Eist Linn Child & Adolescent In-patient Unit

ID Number: AC0082

2019 Approved Centre Inspection Report (Mental Health Act 2001)

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

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
22 December 2016

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Morrison, General Manager, Mental Health Services – Cork Kerry Community Healthcare

Inspection Team:
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Inspection Date:
12 – 14 February 2019

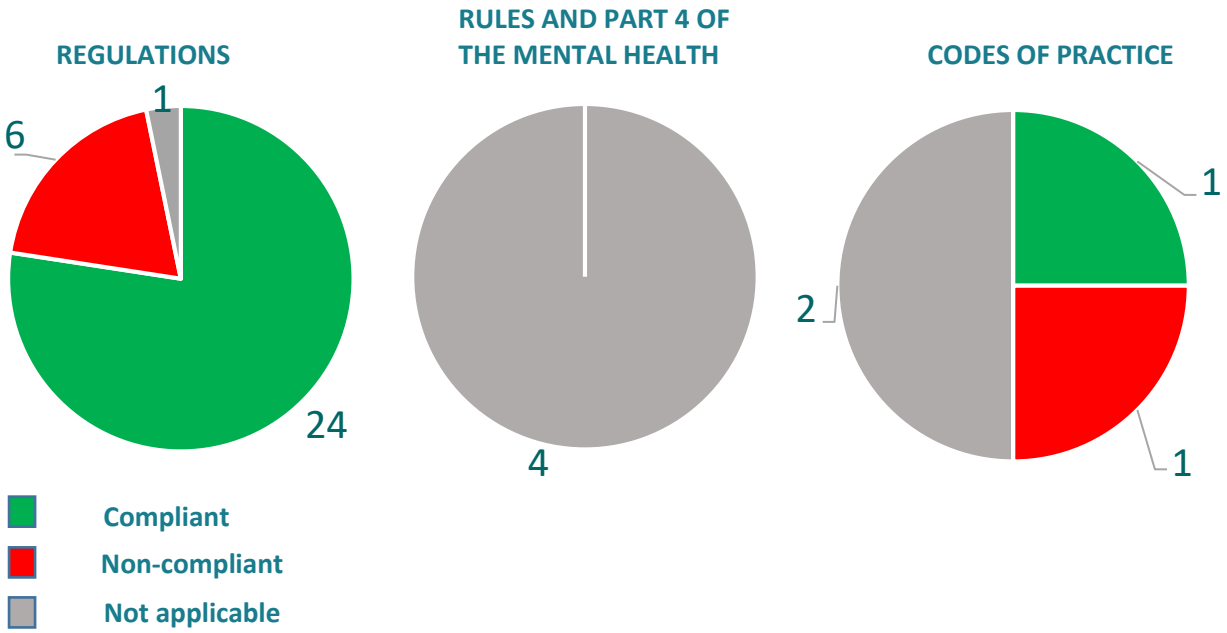
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
24 – 27 April 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 11 July 2019

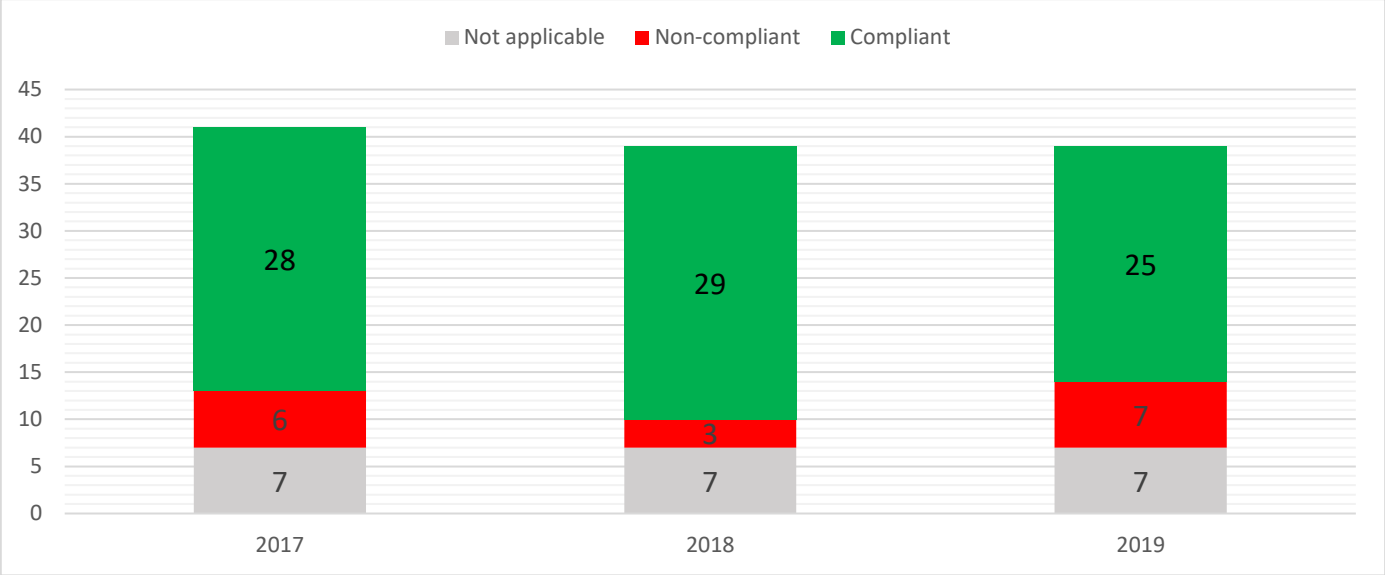
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

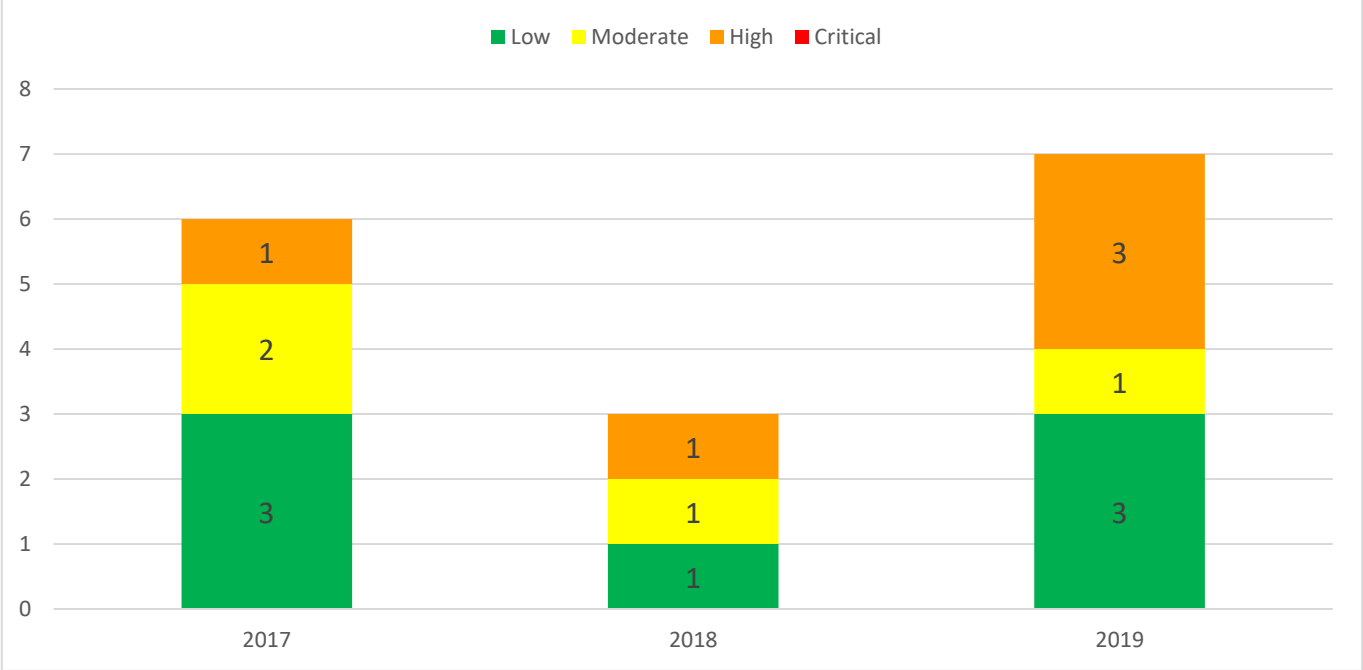
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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

Chart 2 – Comparison of overall risk ratings 2017 – 2019



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

Eist Linn Child and Adolescent Mental Health inpatient unit was located in the Cork suburb of Blackrock in the grounds of the Bessborough Centre. It had 18 operational beds at the time of inspection, although it was registered for 20 in total. Eist Linn was one of four national child and adolescent mental health inpatient facilities in Ireland. Admitting teams included Kerry, Cork, South Tipperary, Waterford, Wexford and Kilkenny/Carlow.

There was a decrease in compliance with regulations, rules and codes of practice since 2018, when there was 91% compliance, to this inspection where there was 78% compliance. The approved centre had been non-compliant with the Code of Practice on Physical Restraint and Regulation 26 Staffing for three consecutive years. Nine compliances with regulations had a quality rating of excellent.

Conditions to Registration

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

Safety in the approved centre

- The approved centre used the name, photograph, and medical record number of each resident as identifiers.
- Appropriate identifiers and alerts were used to assist staff in distinguishing between residents with the same or a similar name.
- The ordering, prescription, storage and administration of medication was excellent.
- There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

However:

- Although we found no deficiencies in food safety practices, food safety audits had not been completed periodically.
- Since the 2018 inspection, there had been no improvement in the numbers of staff trained in the area of the Management of Aggression and Violence, as there were difficulties releasing staff to attend these trainings. There was little or no change in numbers of staff trained in the areas of Basic Life Support and the Mental Health Act (2001). There had been a small increase in the proportion of nursing and medical staff trained in fire safety.

Appropriate care and treatment of residents

- Each young person had an individual care plan (ICP). A risk assessment was also included. The ICP was discussed and drawn up where practicable with the participation of the resident and their representative. A key worker was identified for each young person and all ICPs were reviewed on a weekly basis. All ICPs included the child's educational requirements.
- The therapeutic services provided by the approved centre were evidence-based. Therapeutic services were provided in a separate, dedicated room containing facilities and space for individual and group therapies.
- Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Records were available demonstrating residents' completed general health checks and associated results.

However:

- ICPs were not drawn up by a full multi-disciplinary team (MDT) and the assessed needs of the residents as documented in their care plans were not all met, due to the continued absence of an occupational therapist within Eist Linn.
- Four ICPs reviewed did not contain appropriate goals for the resident. One ICP reviewed did not contain an individual risk management plan. One ICP did not contain a preliminary discharge plan.

Respect for residents' privacy, dignity and autonomy

- Appropriate and reasonable visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private.
- Residents did not have access to their mobile phones, but they could use the approved centre's telephone in private if they wished. They had access to supervised use of the internet in the approved centre's computer room.
- Searches were only conducted for the purpose of maintaining a safe and therapeutic environment for residents and staff. Each resident's consent was sought and documented prior to a search. There was a minimum of two clinical staff in attendance at all times when the search was being conducted and it was implemented with due regard to each resident's dignity, privacy and gender.
- All bedrooms were single with en suite facilities. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. Shared bathrooms were lockable and these locks had an override function for safety reasons.
- Seclusion was not used in Eist Linn.

However:

- Resident bedrooms and en suites did not have a lock on the inside of the door. While the residents' bedroom door observation panels were fitted with an opaque film, this did not adequately cover the observation panels of some of the bedroom doors.

- CCTV cameras had the capability to submit a resident image to a monitor that was viewed by administration staff, and this meant that images of the residents were viewed by personnel other than the health professional responsible for the resident.
- Not all resident records were maintained in good order as a number of records contained loose pages, which was a potential confidentiality breach.
- There were a number of breaches of the Code of Practice on Physical Restraint:
    - In one case, the consultant psychiatrist on duty was not notified of the physical restraint; a note was put into the file indicating that staff could not contact the consultant psychiatrist on duty.
    - In two cases, the registered medical practitioner did not complete a medical examination of the resident within three hours of the physical restraint taking place.
    - None of the episodes examined indicated that the resident was informed of the reasons for, likely duration of and circumstances that would lead to the discontinuation of physical restraint.
    - In two cases, there was no evidence that the episodes of physical restraint were reviewed by members of the MDT within two working days.

Human Rights

The approved centre did not physically restrain young people in accordance with the Code of Practice on Physical Restraint as outlined above.

Responsiveness to residents' needs

- 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 and residents had at least two choices for meals every day.
- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Activities included DVDs, TV, books, board games, a pool table, and computers. Recreational groups ran daily for sport related exercise and art. Opportunities were available for indoor and outdoor exercise and physical activity. The approved centre had a computer room, pool room, art room, and TV rooms upstairs and downstairs.
- The approved centre had a dedicated school of sufficient size for the number of residents in the approved centre. The school had two classrooms, a recreational hall, an arts and crafts room, and a gym. Child residents were assessed in terms of their individual educational requirements, with consideration of their needs and age on admission.
- Residents were provided with an information booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, and residents' rights and the information was clearly and simply written. Details of relevant advocacy and voluntary agencies details, including the Headspace Toolkit was given to residents. Residents were provided with written and verbal information on diagnosis and medication in a format appropriate to the resident needs.
- The complaints procedure in the approved centre was excellent.

- The approved centre was clean and well maintained. It was bright, suitably furnished and had sufficient space.

Governance of the approved centre

- The approved centre was represented on the area management team which met on a monthly basis. Four management meetings were scheduled on a rolling basis within the approved centre: the monthly risk management meeting, the policy review meeting, business meetings and the audit committee.
- There was a strong ethos of staff supervision in all of the departments and clear lines of responsibility and reporting in place. Staffing was identified as an operational risk for the nursing, medical and occupational therapy departments. Difficulties releasing staff to attend Professional Management of Aggression and Violence (PMAV) training were also highlighted.
- There was a well-established system of governance within the approved centre, evidenced by the ongoing system of auditing and policy development, the emphasis on staff development and the strong risk management procedures.
- The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes. The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation.
- Eist Linn was a pilot site for E-rostering. This system could potentially manage staff more efficiently, build staffing rosters quickly and ensure the correct staff skill mix at all times within the approved centre.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

The following quality initiatives had been introduced since the 2018 inspection:

1. Eist Linn was a pilot site for E-rostering. This system could potentially manage staff more efficiently, build staffing rosters quickly and ensure the correct staff skill mix at all times within the approved centre.

2. Staff had taken part in a number of training initiatives since the previous inspection. These included training in Avoidant Restrictive Food Intake Disorder (AFRID), Quality and Safety, art therapy and play therapy.

3. Staff in Eist Linn had been involved in three research initiatives since the last inspection. These included a service based research within the approved centre evaluating the family meal service as well as a conference presentation on the lack of advocacy rights of young people admitted to in-patient CAMHS in Ireland. The third piece of research aimed to gather the experiences of parents whose children are admitted to in-patient CAMHS units.

4. A multi-disciplinary team in Eist Linn was involved in an external, long-term project called 'Trauma Informed Care.' The project aims to facilitate access to trauma-specific interventions and services for residents. At the time of the inspection, the team were providing staff with training on the various aspects of Trauma Informed Care, including workforce development, trauma-focused services and integrating the findings from the project into organisational practices.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Eist Linn Child and Adolescent Mental Health Services were located in the Cork suburb of Blackrock within the grounds of the Bessborough Health Centre. In total, it had 18 operational beds at the time of inspection, although it was registered for 20 in total. The bed numbers had increased from 10 to 18 the previous October with the arrival of a new locum consultant psychiatrist. Eist Linn was one of four national child and adolescent mental health inpatient facilities in Ireland.

The approved centre was located on a large green space. The ground floor had a therapy corridor which comprised of several meeting and therapy rooms. There was also a kitchen, a large dining room, a sitting room, a library sitting room, a computer room and a parent's flat which contained sleeping accommodation for residents' family members. There was a school located at the back of the approved centre which contained six classrooms, a large gym and a Home Economics Room. Upstairs it had all single room accommodation and an Intensive Care Unit that was due for refurbishment in the coming months. Two nurse's stations, a clinical room and a relaxation room were also located upstairs.

Admitting teams included Kerry (two vacant posts, one filled), North Cork, West Cork, Cork City including North Lee (one vacant post) and South Lee (one vacant post, one filled), South Tipperary, Waterford (three vacant posts), Wexford (two vacant posts) and Kilkenny/Carlow. The two vacant posts in Wexford meant that there was no CAMHS psychiatrist for the area. The approved centre served a population of 1.2 million people and some residents and their families had to travel long distances often by way of Dublin due to poor regional public transport links.

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

Resident Profile	
Number of registered beds	***18***
Total number of residents	**15**
Number of detained patients	0
Number of wards of court	0
Number of children	15
Number of residents in the approved centre for more than 6 months	0

3.2 Governance

The approved centre was a regional child and adolescent in-patient unit for HSE South, including Community Health Organisation (CHO) Area 4; Kerry, North Cork, North Lee, South Lee, West Cork as well as CHO Area 5; South Tipperary, Carlow/Kilkenny, Waterford, Wexford. Operational capacity had been reduced until October 2018; however, the approved centre had 18 operational beds in place from this time, due to the appointment of a new, locum consultant psychiatrist.

Four management meetings were scheduled on a rolling basis within the approved centre. The monthly risk management meeting discussed the local risk review log including issues relating to the functionality of staff alarms and structural issues relating to the building. Policy review meeting took place to discuss and approve policies relating to Eist Linn. Business meetings happened on a bi-monthly basis to review the progress on capital projects, the impacts of GDPR, the Quality Network for Inpatient CAMHS (QNIC) inspection visit and other issues such as best practice guidelines and training. The audit committee met quarterly in order to schedule and review audits completed. The approved centre was represented on the area management team which met on a monthly basis. This meeting allowed for heads of discipline to discuss issues that had been escalated for review and the update of the area risk register.

The inspection team received feedback from each of the disciplines operating in Eist Linn regarding their governance structures. There was a strong ethos of staff supervision in all of the departments and clear lines of responsibility and reporting in place. Staffing was identified as an operational risk for the nursing, medical and occupational therapy departments. Difficulties releasing staff to attend Professional Management of Aggression and Violence (PMAV) training were also highlighted.

A lot of work had taken place in order to ensure that nursing governance for CAMHS was clearly documented and the introduction of new roles such as the Advanced Nurse Practitioner in Child and Adolescent Mental Health facilitated development in this area. There was a well-established system of governance within the approved centre, evidenced by the ongoing system of auditing and policy development, the emphasis on staff development and the strong risk management procedures.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 15: Individual Care Plan	✓		✓		✗	Low
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	Low
Regulation 21: Privacy	✓		✓		✗	Low
Regulation 25: Use of Closed Circuit Television	✓		✗	High	✗	High
Regulation 26: Staffing	✗	Low	✗	Moderate	✗	High
Regulation 27: Maintenance of Records	✗	Moderate	✓		✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✗	Low	✗	High

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

4.2 Areas of compliance rated "excellent" on this inspection

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 13: Searches
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 31: Complaints
Regulation 32: Risk Management Procedures

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As this was a Child and Adolescent Mental Health unit, this regulation did not apply.
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 this was a child and adolescent facility, this Code of Practice was not applicable
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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

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

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

The inspection team met with a total of 11 residents. They indicated that the quality of the accommodation was of a high standard although at times the temperature of the bedrooms could be uncomfortably warm. They reported that while staff were accessible to residents, not everyone was consistently made aware of who their keyworker was. Residents were accommodated to receive visitors and to make phone calls as per the approved centre policy. Residents felt that communication could be improved and they were aware of staff shortages including the lack of an occupational therapist.

Residents indicated that more access to 'Sports Exercise' and to the computer room would be welcomed as they enjoyed these activities a lot. The fact that residents tended to be in one group at all times was noted- residents would have preferred to separate into smaller groups if possible. This was highlighted by the fact that when the entire group of residents (up to 18 young people) are in the sitting room at the same time, then there would not be sufficient seats for everyone. Residents were aware of how to go about making a complaint.

Seven questionnaires were returned to the inspection team. Six of these indicated that residents did not have enough activities to do during the day. Six respondents specified that they knew who their multi-disciplinary team were. Six respondents felt that they could communicate freely with their family and friends. Staffing issues, (particularly the lack of staff available to the residents) were highlighted in the comments section of the questionnaire.

6.0 Feedback Meeting

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

- Executive Clinical Director
- General Manager
- Principal Social Worker
- Area Director of Nursing
- Consultant Child and Adolescent Psychiatrist
- Acting Clinical Nurse Manager 2
- Clinical Nurse Manager 3
- Clinical Nurse Specialist
- Senior Psychologist
- Occupational Therapy Manager
- Head of Service (Cork and Kerry)

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 about the transfer and discharge processes in place within the approved centre.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in 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 the identification of 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 approved centre used name, photograph, and medical record number of each resident as identifiers. The preferred person-specific identifiers used were appropriate to the residents' communication abilities, and were detailed within residents' clinical files. The identifiers were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used to assist staff in distinguishing between residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

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

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

Evidence of Implementation: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Irish Food Pyramid. Residents had at least two choices for meals every day. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot and cold drinks were offered to residents regularly.

For residents with special dietary requirements, their nutritional and dietary needs were assessed, where necessary and addressed in residents' individual care plans. The dietician conducted evidence-based nutrition assessments and regularly reviewed residents' special dietary need. Intake and output charts were maintained for residents, where appropriate. Dietitians educated residents and their parents about residents' diets, where appropriate, specifically in relation to any contraindications with medication.

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

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

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was cooked off site in the main kitchen and was transferred to Eist Linn in insulated boxes. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

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 on residents' clothing. Relevant staff interviewed were able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. No resident was prescribed to wear night clothes during the day since the last inspection.

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

The approved centre was compliant with this regulation. The quality assessment was 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 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 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: The residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre's policy.

Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions. All residents could store their property in the property room and in a safe. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of nursing staff and the resident or their representative.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in 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 recreational activities, as set out in the policy.

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Information on the activities available to residents was provided in the information booklet that each resident received on admission. Formalised activities timetables were displayed to residents during the week on the whiteboard, and less formalised timetables were displayed at weekends.

Activities included DVDs, TV, books, board games, a pool table, and computers. Recreational groups ran daily for sport related exercise and art. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. The approved centre had a computer room, poolroom, art room, and TV rooms upstairs and downstairs.

As well as indoor activities such as yoga, residents could partake in outdoor physical activity such as running, and sports exercise or 'Sportercise' classes. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at events were maintained in group records or in the clinical files.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **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 included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents' rights to practice religion could be facilitated within the approved centre if requested by residents, but residents in the approved centre had not requested any religious input. Mass times were given to residents. Chaplains or priests did not visit the approved centre. Residents had access to multi-faith chaplains, if required, and to local religious services. 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 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 interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on residents' rights to receive visitors was monitored and reviewed on an ongoing basis. Analysis was not completed to identify opportunities to improve visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. Clinical files documented the names of visitors the resident did not wish to see and those who posed a risk to the resident. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting room and area available 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 included 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 monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents could use mail and fax if they wished. Residents did not have access to their mobile phones, but they could use the approved centre's telephone if they wished. Residents had access to supervised use of the internet in the approved centre's computer room. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. As there was no reasonable cause to believe that communication may result in harm to the resident or others, there was no examination of incoming and outgoing resident communication at the time of the inspection by Clinical Directors or other designated senior staff.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all 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 in relation to the implementation of resident searches. The policy was last reviewed in January 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

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

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

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

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

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

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was last reviewed in January 2017. The policy and protocols 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 end of life care, as set out in the policy.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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 included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: In total 10 ICPs were reviewed. In each case the ICP was a composite set of documents with space for goals, treatment, care and resources required. The ICP documents were stored within the clinical files and were identifiable and uninterrupted. Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address the young person's immediate needs. An ICP was developed by the multi-disciplinary team following a comprehensive assessment within seven days of admission. Each assessment contained the required medical, psychiatric and psychosocial history as well as a current physical health assessment. A risk assessment was also included.

The ICP was discussed and drawn up where practicable with the participation of the resident and their representative. The ICP identified appropriate resources for the resident and a key worker was identified for each young person to ensure continuity of care. The ICP identified resources required to provide the care and treatment identified. All ICPs were reviewed on a weekly basis. All ICPs included the child's educational requirements.

Due to the absence of the occupational therapist, ICPs were not drawn up by a full multidisciplinary team. Four ICPs reviewed did not contain appropriate goals for the resident. One ICP reviewed did not contain an individual risk management plan. One ICP did not contain a preliminary discharge plan.

The approved centre was non-compliant with this regulation because four of the ICPs reviewed did not have a documented set of appropriate goals within their ICPs.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(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 August 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities in relation to the provision of therapeutic services and programmes
- The planning and provision of therapeutic services and programmes within the approved centre
- Assessing residents as to the appropriateness of services and programmes.

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

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

Evidence of Implementation: The therapeutic services provided by the approved centre were evidence based and were directed towards restoring and maintaining optimal levels of psychosocial functioning of residents. A list of all therapeutic services and programmes provided in the approved centre was available to residents. Therapeutic services were provided in a separate, dedicated room containing facilities and space for individual and group therapies. A record was maintained of participation and engagement in therapeutic services and programmes.

The therapeutic services and programmes provided by the approved centre were not appropriate to meet the assessed needs of the residents as documented in their individual care plans, due to the continued absence of an occupational therapist within Eist Linn.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services in accordance with needs identified in their individual care plan, as there was no occupational therapist available to residents at the time of inspection, 16 (1).

Regulation 17: Children's Education

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: There was a written policy dated May 2017 in relation to the provision of education to child residents in the approved centre. The policy included the 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 qualified in line with their role and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs.

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

Evidence of Implementation: The approved centre had a dedicated school of sufficient size for the number of residents in the approved centre. The school had two classrooms, a recreational hall, an arts and crafts room, and a gym. Child residents were assessed in terms of their individual educational requirements, with consideration of their needs and age on admission.

Sufficient personnel and resources were available to support child residents' access to education services. The school had four teachers in total, with one full-time teacher and three part-time (50% of full time hours) teachers. Each child was provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan. The educational provisions available within the approved centre were effectively communicated to child residents and their representatives. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum.

The 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 policies and procedures in relation to the transfer of residents, which was last reviewed in August 2017. The policy included the 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: The clinical file of one patient (a ward of court), who had been transferred from the approved centre for overseas care in the UK was examined. Four staff members accompanied the patient abroad. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident's care and treatment plan, including needs and risks, and the resident's accompaniment requirements on transfer.

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

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: National screening programmes were not applicable to the young age profile of residents. At the time of the inspection, no resident was in the approved centre for over six months. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency resuscitation trolley upstairs in the clinical room, and staff had access at all times to an Automated External Defibrillator. Emergency equipment was checked weekly. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and as indicated by the residents' specific needs. No resident in the approved centre, at the time of the inspection, had been a resident for longer than six months.

Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. National screening programmes were not applicable to the young age profile of residents.

The approved centre's team educated residents in relation to smoking cessation and implemented a smoking cessation programme where applicable.

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 series of written operational policies and procedures in relation to the requirements of the *Judgement Support Framework,* with the following exceptions:

- The process for identifying 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 monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with an information booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team (MDT).

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

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. The content of medication

information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. The quality assessment was 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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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 December 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for addressing a situation where resident privacy and dignity was 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 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 and the general demeanour of staff was respectful to residents at all times. Staff appearance and dress was appropriate at all times, and staff used discretion when discussing a resident's condition or treatment needs. Staff sought permission before entering residents' rooms and all residents were wearing clothes that respected their privacy and dignity. All bedrooms were single with en suite facilities. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

Resident bedrooms and en suites did not have a lock on the inside of the door. Shared bathrooms were lockable and these locks had an override function for safety reasons. While the residents' bedroom door observation panels were fitted with an opaque film, this did not adequately cover the observation panels of some of the bedroom doors.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents' privacy was appropriately respected at all times, as the observation panels on the bedroom doors were only partially fitted with an opaque film.

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 policy in place, dated February 2017, in relation to the premises. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Accommodation for each resident in the approved centre assured their comfort and privacy and met their assessed needs. All bedrooms were appropriately sized to match residents' needs. Bedrooms were all single with en suite facilities. There was adequate and suitable furnishings, and appropriately sized communal rooms. It was adequately lit, heated, and ventilated. The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards were minimised. Ligature points were minimised, monitored, and actively managed. The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained. Remote or isolated areas of the approved centre were monitored.

The property and storage room, beside the nurses' station in the intensive care unit, was disorganised and very untidy. Not all rooms had appropriate signage and sensory aids to support resident orientation needs, rooms were incorrectly labelled. Where faults or problems were identified in relation to the premises, this

was communicated through the appropriate maintenance reporting process. The approved centre was clean, hygienic and free from offensive odours. Heating was controlled centrally, however it was not possible to control heating in the resident's own room. Back-up power was available to the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the 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 operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in November 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's MPAR. A record in the form of a symbol '3' was kept when medication was refused by the resident.

Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition. This was documented in the clinical file. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration; and expired medications were not administered. All medicines were administered by a registered nurse or registered medical practitioner and, any advice provided by the resident's pharmacist regarding the appropriate use of the product was adhered too. Good hand-hygiene techniques were implemented during the dispensing of medications.

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

Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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 series of written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in June 2018. The policy addressed all the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

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 September 2018. The policy addressed the 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 used CCTV cameras or other monitoring equipment.
- The maintenance of the CCTV cameras by the approved centre.
- The disclosure of the existence and usage of CCTV or other monitoring devices to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.
- The process for ensuring that the use of CCTV by the approved centre was overt and clearly identifiable through the use of signage and communication with residents and 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. A resident was monitored solely for the purposes of ensuring their health, safety and welfare. The usage of CCTV was disclosed to the Mental Health Commission at the time of the inspection. CCTV was not used to monitor a resident if they started to act in a manner that could compromise their dignity.

CCTV cameras had the capability to submit a resident image to a monitor that was viewed by administration staff, and this meant that CCTV was potentially viewed by personnel other than the health professional responsible for the resident.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that closed circuit television was used solely for the purposes of observing a resident by the health professional that was responsible for the welfare of that resident, 25 (1)(a).

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in May 2018. The policy addressed 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 job description requirements.
- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

Training and Education: 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: The approved centre had an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre's staff. A

planned and actual staff rota, showing the staff on duty at any one time during the day and night was maintained in the approved centre.

Staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection and appointment. All staff were vetted in accordance with the approved centre's recruitment, selection and appointment policy. Staff had the appropriate qualifications to do their job. An appropriately qualified staff member was on duty and in charge at all times. This was documented. There was a written staffing plan for the approved centre. The required number of staff were on duty at night in order to ensure the safety of the residents. Where agency staff were used there was a comprehensive contract between the approved centre and the registered staffing agency.

Orientation and induction training was completed for all staff. Staff had completed manual handling, infection control and prevention, care for resident with an intellectual disability, resident rights, risk management and recovery-oriented approaches to mental health treatment. All staff training was documented and training logs were maintained. Opportunities were made available to staff by the approved centre for further education. In-service training as completed by appropriately trained and competent individuals. Facilities and equipment were made available for staff in-service education and training.

The Mental Health Act 2001, the associated regulations (S.I No. 551 of 2006) and Mental Health Commission Rules and Codes as well as all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

The following discrepancies were found on inspection:

- The number of staff employed was sufficient to meet resident needs; however, the skill mix was not sufficient due to the lack of an occupational therapist.
- Since the 2018 inspection, there had been a small increase in the proportion of nursing and medical staff trained in Fire Safety. There had been no improvement in the numbers of staff trained in the area of the management of aggression and violence which was reportedly difficult to access. There was little or no change in the areas of Basic Life Support and the Mental Health Act (2001).
- The table below highlights the percentages of staff per department who were trained in each of the five mandatory training topics.

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (30)	22	73%	24	80%	22	73%	30	100%	30	100%
Consultant Psychiatrist (2)	1	50%	2	100%	0	0%	1	50%	2	100%
Medical (2)	0	0%	2	100%	0	0%	0	0%	2	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (2)	2	100%	1	50%	0	0%	2	100%	2	100%

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

Ward or Unit	Staff Grade	Day	Night
	Area Director of Nursing	9-5	
	Assistant Director of Nursing	9-5	
	CNM2	1	1
	RPN	6	3
	HCA	1	
Eist Linn	Occupational Therapist	0	
	Social Worker	2	
	Psychologist	2	
	Dietician	1	
	Consultant Psychiatrist	2	
	Non Consultant Hospital Doctor	2	
	Teacher	3	

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

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

a) **The residents in the approved centre did not have access to an occupational therapist, 26 (2).**
b) **Not all staff were trained in fire safety, PMAV and Basic Life Support, 26 (2).**
c) **Not all staff were trained in the Mental Health Act, 26 (3).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records. The policy was last reviewed in January 2017. The policy addressed the following requirements of the *Judgement Support Framework*:

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

The policy did not address the record review requirements.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. Not 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 records were stored securely in a locked cabinet in the nurses' station. All resident records were stored together where physically possible. A record was initiated for every resident provided with care by the approved centre. Resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Resident records were accessible to authorised staff only.

Staff had access to the data and information needed to carry out their job responsibilities. Resident access to their records was managed in accordance with the Freedom of Information Acts. Records were written legibly in black ink and entries were factual, consistent and accurate. While each entry included the date, the timing of entries detailed in the notes was not consistently documented. Not all resident records were

maintained in good order as a number of records contained loose pages, which was a potential confidentiality issue.

Where an error was made, this was scored out with a single line and the correction was written alongside it. Two appropriate resident identifiers were recorded on all documentation. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained in a manner that ensured completeness. Not all records were maintained in good order as a number of clinical files contained loose pages, 27 (1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented up-to-date, register of residents admitted. The register contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **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 2019. It included the 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.

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

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

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

The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame, were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Where generic policies were used, the approved centre had a written statement to this effect adopting the generic policy, which was reviewed at least every three years.

The approved centre was compliant with this regulation. The quality assessment was 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 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in January 2019. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed for senior management to consider. Details of the analysis were considered by senior management.

Evidence Of Implementation: There was a nominated person responsible for dealing with all complaints available and based in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed, and it was detailed within the service user's information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made through noticeboards and information booklets. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

There was one complaint lodged and documented since the last inspection. All complaints were handled promptly, appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All

complaints were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process made available to them.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan.

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

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 protecting children and vulnerable adults in the care of the approved centre.

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

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

Evidence Of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure

their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and at resident admission and transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, remained but were effectively mitigated.

The requirements for the protection of children within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format, and were recorded. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The risk manager reviewed incidents for any trends or patterns occurring in the service.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator, in line with the Code of Practice on the Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was 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 by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.3 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001: Consent to Treatment, was not applicable to this approved centre. Please see *Section 4.3 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated January 2019. It addressed the following:

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

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

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

Evidence of Implementation: Three episodes of physical restraint were reviewed as part of the inspection. In each case, physical restraint was used in rare, exceptional circumstances and in the best interests of the resident where he or she posed immediate threat of serious harm to self or others. All alternative interventions to manage the resident's unsafe behaviours were considered prior to the use of physical restraint. Cultural awareness and gender sensitivity were demonstrated when using physical restraint. A registered nurse initiated physical restraint in each of the three cases examined and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring their head and airway.

All episodes of physical restraint were recorded in the clinical file and the clinical practice form was completed by the person who ordered the use of physical restraint within the required three hour timeframe. As soon as was practicable the resident's next of kin was informed about the physical restraint. The resident was afforded an opportunity to discuss the episode with members of the MDT as soon as was practicable. The completed clinical practice form was place in the residents' file.

The parent or guardian of the young person who was restrained was informed about the child's physical restraint as soon as was possible. There were child protection policies and procedures in place within the approved centre at the time of the inspection. These policies addressed appropriate training for staff in relation to child protection.

The following was found on inspection:

- In one of the three cases examined, the consultant psychiatrist on duty was not notified of the physical restraint; a note was put into the file indicating that staff could not contact the consultant psychiatrist on duty.
- In two cases, the registered medical practitioner did not complete a medical examination of the resident within three hours of the physical restraint taking place.

- None of the episodes examined indicated that the resident was informed of the reasons for, likely duration of and circumstances that would lead to the discontinuation of physical restraint. The reasons for not informing the resident were not documented in the clinical file.
- In two cases, there was no evidence that the episodes of physical restraint were reviewed by members of the MDT within two working days.

The approved centre was non-compliant with this code of practice because:

a) **In one case, the consultant psychiatrist was not notified about the physical restraint as soon as was practicable, 5.3.**
b) **In two cases, the registered medical practitioner did not complete a medical examination of the resident within three hours of the physical restraint taking place, 5.4.**
c) **None of the episodes of physical restraint examined indicated that the resident had been informed of the reasons for, the likely duration of and the circumstances that would lead to the discontinuation of the physical restraint. The reasons for this were not documented, 5.8.**
d) **In two cases, there was no evidence that the episodes of physical restraint had been reviewed by members of the MDT within two working days, 9.3.**

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 a separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in January 2018, the transfer policy was last reviewed in August 2017, and the discharge process policy was last reviewed in August 2017. All policies combined included the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan (ICP). All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the MDT, and the resident's mother. A comprehensive pre-discharge assessment was completed; which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. A family member was involved in the discharge process.

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

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10000108		**Four of the ICPs reviewed did not have a documented set of appropriate goals within their ICPs.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training on the ICP policy will be rolled out for staff at the Peer Learning slot on a monthly basis	Training will be on a monthly basis for 6 months	Achievable	01/07/2019	CNM3 and CNS
Preventative Action	Training on the ICP policywill be rolled out for staff at the Peer Learning slot on a monthly basis. Audit of ICPs will continue.	Audit of ICPs will continue	Achievable	01/07/2019	CNM3 and CNS

Regulation 16: Therapeutic Services and Programmes

Reason ID : 10000109		The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services in accordance with needs identified in their individual care plan, as there was no occupational therapist available to residents at the time of inspection, 16 (1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An Occupational Therapist is now in post	An Occupational Therapist is in post	Achieved	17/04/2019	Occupational Therapy Manager
Preventative Action	An Occupational Therapist is now in post	An Occupational Therapist is in post	Achieved	17/04/2019	Occupational Therapy Manager

Regulation 21: Privacy

Reason ID : 10000110		The registered proprietor did not ensure that residents' privacy was appropriately respected at all times, as the observation panels on the bedroom doors were only partially fitted with an opaque film.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Opague Film has been placed on all observation panels	Opague Film has been placed on all observation panels	Achieved	29/03/2019	CNM3
Preventative Action	Opague Film has been placed on all observation panels	Opague Film has been placed on all observation panels	achieved	29/03/2019	CNM3

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10000111		**The registered proprietor did not ensure that closed circuit television was used solely for the purposes of observing a resident by the health professional that was responsible for the welfare of that resident, 25 (1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The monitoring system was deactivated / removed following the Mental Health Commission visit. There is no recording equipment in the unit now.	There is no recording equipment in the unit now.	Achieved	28/02/2019	Area Director of Nursing
Preventative Action	The policy on CCTV will be amended to reflect that Eist Linn CCTV is incapable of recording or storing a young persons image	Once the policy is revised and signed off, all staff will be made aware of same.	Achievable	30/09/2019	Clinical Nurse Specialist

Regulation 26: Staffing

Reason ID : 10000112		The residents in the approved centre did not have access to an occupational therapist, 26 (2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An Occupational Therapist is now in post	An Occupational Therapist is now in post	Achieved	17/04/2019	Occupational Therapy Manager
Preventative Action	An Occupational Therapist is now in post	An Occupational Therapist is in post	Achieved	17/04/2019	Occupational Therapy Manager
Reason ID : 10000113		**Not all staff were trained in fire safety, PMAV and Basic Life Support, 26 (2). Not all staff were trained in the Mental Health Act, 26 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	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	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.	Achievable	01/07/2019	CNM3
Preventative Action	Each discipline line manager will oversee compliance for the staff that report to them	Each discipline line manager will review staff training records on the common training folder	Achieable	31/07/2019	All line managers; ECD, ADON, Area Administrator, Social Work Manager, OT Manager, Principal Psychology Manager, SLT Manager

Regulation 27:Maintenance of Records					
Reason ID : 10000115		**The registered proprietor did not ensure that records were maintained in a manner that ensured completeness. Not all records were maintained in good order as a number of clinical files contained loose pages, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Director of Nursing raised the possibility of a ward clerk for the unit however this would be dependent on securing funding for this position. The DON and Area Administrator are to liaise and explore feasibility of same.	The ward clerk would be responsble for ensuring records are maintained in good order and completeness of same.	Funding dependent. Budget and available resources.	30/09/2019	Director of Nursing and Area Administrator
Preventative Action	The Director of Nursing raised the possibility of a ward clerk for the unit however this would be dependent on securing funding for this position. The DON and Area Administrator are to liaise and explore feasibility of same.	The ward clerk would be responsbile for ensuring records are maintained in good order and completeness of same.	Funding Dependent. Budget and available resources	30/09/2019	Director of Nursing and Area Administrator

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10000104		**In one case, the consultant psychiatrist was not notified about the physical restraint as soon as was practicable, 5.3. In two cases, the registered medical practitioner did not complete a medical examination of the resident within three hours of the physical restraint taking place, 5.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training regarding Physical Restraint Policy for nursing and medical staff at the Peer Learning slot once monthly for the next 6 months. Consultants will also include at NCHD induction every 6 months	The training will be rolled out once monthly for the next 6 months	Achievable	01/07/2019	CNM3 and CNS
Preventative Action	Continue audits of Physical Restraing	Continue audits of Physical Restraint	Achievable	01/07/2019	CNM3 and CNS
Reason ID : 10000106		**None of the episodes of physical restraint examined indicated that the resident had been informed of the reasons for, the likely duration of and the circumstances that would lead to the discontinuation of the physical restraint. The reasons for this were not documented, 5.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training regarding Physical Restraint Policy for Nursing and Medical staff at the Peer Learning slot once per month for the next 6 months. Consultants will also include at NCHD induction every 6 months.	Training will be rolled out once monthly for the next 6 months	Achievable	01/07/2019	CNM3 and CNS

Preventative Action	Audit of Physical Restraint	Continue audit of Physical Restraint	Achievable	01/07/2019	CNM3 and CNS
Reason ID : 10000107		**In two cases, there was no evidence that the episodes of physical restraint had been reviewed by members of the MDT within two working days, 9.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training regards Physical Restraint policy for nursing/ medical staff at the Peer Learning slot once per month for the next 6 months. Consultants will also include at NCHD induction every 6 months	Training will be rolled out monthly for the next 6 months	Achievable	01/07/2019	CNM3 and CNS
Preventative Action	Audit of Phsyical Restraint	Continue audit of Physical Restraint	Avhievable	01/07/2019	CNM3 and CNS

Appendix 2: Background to the inspection process

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

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

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

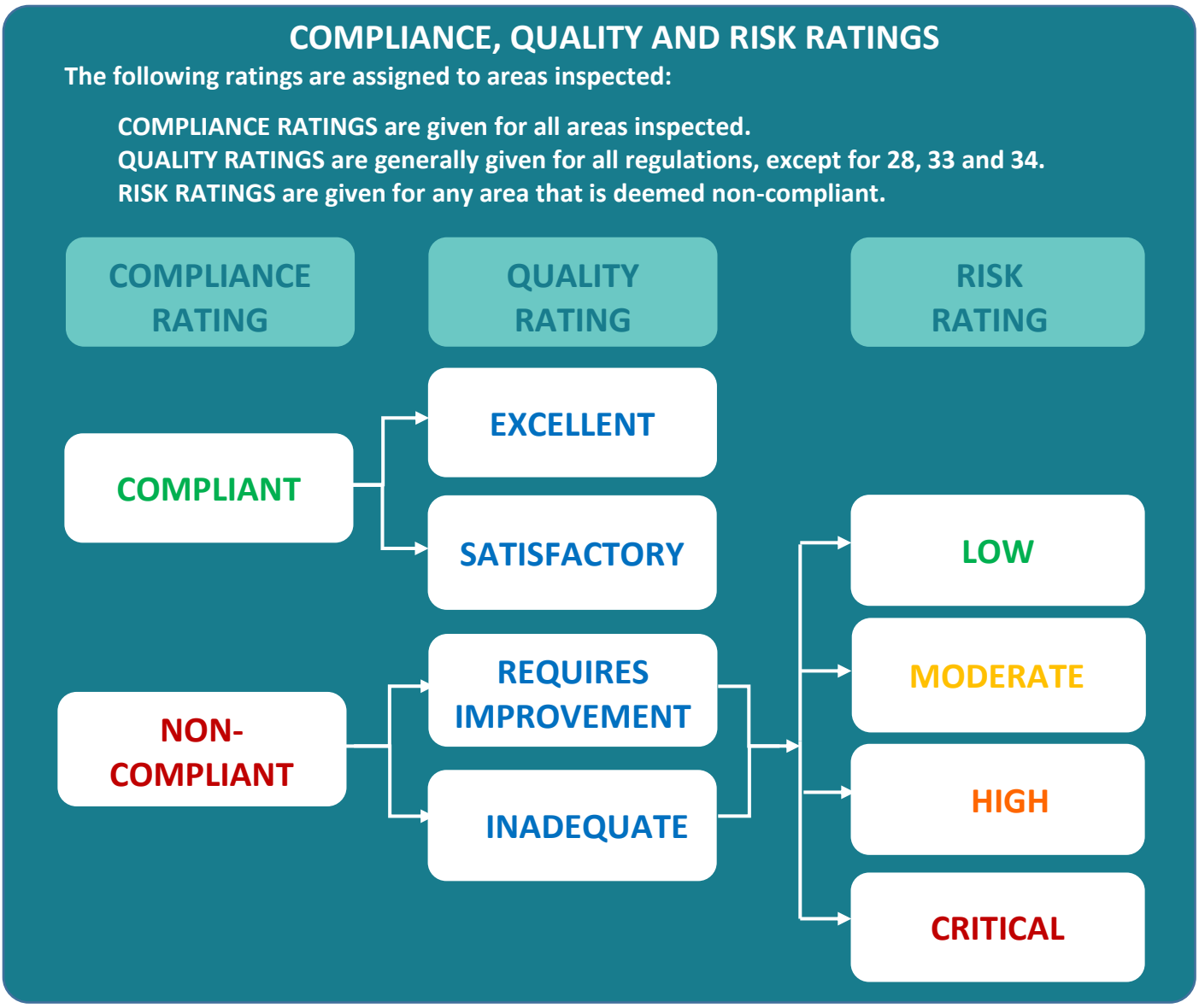
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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