Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard

ID Number: AC0097

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Linn Dara Child & Adolescent Mental Health In-patient Unit,
Cherry Orchard Hospital Campus
Ballyfermot Road
Ballyfermot
Dublin 10

Approved Centre Type:
Child and Adolescent In-patient Unit

Most Recent Registration Date:
10 December 2015

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Kevin Brady, Head of Service, Mental Health CHO 7

Inspection Team:
Orla O'Neill, Lead Inspector
Barbara Morrissey
Siobhán Dinan

Inspection Date:
7 – 10 March 2017

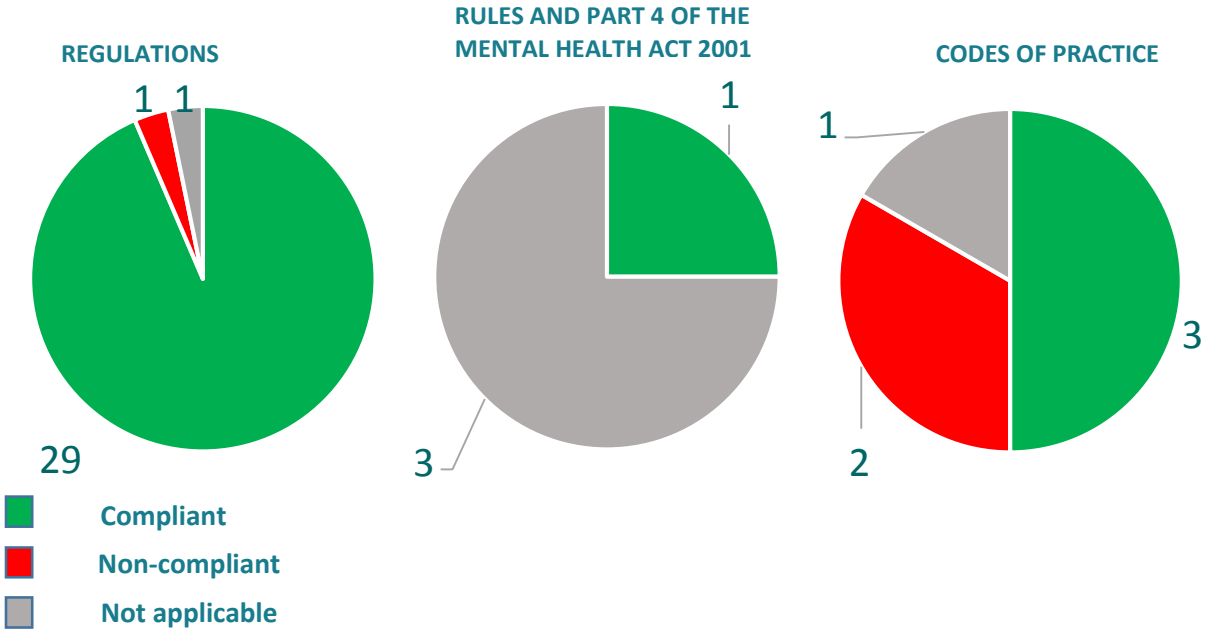
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
30 – 31 August and 1 September 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
31 August 2017

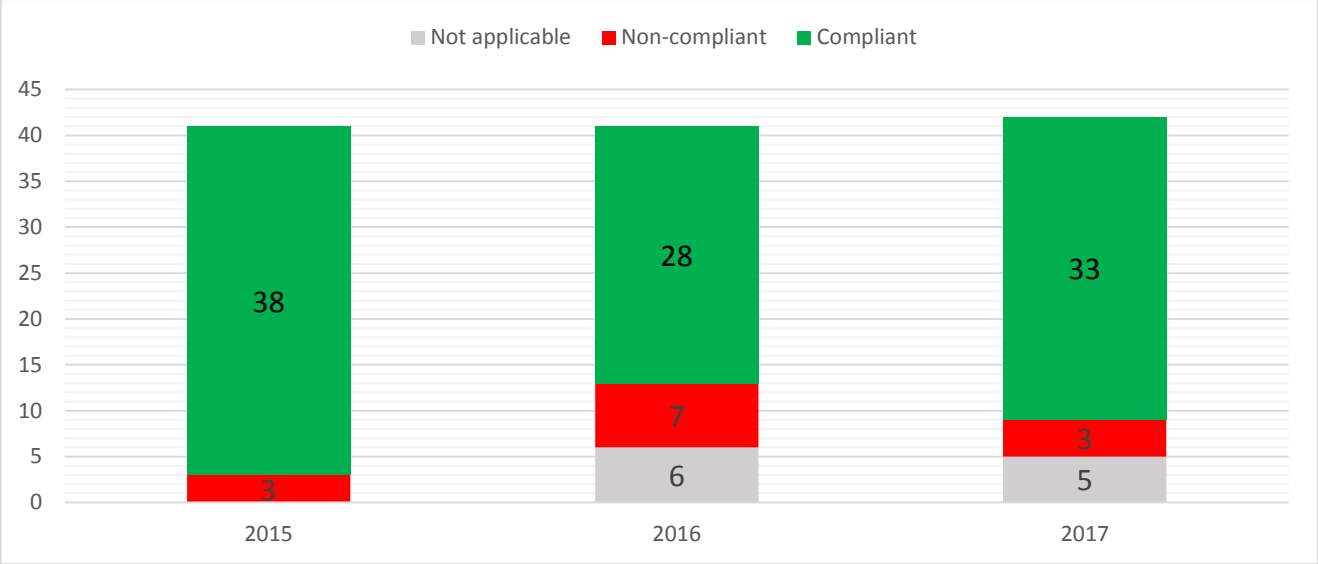
COMPLIANCE RATINGS 2017



RATINGS SUMMARY 2015 – 2017

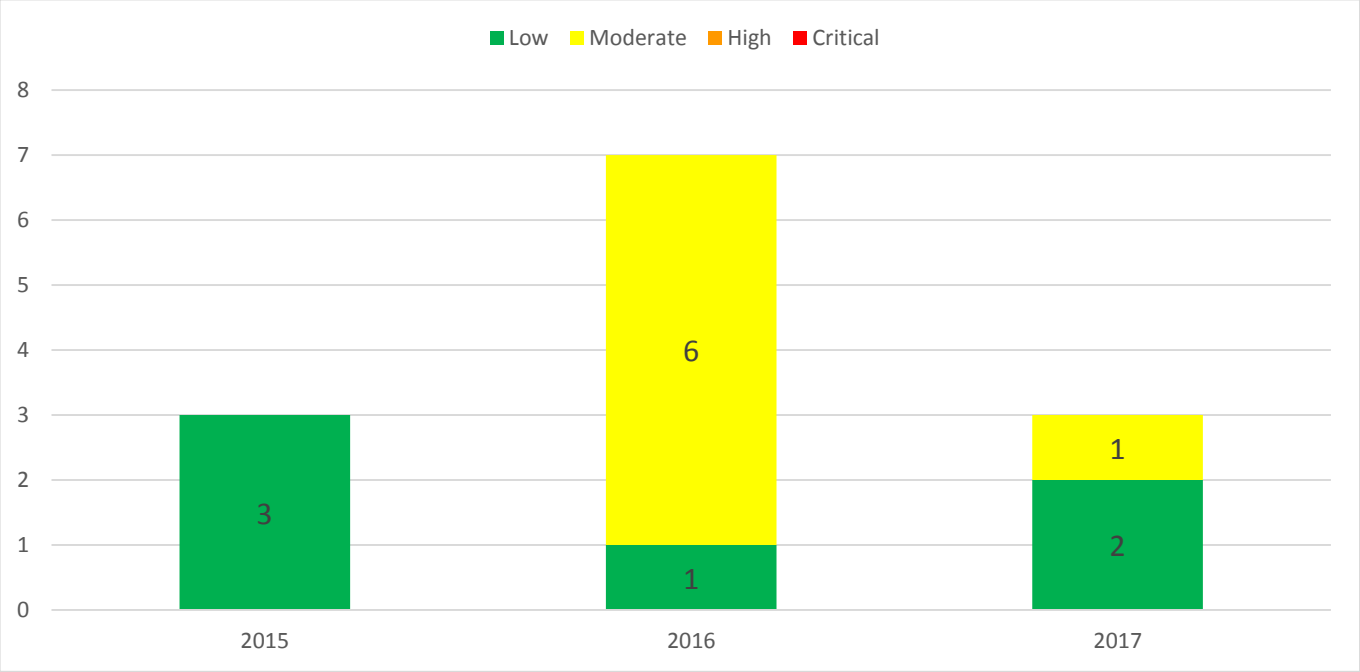
Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017



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

Chart 2 – Comparison of overall risk ratings 2015 – 2017



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1.0 Introduction to the Inspection Process

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

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

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

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

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

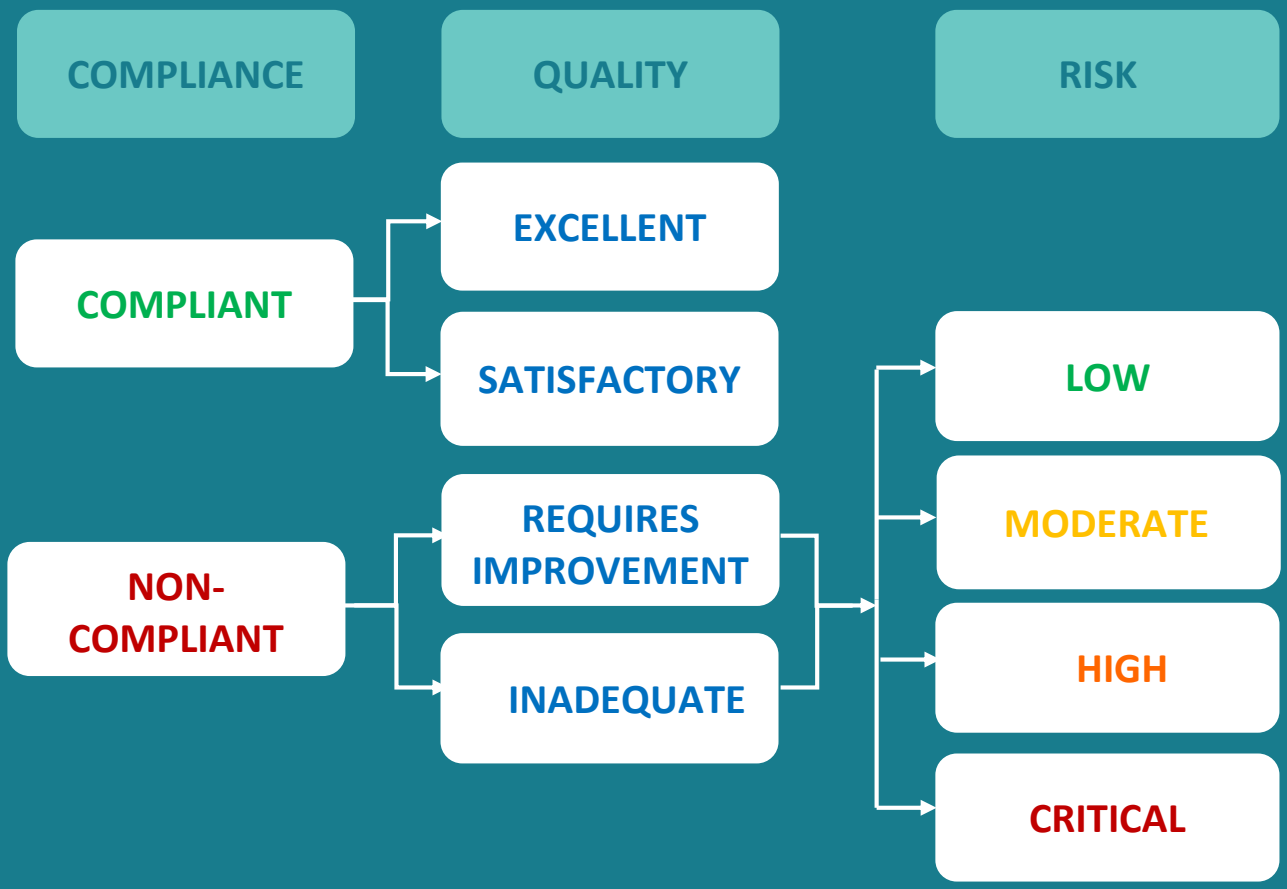
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

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

COMPLIANCE, QUALITY AND RISK RATINGS

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



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

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

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

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

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

Safety in the approved centre

There was a comprehensive written policy in relation to risk and incident management processes. Relevant staff were trained in the identification, assessment, management of risk. The clinical departmental heads other than nursing could not verify that they had health and safety training. Clinical staff were trained in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. There was a written safety statement in place dated January 2016 in relation to health and safety. A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. Food safety audits were periodically conducted and hygiene was maintained to support food safety requirements. Ligature points were minimised. Ordering, prescribing, storage and administration of medication was excellent. Fourteen staff had a post-graduate qualification in Child and Adolescent Mental Health. Not all health care staff were trained in the following: fire safety, Basic Life Support, management of violence and the Mental Health Act 2001.

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

Appropriate care and treatment of residents

A Healthy Bodies-Healthy Minds group had commenced for residents with a dietician and qualified physical education teacher providing input. Each resident had an individual care plan (ICP), which was developed by the multi-disciplinary team, following a comprehensive assessment. ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. There was a wide range of evidence based therapeutic services and programmes provide for residents and outlined in their ICPs. Adequate resources and facilities were available to provide therapeutic services and programmes. Programmes and services included input from occupational therapy, social work, psychology, speech and language therapy, the dietician, and nursing and medical staff. Child residents were assessed regarding their individual educational requirements and provided with education appropriate to their individual needs and age on admission. Residents' general health needs were monitored

and assessed as indicated by their specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. Clinical files reviewed demonstrated that residents' records were secure, up to date and maintained in good order. Seclusion was compliant with the Rules Governing the Use of Seclusion. Physical restraint was compliant with the code of practice except for the filing of documentation. The approved centre was compliant with the code of practice on the admission of children.

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

Respect for residents' privacy and dignity

All residents' clothing was clean and appropriate to the residents' needs. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them and residents were supported to manage their own property. Resident consent was sought and documented in all of the search episodes reviewed. The resident search policy and procedure was communicated to all residents. There was a minimum of two clinical staff in attendance at all times when searches were being conducted. Searches were implemented with due regard to the residents' dignity, privacy and gender. The general demeanour of staff and the way in which staff addressed and communicated with residents was respectful. All sleeping accommodation was in single, en suite rooms, and there was a sufficient number of toilets and showers for residents. Clinical rooms, interview rooms, and family therapy rooms all provided adequate privacy to residents. There were clear signs in prominent positions where CCTV cameras were located. A resident was monitored solely for the purpose of ensuring his/her health, safety, and welfare. Cameras were incapable of recording or storing a resident's image in any format, and they did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.

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

Responsiveness to residents' needs

Residents were provided with a variety of wholesome, nutritious, and varied food choices. Residents said that they enjoyed the food and that they felt there was a good choice overall. The approved centre provided excellent access to recreational activities appropriate to the resident group profile, on weekdays and during the weekend. The care and services provided within the approved centre were respectful of the residents' religious beliefs and values. Visiting times were appropriate, reasonable, and flexible. A dedicated visitor rooms were available where residents could meet visitors in private. A family accommodation suite with three rooms was also available if parents and siblings wished to stay. Residents could use mail, fax, e-mail, and Internet but were not allowed mobile phones as per the approved centre's policy. They could only use their mobile phones under supervision of their parents. Linn Dara provided information to young people and

their families in both written and electronic formats. The Linn Dara web page provided clear, comprehensive, and user-friendly information on the services. Residents were given written information on their diagnosis and medication. All information was specifically aimed at young people. The approved centre was kept in a good state of repair externally and internally and was clean. There was an excellent complaints procedure in place that was well advertised to residents.

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

Governance of the approved centre

Linn Dara inpatient CAMHS unit came under the CHO 7 Area management team governance. A local CAMHS management team was in place. The Linn Dara clinical director was a member of both of these management teams. Membership of the local management team comprised heads of clinical disciplines and senior managers. The Quality Safety Executive Committee met monthly. There was an Operational Committee for Linn Dara, which consisted of the clinical director, the assistant director of nursing, the business manager, and a rotating health and social care professionals heads of discipline representative. An appropriately qualified staff member was on duty at all times. The operating policies and procedures required by the regulations were reviewed within three years.

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

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A parenting group had commenced in January 2017.
2. Linn Dara admitted residents seven days per week and provided an emergency admission service.
3. The Linn Dara website had been updated to enable children and their families access information about the service.
4. “Hello My Name Is” new staff identification badges were in use.
5. A nutritional screening tool had been developed for use with young persons.
6. Linn Dara was the pilot site for the Best Practice Guidance toolkit in conjunction with the HSE’s Quality Service User Safety and National Mental Health Division.
7. Linn Dara was in the process of building capacity in its mental health intellectual disability and its eating disorder teams and services.
8. An equine project for residents had been introduced.
9. The Paediatric Early Warning System (PEWS) was used in Linn Dara. It was part of the National Clinical Programme for Paediatrics and Neonatology and aimed at improving the quality and safety of paediatric in-patient care.
10. A Linn Dara safety management process flow chart had been developed to provide staff with a clear overview of the process in CHO 7.
11. A Healthy Bodies-Healthy Minds group had commenced for residents. A dietician and qualified physical education teacher provided input.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Linn Dara Child and Adolescent Mental Health Services (CAMHS) in-patient unit moved into its current, purpose-built premises in December 2015. The building, which won the Best Universal Design Award 2016 at the Royal Institute of Architects Ireland 2016, was located on the Cherry Orchard campus in Palmerstown, Dublin 20.

Linn Dara consisted of two 11-bed units, Hazel and Rowan, and a 2-bed intensive care area, Oak. It provided treatment for children up 18 years of age. Each child had their own en suite bedroom. Integral to the unit was a six-room school, which included an art and crafts room and a home economics kitchen. There was a sports hall, gymnasium, and outdoor basketball court plus internal courtyards, which were landscaped and suitable for outdoor recreation. The unit had a three-bedroom family apartment to facilitate families staying over when their child was admitted. The approved centre was attractively decorated and furnished with bright and age-appropriate furniture and artwork. There was a nice café room.

The majority of admissions to Linn Dara in 2016 were from the CHO Dublin Mid-Leinster areas 6, 7, and 8: 61% were admitted from home, just under 16% were admitted from a paediatric medical unit, and 6% were transferred from an adult approved centre. In relation to admissions, 25% took place on the same day that the referral was received, 20% were within two days of the receipt of referral, and 14% were within six days of referral. Overall, 61% of admissions were within six days of referral. The average length of stay was 62 days; however, over half of all children were discharged within three months and just under one-fifth of children were discharged within two to four weeks. All except three admissions in 2016 had been voluntary. Care and treatment was provided by three consultant psychiatrists, 2.1 whole-time equivalent (WTE), and multi-disciplinary team members such as nursing, psychology, occupational therapy, social work, dietetics, and speech and language therapy.

The resident profile on the first day of inspection was:

Resident Profile	
Total number of residents	**23**
Number of detained patients	0
Number of Wards of Court	0
Number of children	23
Number of residents in the approved centre for more than 6 months	3

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

Linn Dara inpatient CAMHS unit was a constituent of CHO 7 Area and came under the CHO 7 Area management team governance. A local CAMHS management team was in place, which generally convened a week before the monthly area management team to ensure timely communication. The Linn Dara clinical director was a member of both of these management teams. Membership of the local management team comprised heads of clinical disciplines and senior managers. The minutes of these meetings were made available to the inspection team. The Quality Safety Executive Committee also met monthly. There was a weekly Operational Committee for Linn Dara, which consisted of the clinical director, the assistant director of nursing, the business manager, and a rotating health and social care professionals heads of discipline representative. A review of the minutes provided for the various governance meetings and interviews with senior staff indicated clear structures and processes, roles and responsibilities, and transparent and timely management and planning of services. Each of the committees dovetailed in scope and presented a picture of a cohesive service. An annual strategic planning day had been held for the Linn Dara service.

5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 30 – 31 August and 1 September 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

Regulation/Rule/Act/Code	2017 Inspection Findings
Regulation 15: Individual Care Plan	Compliant
Regulation 18: Transfer of Residents	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Compliant
Regulation 25: Use of Closed Circuit Television	Compliant
Regulation 26: Staffing	Non-Compliant
Regulation 31: Complaints Procedures	Compliant
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Compliant

5.2 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2016 and 2015:

Regulation/Rule/Act/Code	2015 Compliance	2016 Compliance	2017 Compliance
Regulation 26: Staffing	✓	✗	✗
Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	✓	✓	✗
Code of Practice on the Use of Physical Restraint in Approved Centres	✓	✓	✗

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

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection.

Regulation
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 13: Searches
Regulation 16: Therapeutic Services and Programmes
Regulation 17: Children's Education
Regulation 18: Transfer of Residents
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 22: Premises
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 31: Complaints Procedures

6.0 Service-user Experience

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

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

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.

There is no advocacy service available for residents in any HSE-owned Child and Adolescent Mental Health Service (CAMHS) approved centre in Ireland.

Fourteen young persons met with the inspection team and seven also completed a written feedback form on their experience in Linn Dara. The residents commented positively about the welcoming and reassuring process for admission screening, being shown around the unit and information provided before admission. Also, that staff were very attentive and did not leave a resident on their own during their initial settling in period. Each of the residents knew who their key worker was and were knowledgeable about their individual care plan (ICP). Residents said that they met with their key worker weekly and found this useful and they would like to have more frequent access and time to read their ICPs. Staff were said to be approachable and supportive. Meals were said to be good and that there was enough choice and healthy options. Some residents expressed a wish for more pizzas and spaghetti bolognese and for takeaway meals at the weekend specifically "spice-bags". The approved centre subsequently advised that pizza and pasta were now on the menu.

The residents knew how to make a complaint but thought the comments box could be more prominently displayed. Outdoor recreation and gym time was valued by the residents but staff shortages often affected staff availability to accompany residents to the gym and reduced access. Residents enjoyed the fortnightly community outings, such as the cinema, going for walks in the Phoenix Park and to cafes and would have liked to go out more. The weekends were said to be boring. The residents found school helpful and commented on the good facilities and individual support provided, but said that regrettably home economics was no longer provided as a subject. Residents were dissatisfied with the selection of television channels available in Linn Dara and would have liked a music channel and a larger selection of console games.

7.0 Interviews with Heads of Discipline

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

- The Clinical Director
- The Assistant Director of Nursing
- The Acting Assistant Director of Nursing
- The Business Manager
- The Occupational Therapy Manager
- The Principal Psychologist
- The Social Work Manager (Temporary)
- The Speech and Language Therapist (Temporary)

All clinical heads of discipline (HODs) made themselves available to speak with the inspectors and each provided a clear overview of the governance within their respective departments.

Heads of discipline were based on the Linn Dara, Cherry Orchard, campus, allowing them to fulfil their management role on-site. Defined lines of responsibility were evident in each department. Consequently, staff supervision was facilitated within the departments and regular meetings were scheduled with staff to ensure that they were adequately supported. All heads of discipline identified strategic aims for their teams and discussed potential operational risks with their departments. Three managers cited staffing as a risk and said 32% of nursing posts in the approved centre were vacant and there was a high rate of agency staff use.

There was an established culture of supervision and departmental performance data was collected and used to support quality improvement. Three HODs had completed postgraduate training in quality improvement. Linn Dara had engaged with the HSE's Performance and Development Division to review and strategically plan their service. Building capacity, team building and developing core competencies for CAMHS staff were service priorities in 2017. Linn Dara had established a parents' group in 2016 and this provided service user feedback to inform service improvements.

8.0 Feedback Meeting

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

- Clinical Director/Executive Clinical Director
- Clinical Nurse Manager 1 (Rowan Unit)
- Clinical Nurse Manager 2 (Hazel Unit)
- Consultant Psychiatrist
- Director of Nursing
- Occupational Therapy Manager
- Principal Linn Dara School
- Principal Psychologist
- Principal Social Worker
- Registered Proprietor Nominee
- Senior Dietician

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.

9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a policy dated January 2016 on the identification of residents. The policy included the requirements of the *Judgement Support Framework,* with the exception of the required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.

Training and Education: Relevant staff had signed a document indicating that they had read and understood the policy on the identification of residents. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit was undertaken to ensure there were appropriate resident identifiers on clinical files. Audit results showed 100% compliance with the regulation. A documented analysis had been completed to identify opportunities for improving resident identification processes.

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

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

The approved centre used photographs and the personal identification number of each resident as identifiers. Where the resident did not consent to have their photograph taken, the resident's name or date of birth, in addition to personal identification number, was used. There was an alert system in place for same-and similar-name residents.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy on food and nutrition dated January 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a document indicating that they read and understood the policy on food and nutrition. Relevant staff interviewed were able to articulate the processes relating to food and nutrition, as outlined in the policy.

Monitoring: A systematic review of menu plans was conducted monthly by the dietician. The review ensured residents were provided with wholesome and nutritious food suitable to their needs. A documented analysis was completed to enhance the food and nutrition processes, with an audit completed on food and nutrition twice a year.

Evidence of Implementation: Meals were prepared in the main kitchen in Cherry Orchard Hospital and delivered daily in Thermos insulated boxes to the Linn Dara Child and Adolescent Mental Health Services (CAMHS) unit. The approved centre's menus had been reviewed and approved by a dietician to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome, nutritious, and varied food choices within the approved centre's menus. Residents had a choice of four options at lunchtime and two options at teatime. Supper was offered by staff each evening. Residents said that they enjoyed the food and that they felt there was a good choice overall.

Both hot and cold drinks were offered regularly to residents. Residents had sufficient supplies of safe and fresh drinking water provided by staff at regular intervals. A water dispenser was not available on each unit due to the assessed risk of slips and falls on a wet floor surface.

The dietician advised that an evidence-based, validated nutrition assessment tool for CAMHS did not currently exist. The dietician was using a nutritional assessment developed collaboratively with input from other dieticians at the time of the inspection.

All residents were nutritionally screened at admission. Nutritional and dietary needs were assessed, where necessary, and addressed and documented in the resident's individual care plan. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietician or nutritionist.

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 **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place on food safety dated January 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed indicating that they had read and understood the policy on food safety. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All catering management and staff had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). The training was documented.

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

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

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

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, dated January 2016, in relation to residents' clothing. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a document indicating that they had read and understood the policy on residents' clothing. Relevant staff interviewed were able to articulate the processes on 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. There was a petty cash fund available to buy emergency clothing. All admissions were planned.

Evidence of Implementation: Emergency clothing could potentially be purchased on the day of admission when resident size was known. No resident was observed in night garments during daytime hours over the course of the inspection. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans.

Residents were provided with appropriate emergency personal clothing that took into account the residents' preferences, dignity, bodily integrity, and religious and cultural practices. All residents' clothing was clean and appropriate to the residents' needs. Residents were encouraged to have their family take home laundry. If necessary, staff could do residents' laundry in the approved centre.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated January 2016 in relation to residents' personal property and possessions. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Personal property logs were maintained and monitored by nursing staff and key workers in the approved centre. An annual audit was completed on personal property. A documented analysis was completed to identify opportunities to improve the processes for managing residents' personal property and possessions.

Evidence of Implementation: A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each resident's personal property and possessions, and a property log book was maintained on each unit. Resident clinical files inspected showed property lists were completed and signed. The property checklist was kept separately to each resident's individual care plan. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **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 dated January 2016 in relation to the provision of recreational activities. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a document indicating that they had read and understood the policy on recreational activities. Relevant staff were able to articulate the processes for residents' recreational activities, as set out in the policy.

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile, on weekdays and during the weekend. A weekly schedule of recreational activities was available to residents and displayed on the whiteboard on each unit of the approved centre. Residents had access to a wide range of appropriate recreational activities such as TV, DVDs, board games, hockey, basketball, baking, and arts and crafts. Each unit had a games room with table tennis and Fussball. Opportunities were provided for indoor and outdoor exercise and physical activity. Each unit had access to a gym, a sports hall, and an enclosed garden area.

Outings were organised for the weekends but were staff-dependent. Some residents went on home leave at the weekend. Residents communicated that, when they were not on leave, they would like more to do on the weekends. Resident views on recreational activities were taken into account by staff at committee meetings, and efforts were made to incorporate requests from residents in relation to activities. Attendance and participation in recreational activities was documented on an occupational therapy group attendance sheet, which was placed in each resident's clinical file.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a policy dated January 2016 on the facilitation of religious practices. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a document indicating that they had read and understood the policy on religion. Relevant staff interviewed could 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 had been reviewed every three years to ensure that it reflected the identified needs of the residents. This was documented.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable, and there were facilities provided for residents' religious practices. Residents had access to chaplains, and they were facilitated to observe or abstain from religious practice in accordance with their wishes. The care and services provided within the approved centre were respectful of the residents' religious beliefs and values.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written operational policy dated January 2016 in relation to visits. It included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed to indicate that they had read and understood the policy on visits. Relevant staff interviewed could articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed by nursing staff on an ongoing basis. A documented audit and analysis of the processes relating to visits was completed.

Evidence of Implementation: Visiting times were publicly displayed at both the reception area and within each individual unit. Visiting times were appropriate, reasonable, and flexible. A dedicated visitor room was available on both units where residents could meet visitors in private, unless there was an identified risk to the resident or to others, or a health and safety risk. A family accommodation suite with three rooms was also available if parents and siblings wished to stay.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. All visitors signed a visitors' book at the main reception. Visitors were also given a visitors' badge to wear upon their arrival. Children could visit, if accompanied by an adult and supervised at all times. The visiting rooms, spaces, and facilities available were suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated January 2016, and associated procedures in relation to communication. The policy included *Judgement Support Framework* criteria, with the exception of specifying the policy on individual risk assessment in relation to limiting resident communication activities.

Training and Education: Relevant staff had signed a document indicating that they had read and understood the policy on communication. Staff were trained on the communication policy during induction. 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 daily in the residents' progress notes and at the weekly multi-disciplinary team meeting. Analysis was undertaken to identify opportunities to improve the communication process by the approved centre.

Evidence of Implementation: The approved centre completed individual risk assessments, when necessary, in relation to any risks associated with residents' external communications. These were documented in each resident's individual care plan and within Functional Analysis of Care Environments, or FACE, risk assessment documentation.

Residents had access to communication devices, unless otherwise risk assessed with due regard to the residents' wellbeing, safety and health. Residents could use mail, fax, e-mail, and Internet. Residents were not allowed mobile phones as per the approved centre's policy. They could use their mobile phones under supervision of their parents to check text messages, and phone calls.

Relevant senior staff only examined incoming and outgoing resident communication if there was cause to believe the resident or others may be harmed.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy, dated January 2016, available in relation to the implementation of resident searches by the approved centre. The policy addressed the complete requirements of the *Judgement Support Framework*, including:

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

Training and Education: Relevant staff had signed a document to indicating that they had read and understood the policy on searches. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

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

Evidence of Implementation: Five clinical files and search forms were inspected. Risk had been assessed prior to the search of the residents and their belongings in each search. Resident consent was sought and documented in all of the search episodes reviewed. General written consent was sought for routine

environmental searches when required, although there had been no environmental searches in the approved centre since the last inspection.

The resident search policy and procedure was communicated to all residents. Residents were informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when searches were being conducted.

Searches were implemented with due regard to the residents' dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched, in all five searches. Search forms were completed for all of the five clinical files reviewed.

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

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, which was last reviewed in 2016, in relation to care of the dying. The policy included requirements of the *Judgement Support Framework,* with the exception of the following:

- The process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere (e.g. for general health care services).

Training and Education: Relevant staff had signed a document indicating that they had read and understood the policy and protocols on care of the dying. Relevant staff interviewed could 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, Linn Dara was only assessed under the two pillars of processes and training and education.

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 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

INSPECTION FINDINGS

Processes: There was a policy on individual care plans (ICPs) dated January 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: All clinical staff had signed a document indicating that they had read and understood the policy on individual care planning. All clinical staff interviewed could articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members were trained in individual care planning during their induction training.

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

Evidence of Implementation: Each resident had an ICP, and 12 of these were inspected. Each resident had been assessed at admission by the admitting clinician and an initial care plan was established. The ICPs were then developed by the MDT, following a comprehensive assessment, within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

In all 12 ICPs reviewed, the ICP was a composite set of documentation that included goals, treatment, and the care and resources required to meet assessed needs. Details of reviews were included. The documents were stored within residents' clinical files and were identifiable and uninterrupted. The documents were not amalgamated with progress notes. In each ICP inspected, the ICP was reviewed weekly by the MDT in consultation with the resident. The ICPS were updated following review as indicated by the resident's changing needs, condition, circumstances, and goals; this was documented, and the ICPs of child residents included their educational requirements.

Of the 12 ICPs reviewed, only 10 indicated that residents were offered a copy of their ICPs.

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

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to therapeutic services and programmes dated January 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: All clinical staff had signed a document indicating that they had read and understood the policy on therapeutic services and programmes. All clinical staff interviewed were able to articulate the processes for therapeutic activities and programmes, as set out in the policy.

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

Evidence of Implementation: A list of therapeutic services and programmes was provided to residents within the approved centre via a weekly schedule of activities. The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, and met the needs of the residents, as documented in their individual care plans (ICPs).

The therapeutic services and programmes were also directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. These included groups on problem solving, decider skills, psychosis, acceptance commitment therapy, process, Dialectic Behavioural Therapy, self-esteem, equestrian, medication, and carers. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location or on-site.

Adequate resources and facilities were available to provide therapeutic services and programmes. There was an occupational therapy suite, multi-sensory room, and various group therapy rooms. Programmes and services included input from occupational therapy, social work, psychology, speech and language therapy, the dietician, and nursing and medical staff. Therapeutic services and programmes were provided in a separate dedicated room, containing facilities and space for individual and group therapies, either in the occupational therapy suite or on the units. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within the residents' ICPs or 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 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: There was a written policy dated January 2016 in relation to the provision of education to child residents in the approved centre. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Individual providers of educational services on behalf of the approved centre were appropriately qualified in line with their role and responsibilities. All of the teachers were qualified secondary school teachers. One teacher was dually qualified as both a part-time primary school teacher, and a secondary school teacher. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs. Seven teachers were trained in special education. All staff had completed Children First training.

Monitoring: A daily record was kept of attendance at internal and external educational services on the Aladdin system, which was an electronic role system.

Evidence of Implementation: Child residents were assessed regarding their individual educational requirements with consideration of their individual needs and age on admission. An individual educational plan was then developed for each resident. This included children who may have left school prior to admission. The school provided tuition for the Junior Certification, Leaving Certificate, Leaving Certificate Applied, and Leaving Certificate Vocational Programme.

Sufficient personnel and resources were available for the provision of education to child residents within the approved centre. The teacher to pupil ratio was 1:6. 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 school principal attended the multi-disciplinary team meeting weekly.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated January 2016 in relation to the transfer of residents. The policy detailed the requirements of the *Judgement Support Framework,* with the exception of the process for ensuring resident privacy and confidentiality during a transfer, specifically in relation to the transfer of personal information.

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

Monitoring: A log of transfers was maintained. Each transfer record was systematically reviewed to ensure all relevant information was provided to the receiving facility. Audits and analysis of transfers had been completed.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre to A&E was inspected. This was a pre-planned transfer and not an emergency transfer. Documented consent of the resident to transfer was available.

Full and complete written information regarding the resident was transferred when he/she moved from the approved centre. As this was a pre-planned transfer, this information was sent in advance and, in addition, accompanied the resident upon transfer to a nurse within the emergency department. The social worker accompanied the resident to the emergency department.

Prior to transfer, the resident was assessed, which included an individual risk assessment relating to the transfer and an assessment of the resident's needs. This was documented and forwarded to the receiving facility in the form of a referral letter. The clinical file recorded the documentation released to the receiving facility as part of the transfer, including the letter of referral, a list of current medications, the resident transfer form, and the required medication for the resident during the transfer process.

The receiving facility received a written referral detailing all relevant clinical information. A copy of this was retained in the resident's clinical file. The approved centre completed checks to ensure comprehensive resident records were transferred to the receiving facility.

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

Regulation 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: There were separate written general health and medical emergency policies available. The policies included requirements of the *Judgement Support Framework* with the exception of the following:

- The medical emergency policy did not include the management of emergency response equipment, including the resuscitation trolley and Automated External Defibrillator (AED).
- The general health policy did not reference resident access to a registered medical practitioner or the resource requirements for general health services, including equipment needs.

Training and Education: All clinical staff had signed a document indicating that they had read the policies. All clinical staff interviewed were able to articulate the processes outlined in the medical emergency policy and the general health care policy.

Monitoring: The recording and monitoring of resident take-up of national screening programmes was not applicable in the approved centre due to the resident demographic. A systematic appraisal was undertaken to ensure six-monthly reviews of general health needs took place. A sticker system on the clinical files indicated when the six-monthly reviews were due. Analysis was completed to identify opportunities to improve general health processes. Audit and analysis was completed through the HSE's Best Practice Guidelines in Mental Health Services.

Evidence of Implementation: In relation to responding to medical emergencies, the approved centre had an emergency trolley with a medical bag containing first-line drugs. Staff had access at all times to an AED. The AED was checked daily and first-line drugs were checked weekly. This was recorded and documented. There had been no medical emergency since the previous inspection.

In relation to the provision of general health services, registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents' general health needs were monitored and assessed as indicated by their specific needs, but not less than every six months. Three residents were in the approved centre for a period of over six months and their six-monthly physical examinations were documented.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. All general health referrals were documented as per the residents' needs. Medical interns in the approved centre were responsible for liaising with general health services and the associated correspondence was documented.

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 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: There was a written operational policy and procedures available in relation to the provision of information to residents, last reviewed in 2016. The policy included all of the requirements of the *Judgement Support Framework,* with the exception of advocacy arrangements. However, there were no advocacy services for children in Ireland.

Training and Education: All staff had signed indicating that they had read the policy on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure the information was appropriate and accurate, particularly where information changed, such as information on medication and housekeeping practices. Audit and analysis had been completed to identify opportunities to improve the processes for providing information to residents. This was documented.

Evidence of Implementation*:* Linn Dara provided information to young people and their families in both written and electronic formats. The Linn Dara web page provided clear, comprehensive, and user-friendly information on the services, care, and treatment, the multi-disciplinary team, voluntary bodies, and useful resources. The in-patient booklet also outlined the procedures for making complaints. Both contained photographs of the in-patient unit and provided contact details.

Residents were provided with written and verbal information regarding their diagnosis, unless the responsible psychiatrist deemed the provision of such information as potentially 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 relevant clinical file.

Residents were given written information on their diagnosis and medication. A large display stand at the main reception contained information on a wide range of issues affecting young persons' mental health, on diagnoses, and on relevant support agencies. All information was specifically aimed at young people and the fact sheets provided were evidence-based. The "Headspace Toolkit" was available to all residents.

Residents were given a medication information sheet as well as verbal information in a format that was appropriate to their needs. Information could be provided in other languages if required. Full support was given by staff to assist the resident in understanding the information. The content of medication information sheets included indications for use of all medications to be administered to the resident, including any possible side-effects.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a policy dated January 2016 available in relation to privacy. The policy included the full requirements of the *Judgement Support Framework.*

Training and Education: All staff had read and understood the policy relating to resident privacy. This was documented. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: An annual review of the implementation of the policy had taken place and this was documented. Analysis was completed to identify opportunities to improve the processes relating to residents' privacy and dignity.

Evidence of Implementation: The general demeanour of staff and the way in which staff addressed and communicated with residents was respectful. Residents were observed to be called by their preferred names. Staff were discreet when discussing the residents' condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had override function.

Rooms were not overlooked by public areas, observation panels on doors were fitted with opaque glass, and noticeboards did not display any identifiable resident information. Residents were facilitated to make and receive private phone calls. Each unit had a telephone room located beside the nursing office for this purpose. The resident could choose to open or close the window blinds.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Excellent**

(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: There was a policy dated January 2016 available in relation to premises. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: There was documented evidence that a hygiene audit had been completed. A ligature audit was completed and documented. There was documented analysis that identified opportunities for improving the premises.

Evidence of Implementation: All resident bedrooms were appropriately sized to address the resident needs. All sleeping accommodation was in single, en suite rooms, and there was a sufficient number of toilets and showers for residents. Accommodation for each resident assured comfort and privacy and met assessed needs. Clinical rooms, interview rooms, and family therapy rooms all provided adequate privacy to residents.

There were appropriately sized communal rooms in the approved centre. The Hazel and Rowan Units each had two sitting rooms, both with television, an arts and crafts room, an activities of daily living (ADL) kitchen, a sensory room, a sports and recreation room, and several areas with window seats in alcoves overlooking an outdoor space.

There was suitable and sufficient heating with a minimum temperature of 18 °C (65°F) in bedroom areas and 21°C (70°F) in day areas and in bedrooms where residents sit during the day. Each resident had a heating control in their bedroom, whereby they could raise or lower the temperature by 3 degrees.

Rooms were ventilated. All rooms overlooked an outdoor space and windows could be opened. The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs and all rooms had a large print sign on the wall at the entrance.

Residents were provided with adequate spaces to move about, including outdoor spaces. There was a large outdoor garden space for both Rowan and Hazel units. These were landscaped with all-weather, rubberised pathways and there were sufficient spaces for ball games. There was also an outdoor basketball court. The Oak Unit had a smaller garden space, which could be divided into two areas if required.

Hazards, including large open spaces, steps and stairs, slippery floor, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised. The approved centre was kept in a good state of repair externally and internally. The operational management team undertook weekly walkabouts to identify any issues. Maintenance issues had become less frequent at the time of the inspection as the building snag list had been addressed by developers.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained for each. No resident of the approved centre had required assistive equipment or technology since the building opened.

The approved centre was clean, hygienic, and free from offensive odours.

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 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 dated 2016 on the ordering, prescribing, storing and administration of medicines. The policy included the requirements of the *Judgement Support Framework.* The section of the policy outlining the procedures for refusal of medication under section 61 of the Mental health Act 2001 still used the word "unwilling". This word was no longer in the legislation which means the policy had not been updated to reflect the change in legislation.

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

Monitoring: Ongoing and quarterly audits had been conducted on Medication Prescription and Administration Records (MPARs). Incident reports were recorded for medication errors and near misses. Analysis had been completed to identify opportunities for improvement of medication management processes.

Evidence of Implementation: Each resident had an MPAR, and 20 of these were inspected. Each MPAR evidenced a record of appropriate medication management practices, including a record of resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included on each MPAR. A record was kept when medication was refused by or withheld from the resident.

All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members prior to administration. The use of appropriate resident identifiers and good hand-hygiene practices and cross-infection control techniques were observed during the administration of medication.

Medication arriving from the pharmacist was verified against the order by two staff members to ensure it was correct and was accompanied by appropriate directions for use. Medication was stored in the appropriate environment, as advised by the pharmacist. Medication was stored in a drugs trolley in a locked room. Scheduled controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. An inventory of medication was kept by the approved centre and unused or out-of-date medications were collected monthly by the pharmacist and sent to Connolly Hospital 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

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: There was a written safety statement in place dated January 2016 in relation to health and safety. It included 12 of the 13 requirements of the *Judgement Support Framework*. It did not reference falls prevention initiatives.

Training and Education: All staff had signed indicating that they had read and understood the health and safety policy. All staff interviewed could articulate the processes relating to health and safety, as set out in the policy.

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

Evidence of Implementation: This regulation was assessed against the approved centre's written policies and procedures only.

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 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a clear written operational policy dated April 2015 in place in regard to the use of closed circuit television (CCTV). The policy included requirements of the *Judgement Support Framework,* including details of the purpose and function of using CCTV for observing residents in the approved centre. The policy did not address the maintenance of CCTV cameras by the approved centre.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on CCTV. Relevant staff could articulate the processes on the use of CCTV, as set out in the policy.

Monitoring: The quality of CCTV images was checked regularly to ensure the equipment was operating appropriately. This was documented. Analysis was completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located: at exits and entrances and in the seclusion room. A resident was monitored solely for the purpose of ensuring his/her health, safety, and welfare. A seclusion room in the Rowan Unit had CCTV. The monitors were in working order and were only viewed by clinical staff in the nursing office.

The Mental Health Commission had been informed about the approved centre's use of CCTV. The cameras were incapable of recording or storing a resident's image in any format, and they did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. Monitors for seclusion were in the nursing station and were only viewed by clinical staff.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a policy dated January 2016 in relation to the approved centre's staffing requirements. There was a separate staff training-related policy. The policies, combined, met the requirements of the *Judgement Support Framework* with the exception of the following:

- The staffing policy did not include the process for transferring responsibility from one staff member to another.
- The staff training policy did not reference the required qualifications of training personnel and the evaluation of training programmes.

Training and Education: All relevant staff had signed a document indicating that they had read and understood the staffing policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

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

Evidence of Implementation: There was an organisational chart in place which identified the leadership and management structure and the lines of authority and accountability of the approved centre's staff. The number and skill mix of staffing were sufficient to meet resident needs.

Staff were recruited and selected in accordance with the approved centre's policy and procedures for recruitment, selection, and appointment. Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. An appropriately qualified staff member was on duty at all times. This was documented.

A written staffing plan was available. Staff were trained in accordance with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan, and there was an active training and education programme for staff. Fourteen staff had a post-graduate qualification in Child and Adolescent Mental Health. Four staff had a post graduate training in cognitive behaviour therapy.

Not all health care staff were trained in the following:

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

All staff training was documented and staff training logs were maintained. All staff in Linn Dara CAMHS unit were trained in Children First.

The Mental Health Act 2001 and Mental Health Commission rules and codes and all other Mental Health Commission documentation and guidance were made available to staff throughout the approved centre.

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

Ward or Unit	Staff Grade	Day	Night
Rowan Unit	CNM HCA CP	CNM1 X 1 CNM2 X 1 Staff Nurse X 3	Staff Nurse X 2 HCA/Social Care Worker X 1
Ward or Unit	**Staff Grade**	**Day**	**Night**
Hazel Unit	CNM HCA CP	CNM1 X 1 CNM2 X 1 Staff Nurse X 3	Staff Nurse X 2 HCA/Social Care Worker X 1

Clinical Nurse Manager (CNM), Health Care Assistant (HCA). The health care assistant - social care worker- works between Hazel and Rowan at different stages of the night. In relation to Oak Unit, to function as an intensive Care area for Rowan and Hazel wards the staffing depends on the clinical needs of residents.

The approved centre was non-compliant with 26(4) of this regulation because not all health care professionals were up to date with the required training in the following:

- **Fire safety.**
- **Basic Life Support.**

- **The management of violence and aggression {e.g. Therapeutic Crisis Intervention (TCI)/Professional Management of Aggression and Violence (PMAV)}.**
- **The Mental Health Act 2001**.

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated January 2016 in relation to the maintenance of records. The policy included requirements of the *Judgement Support Framework,* with the exception of the following:

- Access the residents' records.
- The process for making a retrospective entry in residents' records.

Training and Education: All clinical staff and other relevant staff had signed indicating that they had read and understood the policy relating to the maintenance of records. All clinical staff and other relevant staff interviewed could articulate the processes, as set out in the policy. All clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process, insofar as was practicable. Analysis was completed to identify opportunities to improve the maintenance of records processes through the HSE's Best Practice Guidelines in Mental Health Services.

Evidence of Implementation: All 20 clinical files reviewed demonstrated that residents' records were secure, up to date, and maintained in good order, with no loose pages, and they met the legislative requirements. Records were physically stored together in a locked trolley.

Records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented and up-to-date register of residents. It was available to the Mental Health Commission on inspection. The register included all of the information specified in Schedule 1 to the Mental Health Act 2001.

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 policy dated January 2016 in relation to the development and review of operating policies and procedures. The policy included requirements of the *Judgement Support Framework,* with the exception of the process for making obsolete and retaining previous versions of operating policies and procedures.

Training and Education: There was documented evidence that relevant staff had signed indicating that they had read and understood the policy on developing and reviewing operating policies. Relevant staff were trained on approved operational policies and procedures. Relevant staff could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis was completed to identify opportunities to improve the processes for 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. They were appropriately approved and incorporated relevant legislation, evidence-based best practice, and clinical guidelines.

The operating policies and procedures required by the regulations were reviewed within three years. Where generic policies (e.g. complaints and staffing) were used, the approved centre had a written statement to this effect (adopting the generic policy), which was reviewed at least every three years. All generic policies used were appropriate to the approved centre and the resident group profile.

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 30: Mental Health Tribunals

NOT APPLICABLE

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

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

INSPECTION FINDINGS

As this was a Child and Adolescent Mental Health Service unit, Mental Health Tribunals were not applicable.

Regulation 31: Complaints Procedure

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 dated March 2017 in relation to the management of complaints. It included all of the requirements of the *Judgement Support Framework*. The process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in, or on behalf of, the approved centre, was detailed in the policy.

Training and Education: Relevant staff were trained in the complaints management process during their induction. All staff had signed a document indicating that they had read and understood the policy. All staff interviewed could articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: There was documented evidence that an audit of the complaints log and related records was completed. The audit findings were documented and acted upon. Auditing of complaints had been completed using the HSE's Best Practice Guidelines in Mental Health Services. Complaints data was analysed, discussed, and considered by senior management, with required actions identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The overall complaints officer was the area director of nursing, and this was detailed in a notice in each unit. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. Residents were provided with the complaints policy and procedure at admission or soon thereafter. The information was provided within the resident information booklet.

The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint can be made.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Receipt of complaints was acknowledged within five days. 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.

Patient complaints and feedback were welcomed. This was evident in the community meeting log and the minor complaints log. All complaints (that were not minor complaints) were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: There was a comprehensive written policy dated January 2016 available in relation to risk and incident management processes. The policy included all of the requirements of the *Judgement Support Framework,* including the following:

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

Training and Education: Relevant staff were trained in the identification, assessment, and management of risk. Staff were trained in health and safety risk management. The clinical departmental heads other than nursing could not verify that they had health and safety training.

Clinical staff were trained in individual risk management processes. Management staff were trained in organisational risk management. All staff had signed a log to indicate that they had read and understood the risk management policy. All staff interviewed could articulate the risk management processes, as set out in the policy. All training was documented. All staff were not trained in incident reporting and documentation. While all staff were offered National Incident Management System (NIMS) training in 2016 and two training sessions were provided on-site, the training records for health and social care professionals (HSCPs) showed one manager had attended NIMS training.

Monitoring: The risk register was audited at least quarterly to determine compliance with the approved centre's risk management policy. All incidents in the approved centre were recorded and risk-rated.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable.

Clinical risks were identified, assessed, treated, reported, and monitored. Clinical risks were documented in the risk register as appropriate. The Functional Assessment of Care Environment, Children's Global Assessment Scale, and Health of the Nation Outcomes Scales for Children and Adolescents were used to assess risk. Health and safety risks were identified, assessed, treated, reported, and monitored by the approved centre in accordance with relevant legislation. Health and safety risks were documented within the risk register, as appropriate, and health and safety issues in the approved centre were dealt with by nursing staff.

Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported and monitored by the approved centre. Corporate risks were documented in the risk register. The approved centre implemented a plan to reduce risks to residents while any works to the premises are ongoing.

Individual risk assessments were completed prior to and during episodes of resident seclusion and physical restraint, at admission to identify individual risk factors, prior to transfer and discharge, and in conjunction with medication requirements or administration.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format via NIMS.

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

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had up-to-date insurance cover. The insurance covered public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

10.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

NOT APPLICABLE

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. There was a separate written policy and procedures for training staff in relation to seclusion. The policies included all of the relevant guidance criteria of this rule pursuant to Section 69 of the Mental Health Act 2001.

Training and Education: The approved centre maintained a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy. A record of attendance at training was maintained, and 32 staff were trained in the use of seclusion.

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

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings which did not endanger resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file.

CCTV was evident in the seclusion area and clearly labelled. It was viewed only by nursing staff and the dignity of the resident was not compromised. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

The clinical file of one resident who had been in seclusion on two occasions was inspected. The approved centre complied 100% with the code of practice on the use of seclusion across the two episodes.

In both episodes, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of

seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

The resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident was informed of the ending of seclusion on both occasions.

Both episodes of seclusion were recorded in the resident's clinical file and all uses of seclusion were recorded in the seclusion register. A copy of the seclusion register was in place within the resident's clinical file and available to inspectors.

The approved centre was compliant with this rule.

Section 69: The Use Mechanical Restraint

NOT APPLICABLE

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

INSPECTION FINDINGS

The approved centre did not use mechanical restraint. Therefore, this rule was not applicable.

11.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NOT APPLICABLE

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

As the approved centre did not have any detained patients registered this rule was not applicable.

12.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

Processes: There was a written policy in place dated January 2017, in relation to the use of physical restraint, and it was reviewed annually. There was a separate policy and procedures in relation to staff training on physical restraint, and an additional separate policy on the therapeutic management of aggression and violence. The policies included all of the guidance criteria of this code of practice.

Training and Education: The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy. A record of attendance at training was maintained. Physical restraint was not used to ameliorate staff shortages.

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

Evidence of Implementation: The clinical files of five residents who had been physically restrained were inspected. The approved centre complied with the code of practice on physical restraint across all episodes, with one exception: While all uses of physical restraint were recorded clearly in the clinical practice form, the completed form was not placed in the clinical file in two out of five episodes of physical restraint.

The approved centre was non-compliant with this code of practice because completed clinical practice forms were not included in the clinical files in two cases, (8.3).

Admission of Children

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a policies and protocols in place in relation to the admission of a child, which complied with all elements of section 2.5 of this code of practice. There was a policy requiring each child to be individually risk assessed. Policy and procedures were in place with regard to family liaison, parental consent, and confidentiality.

Training and Education: Staff had received Children First training. The training was documented.

Monitoring: The approved centre had been audited using the Health Service Best Practice Guidelines for Mental Health Services.

Evidence of Implementation: Linn Dara is an in-patient unit for Child and Adolescent Mental Health Services. It met the requirements of this code of practice.

Age-appropriate facilities and a programme of activities appropriate to age and ability were provided. Provisions were in place to ensure the safety of the child. The approved centre had protocols in place to ensure the right of the child to have his/her views heard.

Copies of the Child Care Act 1991, Children Act 2001 and Children First guidelines were available to relevant staff. All staff having contact with the child had undergone Garda vetting through the HSE National Recruitment Service. Consent for treatment was obtained from one or both parents.

The approved centre was compliant with this code of practice.

Notification of Deaths and Incident Reporting

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a risk management policy which covered the notification of deaths and incident reporting to the Mental Health Commission. The policy included all elements of section 4 of this code of practice.

Training and Education: Staff had read and understood the policy on the notification of deaths and incidents. Staff interviewed were able to articulate the policies.

Monitoring: A six-monthly summary report of all incidents occurring in the approved centre was provided to the Mental Health Commission.

Evidence of Implementation: The approved centre was compliant with Article 32 of the regulations. There National Incident Management System was in use. A standardised incident report form was used and made available to inspectors. There had been no deaths in the approved centre since the last inspection.

The approved centre was compliant with this code of practice.

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

NON-COMPLIANT

Risk Rating **LOW**

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

INSPECTION FINDINGS

Processes: There were policies and protocols for staff working with people with intellectual disabilities. The policies reflected person-centred treatment planning and presumption of capacity. Least restrictive interventions, staff roles and responsibilities were detailed in the policy. There was also a policy on the management of problem behaviours. There was no policy in relation to the training of staff in working with people with intellectual disability.

Training and Education: The education and training provided supported the principles and guidance in the code of practice.

Monitoring: The policies were reviewed every three years. The use of restrictive practices was reviewed periodically in accordance with the policies.

Evidence of Implementation: No resident in the approved centre had been diagnosed with an intellectual disability at the time of the inspection.

The approved centre was non-compliant with this regulation because there was no policy on the training of staff in working with people with an intellectual disability, 6.2.

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

NOT APPLICABLE

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

INSPECTION FINDINGS

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

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: There were up-to-date policies on admission, transfer, and discharge in place. The policies included all of the code of practice guidance criteria specific to the three policy types.

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

Monitoring: An audit of the implementation of and adherence to both the admission policy and the discharge policy took place.

Evidence of Implementation:

Admission: The approved centre complied with the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, Regulation 27: Maintenance of Records, and Regulation 32: Risk Management Procedures. The clinical files of six residents were inspected against in relation to the admission process. The admission assessment was comprehensive in each case. All assessments and examinations were documented in the clinical files. Each resident was assigned a key worker.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The files of two residents transferred to another facility to receive specialised treatment were inspected.

In both cases, the registered medical practitioner made the decision to transfer and the decision to transfer was agreed with the receiving facility. A resident assessment, including a risk assessment, was completed. The residents' families were informed of the transfer and consent was obtained from them. A copy of the referral letter was retained in the clinical files of both residents.

Discharge: The clinical files of two residents who had been discharged were reviewed. The decision to discharge was made by a registered medical practitioner in both cases. A discharge plan was in place and documented as part of the residents' individual care plans. Both residents underwent a comprehensive assessment prior to being discharged. A comprehensive discharge summary was sent to the GP and local CAMHS community mental health team within 14 days.

The approved centre was compliant with this code of practice.

Appendix 1 – Corrective and Preventative Actions (CAPAs)

Regulation 26: Staffing

Report reference: Page 50 - 52

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. The approved centre was non-compliant with 26(4) of this regulation because not all health care professionals were up to date with the required training in the following: • Fire safety. • Basic Life Support. • The management of violence and aggression {e.g. Therapeutic Crisis Intervention (TCI)/Professional Management of Aggression and Violence (PMAV)}. • The Mental Health Act 2001.	Reoccurring from 2016. CAPA plan carried over from 2016.	<u>Update on 2016 CAPA Plan (28th July 2017)</u>: Linn Dara staff (all grades) have assimilated into the annual training programme for refreshers programmes over the course of 2017 Commissioned training was pre- arranged for the Month of July for new staff (co incide's with changeover of medical staff and new members of MDT staff)			
		Fire Safety session 13th July 20 staff attended BLS 8 Staff have attended TMVA 12 MDT Staff attended a full TMVA programme in July 2017, 6 Staff have completed refreshers March - July, Remaining staff will assimilate into scheduled TMVA programmes, Oct, Nov & Dec 2017 MHA 2001 – 70% staff have completed MHA elearning programme to date,			
		An Induction programme is scheduled for Week commencing 4th October 2017 to capture new nursing grades, sessions are open to all Linn Dara Staff to attend Content will focus on mandatory training (copy attached)			

[1] Area of non-compliance reoccurring from 2016
[2] Area of non-compliance new in 2017

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
		Preventative Action(s): 1. A coordinated training plan has been developed to ensure that all staff (including Allied Health Staff) in the Approved Centre have up-to-date training and it is recorded as required by section (4). 2. A nominated Head of Discipline will be responsible for maintaining a training log which will be inputted onto a central Training database. Post-Holder(s) responsible: Named Consultant, Designated AHP. CNM III.	1. Ongoing monitoring of the training database by the CNM III in the Approved Centre, Consultant Psychiatrist (Medical Tutor) & nominated AHP Lead. 2. Training will remain a standing item on the Approved Centre Governance Meeting. 3. Monitoring of CAPA's remains a standing item on the Approved Centre Governance Meeting.	The ability to release staff to attend training where there are limited training opportunities before year end is a barrier. Every effort will be made to achieve compliance within these limitations. Training spaces are booked for AHP staff throughout 2017	Q 4 2017

Code of Practice: Use of Physical Restraint

Report reference: Page 73

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
2. Completed clinical practice forms were not included in the clinical files in two cases (8.3)	New	Corrective Action(s): These two clinical practice forms were subsequently placed in the Clinical File Post-Holder(s) responsible: Nurse in Charge A Briefing session with nursing staff was held post the inspection visit			Completed
		Preventative Action(s): As part of the induction programme Oct 2017, a session on MHA inc COP Physical Restraint is scheduled. Post-Holder(s) responsible: ADON	Attendance list at induction Training recorded on training database	Realistic	October 2017

Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

Report reference: Page 76

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
3. There was no policy on the training of staff in working with people with an intellectual disability, 6.2.	New	Corrective Action(s): Section 6.18 Policy No 33 v 1 2016 (Guidance on working with young people with Intellectual Disability) already outlined the arrangements for liaising with ID services for relevant training. This policy has been reviewed and the training section strengthened. Same attached Post-Holder(s) responsible: ADON	Policy amended and circulated. All staff informed of the policy amendment	Achieved	July 2017
		Preventative Action(s): As part of the induction programme Oct 2017, staff have protected time to complete elearning programme Mental health Intellectual disability programme Post-Holder(s) responsible: ADON / Heads of Disciplines	Certificate of completion	Realistic	October 2017