral.

Copies of all records relevant to the resident transfer were retained in the resident's clinical file. A checklist had not been completed by the approved centre to ensure comprehensive resident records had been transferred to the receiving facility.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in August 2017. The medical emergencies policy was last reviewed in June 2017. The policies and procedures addressed the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had read and understood the policies, and this was documented. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred, and at least monthly medical reviews in relation to eating disorder presentations. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: There was a resuscitation trolley, emergency bag and Automated External Defibrillator located in the approved centre, which were checked weekly. Residents' general health was assessed by a registered medical practitioner at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with their Individual Care Plans.

Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly general health assessment documented a physical examination, family/personal history, BMI, weight and waist circumference, blood pressure, nutrition status, and medication review (as per prescriber guidelines). Adequate arrangements were in place for access by residents to general health services and for their referral to other health services as required.

Due to the age profile of residents in the approved centre national screening programmes were not applicable to this cohort.

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 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 policy and in relation to the provision of information to residents. The policy was last reviewed in January 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

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

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

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

Evidence of Implementation: The approved centre's Information Booklet detailed housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents' rights.

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

Medication information sheets, as well as verbal information, were provided in a format that was appropriate to the resident's needs. The content of the medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in January 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The method for identifying and ensuring, where possible, the resident's privacy and dignity expectations and preferences.
- The approved centre's process for addressing a situation where resident privacy and dignity is not respected by staff.

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

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

Evidence of Implementation: Residents' were called by their preferred name. The general demeanour of staff and the manner in which staff addressed and communicated with residents was appropriate. Staff ensured that no offensive comments were made, and showed discretion when discussing the resident's condition or treatment needs.

Residents were accommodated in single occupancy bedrooms. All observation panels on doors of bedrooms and treatment rooms were appropriately covered and rooms in the approved centre were not overlooked by public areas. Residents were facilitated to make phone calls in private.

The policy paradoxically specified that bathroom doors will be lockable and simultaneously that they will not be lockable on safety grounds. Neither bedrooms nor en suite bathrooms were lockable by residents. Common bathrooms were lockable with an override mechanism.

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 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 a written policy in relation to its premises, which was last reviewed in February 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents had access to personal space. Rooms in the approved centre were appropriately sized, ventilated and furnished to remove excessive noise and acoustics. Bedrooms had en suite facilities, and communal toilets were available. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised due to the relatively modern building. Ligature points had been minimised to the lowest practicable level due to the implementation of recent audit findings.

The approved centre was generally well maintained, and a schedule of maintenance was kept in a log. The approved centre was clean, hygienic, and free from offensive odours and a cleaning schedule was implemented. There were no methods of controlling heating from the residents' rooms; temperature control within the premises required adjustment in the central boiler house.

There were sufficient facilities and furnishing in the approved centre, including toilets, showers and accessible toilet facilities. There was a designated sluice room, cleaning room, laundry room, and therapy and examination rooms. The furnishings provided were suitable to support residents' comfort.

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

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

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A MPAR was maintained for each resident that detailed all relevant information, including: resident identifiers; allergy status; the generic name of medications; dose; date of initiation and discontinuation for each medication; record of all medications administered, withheld or refused; and the Medical Council Registration Number (MCRN) of each prescriber. The MPARs of nine residents were inspected.

All entries in the MPAR were legible, and written in black, indelible ink. All MPARs were reviewed and rewritten on a frequent basis and within the six-months, and documented in residents' clinical files. Prescriptions were not altered, and in cases where an alteration was required in the medication order, the medical practitioner rewrote the prescription. All medicines were administered by a registered nurse or registered medical practitioner.

Medicinal products were administered in accordance with directions from the prescriber and advice provided by the pharmacist regarding appropriate use of the product. The expiration date of the medication was checked prior to administration, and expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. No Schedule 2 controlled drugs were in use in the approved centre, no resident was receiving medication in crushed form, and no resident was self-administering medications, at the time of inspection.

Medication was stored in a locked trolley which was kept in a locked room. The medication fridge temperature log was maintained and up to date. Medication storage areas were clean and maintained

through cleaning and housekeeping schedules. Food and drink was not stored in areas used for the storage of medication. A system of medication stock rotation and management was implemented.

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in February 2017, and the Safety Statement was updated in February 2018. The policy and the safety statement included all of the requirements of the *Judgement Support Framework,* with the exception of the infection control measures for linen handling.

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

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

Evidence of Implementation: This regulation is only assessed against the approved centre's written policies and procedures. It does not assess health and safety practices within the approved centre.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre. The policy did not include the following:

- The roles and responsibilities for the use of CCTV within the approved centre.
- The measures used to ensure the privacy and dignity of residents where the approved centre uses CCTV cameras or other monitoring equipment.
- The maintenance of CCTV cameras by the approved centre.
- Ensuring the use of CCTV in the approved centre is overt and clearly identifiable through the use of signage and communication with residents and/or their representatives.
- The process to cease monitoring a resident using CCTV in certain circumstances.

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had not been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: Clear signs were in prominent positions where CCTV cameras were located throughout the approved centre. Residents' were monitored solely for the purpose of ensuring their health, safety, and welfare. The use of CCTV had been disclosed to the Mental Health Commission. The approved centre had both internal and external cameras. Internal cameras were not in use at the time of inspection. It was noted by the inspectors that the system was capable of recording. This was disabled by the approved centre at the request of the inspectors.

The approved centre was non-compliant with this regulation because the monitoring system had been capable of recording, 25(1) (d).

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in February 2018. The policy addressed the requirements of the *Judgement Support Framework*, including the following:

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

The policy did not address the following:

- The roles and responsibilities in relation to staffing processes.
- Staff performance and evaluation requirements.
- The use of agency staff.
- 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 evaluation of training programmes.

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

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

Evidence of Implementation: A planned and actual staff rota was maintained in the approved centre. Duty for nursing staff was planned over an annual period and accounted for skill mix, length of time on the unit and training.

The numbers and skill mix of nursing staff and allied health professionals were sufficient to meet resident needs. The number of residents in the approved centre was low because the number of consultant psychiatrists admitting was reduced due to vacancies. The unit had a set number of nursing staff and in the last year while the minimum numbers have been maintained there have been occasions where the nursing management and clinical nurse specialist had reassigned duties to cover immediate resident needs. Staff were recruited, selected and vetted in line with the approved centre's policy. An appropriately qualified staff member was on duty and in charge at all times, and this was documented. There was a staffing plan which took into consideration the assessed needs of the resident cohort.

The approved centre completed training plans for all staff. Not all staff were trained in Fire Safety, Basic Life Support and the Management of Violence and Aggression (e.g. Therapeutic Crisis Intervention/Professional Management of Aggression and Violence [PMAV]). All health care professionals were trained in The Mental Health Act (2001) and all staff were trained Children First.

Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan, including Manual Handling, Infection Control and Prevention (including sharps, hand hygiene techniques, and the use of Personal Protective Equipment), Care for Residents with Intellectual Disability, Resident Rights, and Risk Management. Staff were not trained in recovery-centred approaches to mental health care and treatment. All staff training was documented.

All staff throughout the approved centre had access to the Mental Health Act (2001), the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, as well as all other Mental Health Commission documentation and guidance.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
	Interim Area DON	9-5 *	
	A/ADON	9-5 *	
	CNM 3	9-5	
	CNM 2	1	1
	CNS X 2	9-5	
	RPN	6	3
	HCA	1(3 days)	
Eist Linn	Occupational Therapist	1 WTE	
	Social Worker	2 WTE	
	Psychologist	2 WTE	
	Dietitian	2 WTE	
	Consultant Psychiatrist	1 WTE (and vacancy)	
	Non Consultant Hospital Doctor	2 WTE (and vacancy)	
	Teacher	2 WTE	

Director of Nursing (DON), Assistant Director of Nursing (ADON), Clinical Nurse Manager (CNM), Clinical Nurse Specialist (CNS), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA).

* Personnel also have responsibility to the community services.

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

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records. The policy was last reviewed in January 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the procedures relating to the creation of, access to, retention of and destruction of records.

Training and Education: All clinical staff and other relevant staff had read and understood the policy, and this was documented. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: All residents' records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of residents' current status and the care and treatment provided. Resident records were developed and maintained in a logical sequence.

Records were written legibly in black indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Professional language was used throughout.

Each entry was followed by a signature, included the date and used the 24-hour clock. The approved centre maintained a record of all signatures used in the resident record. In the case of an error being made, the mistake was scored out with a single line and the correction written alongside with the date, time and accompanying initials. Correction fluid was not used on approved centre records. Two appropriate resident identifiers were recorded on all documentation (Photograph, date of birth and name were used). Members of staff were clearly identified by their full name and title where a referral or consultation with another member of the health care team was made.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering or unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in February 2017. It addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities in relation to the development, management, and review of operating policies and procedures.
- The process for the development of the operating policies and procedures required by the regulations, incorporating relevant legislation, evidence-based best practice, and clinical guidelines.
- The process for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.
- The process for reviewing and updating operating policies and procedures, at least every three years.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: All policies which are required to be reviewed within three years for compliance with this regulation, had been reviewed within this timeframe. Policies were developed with input from clinical and managerial staff, and in consultation with other relevant stakeholders including service users. The operating policies and procedures incorporated relevant legislation and guidelines, and were appropriately approved. The format of policies was standardised. Where generic policies were used, such as the HSE Complaints Policy, a statement adopting that policy was in place.

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

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Audits of the complaints log and related records had been completed. Complaints data was not analysed as no complaints had been made since the last inspection.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. The complaints procedure was publicly displayed. Information was provided to residents and their representative on admission. Residents, their representatives, family and next of kin were informed of all methods by which a complaint can be made.

As no complaints had been received by the approved centre a quality assessment was not completed for this regulation.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in February 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff. Identified risks were actively reduced to the lowest practicable level of risk through active risk management procedures. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with the relevant legislation. The risk register also documented health and safety risks.

Ligature points were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported, monitored by the approved centre and documented in the risk register. A plan to reduce risks to residents, while refurbishment work was underway, was implemented. Individual risks assessments were completed prior to and during physical restraint.

Risk assessments were carried out at admission to identify individual risk factors including general health risks, risk of absconding, and risk of self-harm. Risk assessments were also carried out at resident transfer, resident discharge, and in conjunction with medication requirements or administration. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were risk-rated, recorded in a standardised format, and reviewed by the approved centre. A six-monthly summary report of all incidents was provided by the approved centre to the Mental Health Commission. The emergency plan incorporated evacuation procedures, as well as specifying responses by the approved centre staff to possible emergencies.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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.

9.0 Inspection Findings – Rules

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

None of the rules under the Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Mental Health Act 2001

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

This section of Mental Health Act 2001 Section 52(d) was not applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

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: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually, and it was last reviewed in January 2018. It addressed the following:

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

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

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

Evidence of Implementation: Three episodes of physical restraint were reviewed by the inspector. Physical restraint had been used in rare and exceptional circumstances, after alternative interventions were considered and based on a risk assessment. Cultural awareness and gender sensitivity was considered. Physical restraint was initiated by a member of the multi-disciplinary team (MDT) in accordance with the policy and there was a designated staff member responsible for leading the episodes of restraint. The Consultant Psychiatrist was notified as soon as possible and a registered medical practitioner completed a medical examination of the residents within three hours after the start of an episode. All episodes inspected were recorded in the clinical files, the Clinical Practice Forms had been completed within three hours, and signed by the Consultant Psychiatrist within 24 hours. The next of kin were informed of the use of physical restraint, in all cases, as soon as was practicable.

A same sex staff member was present at all times during the episodes, and each resident had been afforded the opportunity to discuss the restraint with members of the MDT. In all three episodes reviewed the completed clinical practice forms had not been placed in the respective clinical file. Each episode had been reviewed by the members of the MDT and documented in the clinical no later than two working days.

There were child protection policies and procedures in place which included the appropriate training requirements for staff in relation to child protection.

The approved centre was non-compliant with this code of practice because the completed Clinical Practice Form had not been placed in the residents' clinical files, 8.3.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in January 2018, included the policy related criteria assessed under this code of practice.

Transfer: The transfer policy, which was last reviewed in August 2017, included the policy related criteria assessed under this code of practice.

Discharge: The discharge policy, which was last reviewed in August 2017, included the policy related criteria assessed under this code of practice.

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

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

Evidence of Implementation

Admission: One clinical file was reviewed in relation to the admission process. Admission to the approved centre was on the basis of a mental illness or mental disorder. Comprehensive admission assessments were completed which included the presenting problem; past psychiatric, family and medical history; current and historic medication; risk assessment; social and housing circumstances, current mental health state, work situation, education, dietary requirements, and a full physical examination. The resident, and with their consent, their parents, were involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged was inspected. The discharge plan included the date of discharge. A comprehensive discharge assessment was completed which addressed psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs and informational needs. A discharge meeting was attended by the resident and relevant persons. A comprehensive discharge summary was sent to the relevant healthcare providers at the time of discharge. The summary included a follow-up plan, early warning signs of relapse and risks, diagnosis, prognosis, medication and outstanding issues. A timely follow up appointment was scheduled. The discharge had been coordinated by the key worker.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 25: Use of Closed Circuit Television

Report reference: Page 43 & 44

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] 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. The approved centre was non-compliant with this regulation because the monitoring system had been capable of recording, 25(1) (d).	New	Corrective Action(s): The monitoring systems' capability of recording was deactivated post MHC visit. James O Mahony emailed MHC to confirm May 3rd 2018 that recording function was disabled. Post-Holder(s) responsible: Dr. James O Mahony Area Director of Nursing	N/A	No Barriers	Complete
		Preventative Action(s): - Policy on CCTV amended to reflect that Eist Linn CCTV is incapable of recording or storing a Young Persons image (Policy attached). Post-Holder(s) responsible: Kevin Leen CNS	N/A	No Barriers	September 2018

[1] Area of non-compliance reoccurring from 2017
[2] Area of non-compliance not reoccurring from 2017

Regulation 26: Staffing

Report reference: 45 & 46

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)*
2. The approved centre was non-compliant with this regulation because not all staff were trained in Fire Safety, Basic Life Support, and the Management of Violence and Aggression, 26(4).	Reoccurring	Corrective Action(s): 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. Post-Holder(s) responsible: Theresa Tierney CNM3	The Clinical Nurse Manager 3 who coordinates mandatory training will email staff on a monthly basis to request they update the common training folder. Completed training record is uploaded to common training folder. Updates to training folder will be audited monthly (last audit attached 24-08-2018)	Achievable and realistic. Barrier will be the availability of training courses in PMAV & BLS. PMAV Training to be held onsite for multidisciplinary team. Booked for September 26th- 28th 2018.	Fire Safety - 5th October 2018. PMAV - 5th, 26th, 27th & 28th September 2018. BLS – Awaiting training dates from Centre fro Nursing Education.
		Preventative Action(s): Each discipline line manager will oversee compliance for the staff that report to them Post-Holder(s) responsible: Prof. Marcellino Smyth Dr. James O Mahony, Kevin Morrison, Mr David Hughes Mr James Creasey Mr Daniel Flynn Ms Vivienne Foley	Staff training will be discussed as an agenda item at Area Management Team meeting. Monthly audits will continue.	No barriers	As training places become available

Codes of Practice Use of Physical Restraint

Report reference: Page 59

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)*
3. The approved centre was non-compliant with this code of practice because the completed Clinical Practice Form had not been placed in the residents' clinical files, 8.3.	New	Corrective Action(s): All clinical Practice Forms for Young People restrained have been placed in their respective files Post-Holder(s) responsible: Kevin Leen CNS	N/A	No Barriers	Completed
		Preventative Action(s): Notice Placed on Clinical Practice Book (attached) to inform them that Clinical Practice forms are to be filed within the continuation notes of the Young Person upon completion of the form. Post-Holder(s) responsible: Kevin Leen CNS	Clinical Nurse Manager will ensure all completed practice forms are filed correctly.	No Barriers	Completed