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

ID Number: AC0097

2019 Approved Centre Inspection Report (Mental Health Act 2001)

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

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
10 December 2018

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Brady, Health of Service, Mental Health – CHO7

Inspection Team:
Dr Enda Dooley, MCRN004155, Lead Inspector
Marianne Griffiths
Susan O'Neill

Inspection Date:
22 – 25 October 2019

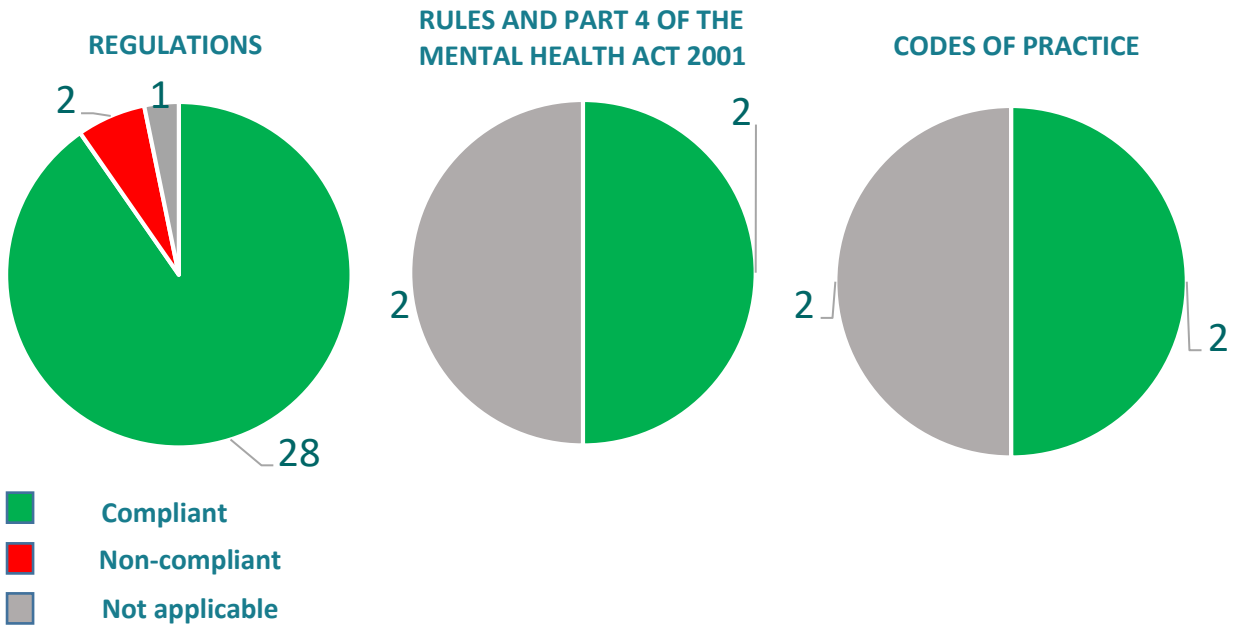
Inspection Type:
Announced Annual Inspection

Previous Inspection Date:
5 – 7 June 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Tuesday 30 June 2020

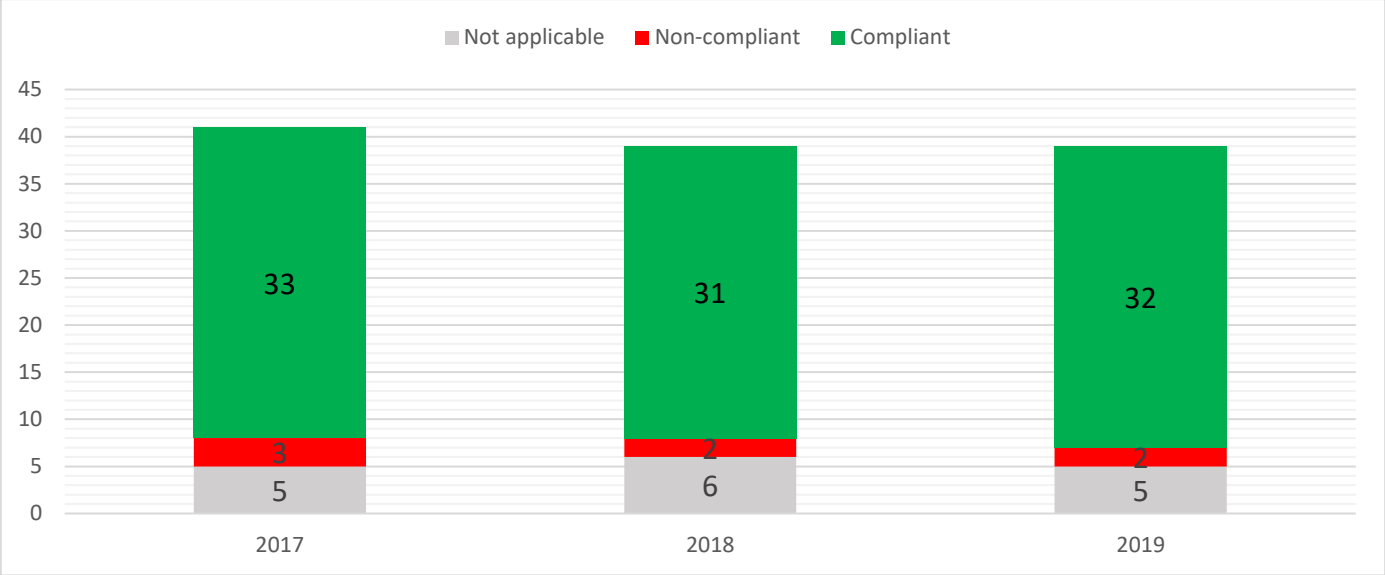
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

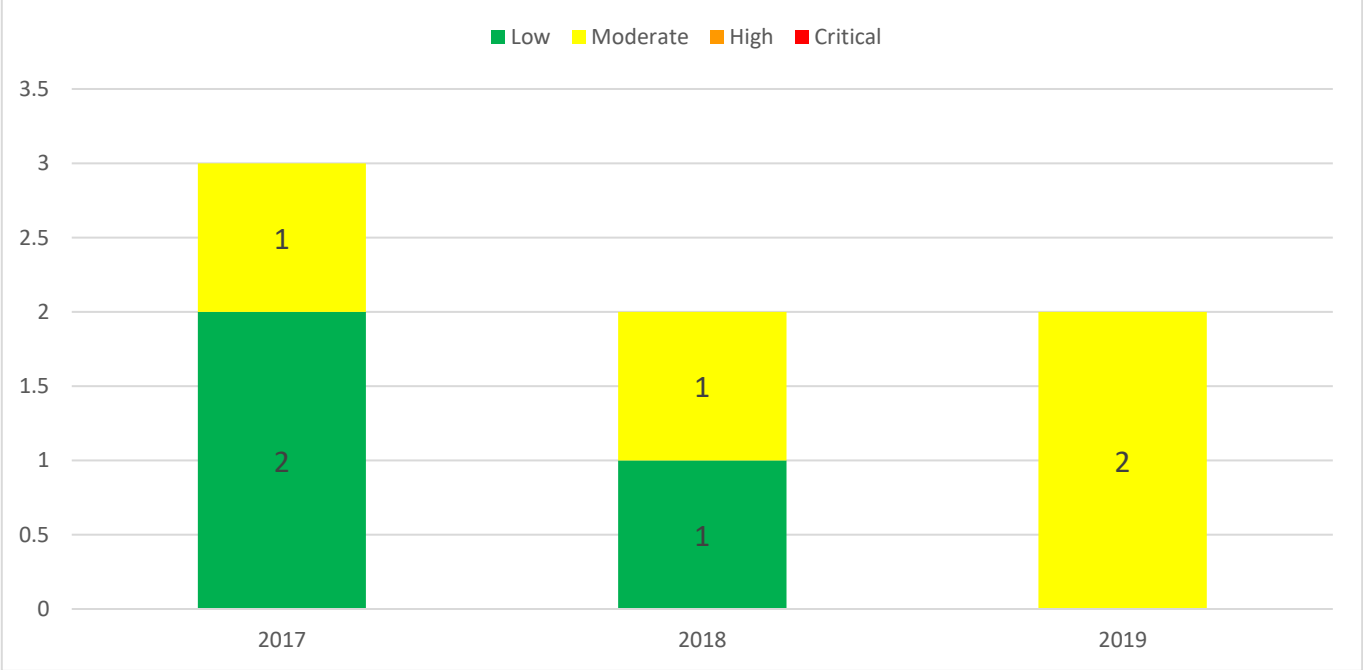
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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

Chart 2 – Comparison of overall risk ratings 2017 – 2019



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

Linn Dara had consistently maintained a high level of compliance ratings and findings of excellent compliance in many areas since 2017. In 2019, in view of this achievement and in line with risk-based regulation, the annual inspection was an announced inspection, and incorporated self-assessment in all regulations, rules and codes of practice. During the annual inspection, the inspectors validated the approved centres' self-assessments and inspected regulations, rules and codes of practice, which had a direct impact on patient care and safety.

In brief

Linn Dara Child and Adolescent Mental Health Service (CAMHS) in-patient unit was located on the Cherry Orchard Hospital campus in Ballyfermot, Dublin 10. It catered for young people under the age of 18 and had a total capacity of 24 beds. At the time of this inspection, the unit was functioning at full capacity. The approved centre consisted of two 11-bed units, Hazel which predominantly accommodated younger residents under the age of 16, and Rowan which accommodated older adolescents, together with a two-bed high observation area (Oak).

All bedroom accommodation was in single, en suite bedrooms and there was a school attached to the unit. To facilitate families visiting from a distance there was a three-bedroom family apartment adjacent to the unit.

There was a high level of compliance with regulations, rules and codes of practice in 2017 (92%) and in 2018 (94%). In the 2019 annual inspection, Linn Dara maintained its high level of compliance at 94%. There were 20 compliances with regulation rated as excellent.

Conditions to registration

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

Safety in the approved centre

- Regular food safety audits are completed and kitchen areas were clean.
- The ordering, prescribing, storing, and administration of medication was completed in a safe manner.
- Ligature anchor points were minimised and regular individual risk assessments were completed.
- All staff had completed mandatory training in fire safety, Basic Life Support, the prevention and management of violence and aggression, and Mental Health Act 2001.

However:

- The process for responding to emergencies, including the roles and responsibilities of key staff; the sequence of required actions; the process for communication; and the escalation of emergencies to management was not documented in risk management policy.

Appropriate care and treatment of residents

- Each resident had an individual care plan (ICP) which met the requirements of Regulation 15 Individual Care Plan.
- Therapeutic services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. The therapeutic services and programmes provided by the approved centre were evidence-based, and since the last inspection had expanded to include art psychotherapy, play therapy, and drama therapy.
- Each young person had access to physical health care as indicated by their needs.
- A dietician assessed the nutritional needs of young people as indicated and provided part of the programme for eating disorders.

However:

- There was no social worker or occupational therapist dedicated to the approved centre.

Respect for residents' privacy, dignity and autonomy

- Each resident had a single room with en suite bathroom.
- Bathrooms, toilets and bedrooms could be locked by the young person. Locks had an override facility which could be used if necessary by staff.
- No room was overlooked by public areas and notice boards did not identify residents.
- The premises was clean and bright, with plenty of both communal and private space.
- There was a programme of maintenance and premises was in good structural and decorative order.
- Clinical files were kept up-to-date, secure and in good order.

Responsiveness to residents' needs

- There was a wide range of recreational activities both indoor and outdoor. These were available at weekends as well as during the week.
- There was a school on the premises.
- Information was available about the approved centre and about the young people's diagnoses and medications.
- There was a robust complaints procedure in place and complaints were dealt with in a timely manner.
- There was a choice of food at mealtimes, and this was presented in an attractive manner.

Governance of the approved centre

- Linn Dara in-patient unit was part of the Linn Dara CAMHS providing a service to Area 7: Dublin South West, Kildare, and West Wicklow Community Healthcare. The in-patient unit also provided a catchment area service to sections of Area 8 (specifically counties Laois, Offaly, Westmeath, and Longford).
- A specific Approved Centre Governance Group, comprising representatives of multi-disciplinary management within the approved centre met at two monthly intervals.
- Staff working within the approved centre had access to regular clinical supervision, either directly within the centre or involving staff working within the broader service. Documented training plans were in place to address identified deficits and to promote staff development.
- A pilot youth advocacy service was being developed to encourage and facilitate service user involvement in service provision.
- An active audit process had been developed within the approved centre to identify and address any deficits in the provision of services. Audits involved various disciplines and were updated in a timely manner.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Development and expansion of the specialist eating disorder programme (Cróga).
2. Development of a pilot youth advocacy programme.
3. Daily Community Meetings in both units.
4. Rainbow Badge initiative – aimed at promoting a message of inclusion of all identities regardless of how people identify themselves.
5. Improved resident and family information leaflets.
6. Restraint Reduction Strategy – introduction of an agreed quality improvement framework to reduce restraint and seclusion episodes.
7. Expanded Therapeutic programme – introduction of art psychotherapy, sessional drama therapy and sessional play therapy.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Linn Dara Child and Adolescent Mental Health Service (CAMHS) in-patient unit was located on the Cherry Orchard Hospital campus in Ballyfermot, Dublin 10. The unit was approximately four years old, having been completed in 2015. The facility catered for young people under the age of 18 and had a total capacity of 24 spaces. It consisted of two 11-bed units, Hazel which predominantly accommodated younger residents under the age of 16, and Rowan which accommodated older adolescents, together with a two-bed high observation area (Oak).

All bedroom accommodation was in single, en suite bedrooms. There was a school attached to the unit. In addition there was a range of communal recreational and therapeutic facilities available, including a sports hall, gymnasium, and outdoor gardens. The unit was appropriately decorated and furnished with age-appropriate furniture and artwork. To facilitate families visiting from a distance there was a three-bedroom family apartment adjacent to the unit. At the time of this inspection the unit was functioning at full capacity (21 of the 22 routinely available spaces were occupied).

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

Resident Profile	
Number of registered beds	***24***
Total number of residents	**21**
Number of detained patients (s.25)	2
Number of wards of court	1
Number of children	20
Number of residents in the approved centre for more than 6 months	4
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Linn Dara in-patient unit was part of the Linn Dara CAMHS providing a service to Area 7: Dublin South West, Kildare, and West Wicklow Community Healthcare. The in-patient unit also provided a catchment area service to sections of Area 8 (specifically counties Laois, Offaly, Westmeath, and Longford). Governance processes concerning the broader community CAMHS service included the approved centre. In addition the approved centre had specific governance processes which are outlined below.

The service organisational chart outlined the relationship of these various groups to both the functioning of the overall service and the specific functioning of the approved centre.

The inspection team was provided with a variety of documents outlining the governance process and associated meeting minutes which incorporated the approved centre. These included the Linn Dara CAMHS Management Group, the Operations Group, the Policy Group, the Governance Group, and the Quality and Patient Safety (QPS) group.

In addition, a specific Approved Centre Governance Group, comprising representatives of multidisciplinary management within the approved centre met at two monthly intervals. This group oversaw the functioning of the approved centre to ensure compliance with the various requirements of the Act, to evaluate activity levels within the centre, promote quality improvement, and ensure standardisation of service delivery in line with best practice. It also had a role in financial oversight within the approved centre and in monitoring service user feedback. It sought to embed an advocacy forum, review quality indicators, and to foster a culture of continuous professional development for staff. An approved centre Quality and Safety group met at approximately six-weekly intervals.

Governance questionnaires were completed by the heads of clinical disciplines. To update this information the inspection team met with heads of clinical disciplines operating within the approved centre. This process clarified the current roles of theses disciplines in the overall governance of the approved centre, specific and generic risks, and processes to manage the risks identified. Key operational risks included the recruitment and retention of necessary staff across a number of disciplines, in particular medical, nursing, occupational therapy and social work. This issue was of increased importance with the development and expansion of the specialised eating disorder programme.

Staff working within the approved centre had access to regular clinical supervision, either directly within the centre or involving staff working within the broader service. Documented training plans were in place to address identified deficits and to promote staff development. A pilot youth advocacy service was being developed to encourage and facilitate service user involvement in service provision.

An active audit process had been developed within the approved centre to identify and address any deficits in the provision of services. Audits involved various disciplines and were updated in a timely manner.

It was evident from the information provided that an active governance process involving both clinical and operational staff was in place to monitor operational, staffing, and clinical risks affecting the approved centre. This process, where specifically involving the approved centre, was focussed on service development and improvement.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 26: Staffing	✗	Moderate	✗	Low	✗	Moderate
Regulation 32: Risk Management Procedures	✓		✓		✗	Moderate

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

4.2 Areas of compliance rated "excellent" on this inspection

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 17: Children's Education
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information
Regulation 21: Privacy
Regulation 22: Premises
Regulation 25: CCTV
Regulation 27: Maintenance of Records
Regulation 29: Operating Policies and Procedures
Regulation 31: Complaints Procedures

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As this was a CAMHS unit specialising in the treatment of children this Code of Practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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

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

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

The inspection team met with ten residents over two sessions. In addition seven residents returned feedback questionnaires outlining their views of the approved centre. In general, residents were happy with tier care and treatment within the approved centre. In particular, they greatly appreciated having access to a personal mobile phone. They did, however, express concern at the lack of organised activities at weekends and a perceived lack of access to staff.

6.0 Feedback Meeting

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

- Head of Service (Registered Proprietor
- Executive Clinical Director
- Clinical Director
- Consultant Psychiatrist
- Area Director of Nursing
- Director of Nursing
- Assistant Director of Nursing
- Acting CNM3 x 1
- CNM 1 x 2
- Senior Clinical Psychologist
- Dietitian Manager
- Dietitian
- Principal Social Worker
- School Principal

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.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in February 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: There were a minimum of two resident identifiers, comprising a photograph and the date of birth of each resident, which were appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services, and one appropriate identifier was used prior to the provision of therapeutic services and programmes. Each resident's preferred identifier was detailed within their clinical file, and identifiers were person-specific and appropriate to residents' communication abilities. For residents with the same or similar names, an alert was posted on the notice board in the nurses' station.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in February 2019. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Menus were approved by a dietitian to ensure that the meals provided were nutritionally adequate, in accordance with residents' needs. Residents were provided with a variety of nutritious, wholesome food, including portions from different food groups, as per the Food Pyramid. Hot meals were provided to residents on a daily basis. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. At least two choices were offered at each meal, aiming to maintain residents' appetite and nutrition. Hot and cold drinks were offered to residents regularly, and a source of fresh, safe drinking water was available in easily accessible locations in the approved centre at all times.

The needs of residents identified as having special nutritional requirements were reviewed regularly by a dietitian, using an evidence-based nutrition tool; nutrition and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Weight, intake, and output charts, as relevant, were implemented, monitored and acted upon for residents, where deemed to be necessary. Residents, their representatives, family, and next of kin were educated about residents' diets, specifically in relation to any contraindications with medication.

The approved centre was compliant with this regulation. The quality assessment was rated excellent as 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 written policy in relation to food safety, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs. Appropriate hand-washing areas were provided for catering services. Appropriate protective equipment, including Personal Protective Equipment (PPE) where required, were used during the catering process. The approved centre had proper facilities for the refrigeration, storage, preparation, cooking, and serving of food, along with suitable and sufficient catering equipment. Hygiene was maintained to support food safety requirements, and catering areas and associated catering and food safety equipment were appropriately cleaned. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

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 in relation to residents' clothing, which was last reviewed in February 2018, and which included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents had an adequate supply of clean, individualised clothing that was appropriate to their needs. Residents were supported to keep and use their own personal clothing, and were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours, unless otherwise specified 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 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Each unit had a secure safe and a locked room for the safeguarding of residents' monies, valuables, personal property, and possessions, as relevant, when the approved centre took responsibility for them. Residents were informed regarding items that were suitable to bring with them to the approved centre. On admission, two members of staff, along with each resident's representative or next of kin, compiled a detailed property checklist that was updated on an ongoing basis. A copy of the property checklist was provided to the resident and their representative, and an additional copy was kept in the resident's file, separate to the resident's individual care plan. The access to and use of resident monies was overseen by two members of staff and the resident's representative: where money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained in a log book which was kept in the valuables safe. Residents were supported to manage their own property, unless this was risk assessed as a danger to the resident or others. Items deemed to be unsafe were sent home or stored in the property press.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The approved centre provided recreational activities appropriate to the resident group profile, both on weekdays and during the weekend. Information was provided in the form of a timetable to all residents, in a format that was accessible and appropriate to their individual needs, and which included the types and frequency of appropriate recreational activities available within the approved centre. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement and discussion at community meetings.

Communal areas for recreation were provided, as were opportunities for both indoor and outdoor physical activity and exercise. Individual risk assessments were completed for residents in relation to the selection of appropriate activities, where deemed necessary. Documented records of attendance were retained for recreational activities in residents' clinical files, and, as appropriate, residents' decisions on whether or not to participate in activities were respected and documented.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: The implementation of the policy to support residents' religious practices was reviewed to ensure that it reflected the identified needs of residents. This was documented in each resident's individual care plan.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre, insofar as was practicable. Residents had access to multi-faith chaplains, and were supported to attend local religious services, if deemed appropriate following a risk assessment. Care and services provided within the approved centre were respectful of residents' values and beliefs, and residents were facilitated to observe or abstain from religious practice in accordance with their wishes. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which was last reviewed in July 2019, and included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Appropriate and reasonable visiting times were clearly displayed on signage at the entrance to each unit in the approved centre. Each resident's clinical file included justifications for any visiting restrictions in place, as well as the names of visitors the resident did not wish to see, and of those who posed a risk to the resident. A separate visitors' room, which was also suitable for visiting children, was provided for residents to meet visitors in private, unless there was an identified risk to the resident, to others, or if there was a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Visiting children were accompanied at all times, so as to ensure their safety, and this was communicated publicly to all relevant individuals.

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 **Excellent**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident's communication. The policy was last reviewed in July 2019, and included all of the relevant requirements of the *Judgement Support Framework*.

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed, in conjunction with Quality Network for Inpatient CAMHS (QNIC) Standards and best practice guidelines, to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, e-mail, telephone, internet, or any device for the sending or receiving of messages unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risk associated with their external communication, and documented in their individual care plan. Either the clinical director, or a senior member of staff who the clinical director had designated, only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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 13: Searches

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the implementation of resident searches and consent to searches, which were each last reviewed in February 2018. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

Training and Education: Relevant staff had signed the signature bank to indicate that they had read and understood the policies; staff were also given additional training on searches, and this was documented on the training database. Staff interviews demonstrated that staff had a good understanding of search processes, as set out in the policy.

Monitoring: A log of searches was maintained and located in the nursing station office. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify opportunities for the improvement of search processes.

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Individual risk assessments were completed prior to each search of a resident, their property, or their environment. Parental consent was sought and documented for each and every search. Where consent was not received, this was documented using a clinical note entry, and the process relating to searches without consent was implemented. The resident

search policy and procedure was communicated to all residents prior to a search commencing, and they were informed by those implementing the search of what was happening during a search and why. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting a search was of the same gender as the resident being searched, and a minimum of two clinical staff were in attendance at all times.

General environmental checks were completed twice during each shift and written records of these were kept. These took the form of general observation of the condition of each unit, together with health and safety and risk management checks. Residents were informed of the twice-daily environmental checks during their orientation to the approved centre, and at the community meetings. A written record of each search of a resident and of every property search was available, including the reason for the search, the names of both staff members who undertook the search, and the details of those who were in attendance for the search. Policy requirements were implemented when illicit substances were found.

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was last reviewed in February 2019. The policy and protocols included all of the relevant requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy, and could articulate the processes for end of life care, as set out in the policy.

There had been no death in the approved centre since the last inspection. This regulation was assessed under the two pillars of processes, and training and education.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. There was no evidence available that all multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: Five ICPs were reviewed on inspection; all were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the relevant resident's clinical file, were uninterrupted and identifiable, and were not amalgamated with progress notes. Each resident was initially assessed at admission, and an initial care plan was completed by the admitting clinician to address their immediate needs. This assessment included a risk assessment. ICPs were discussed, agreed where practicable, and drawn up with the participation of the residents and their next of kin, representative, and family, as appropriate.

ICPs identified appropriate goals for each resident, and were reviewed in consultation with the resident and their representative each week. The plans were updated as indicated by the resident's changing needs, condition, circumstances, and goals. ICPs identified the treatment and care required to meet the goals that had been identified. Resources were identified, although these were non-specific in some cases. Residents had access to their ICP, and were kept informed of any changes. Child residents and their family or next of kin signed their ICP, which included each child resident's educational requirements.

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

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning, as documented in their respective individual care plans. These services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. The therapeutic services and programmes provided by the approved centre were evidence-based, and since the last inspection had expanded to include art psychotherapy, play therapy, and drama therapy. A list of all therapeutic services and programmes were detailed on a therapeutic timetable that was displayed in the approved centre; a copy of which was provided to residents. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services or programmes in residents' individual care plans or clinical files.

There had been a significant reduction in occupational therapy and social workers in the approved centre since the last inspection, and as a result, it was necessary to prioritise the availability of these specific services.

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 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of education to child residents, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The education provided to each child resident was reflective of their assessed age and needs, and the corresponding required educational curriculum. The approved centre was linked with educational authorities and local education providers to ensure that each child resident was appropriately assessed and educated according to their assessed age and educational requirements. Appropriate facilities and sufficient personnel and resources were available for the provision of education to child residents in the approved centre. In addition, there were sufficient personnel and resources to support child residents to access external education services, as required.

The educational provisions, including a daily schooling activity timetable, available within the approved centre were communicated effectively and provided to the child residents and their representatives in the patient information booklet. Child residents' attendance at internal, and relevant external, educational services was documented in the school attendance role, including reasons for non-attendance. The approved centre maintained comprehensive records of each resident's educational history, including schools attended, reports obtained, certificates awarded, assessment reports received, and any remedial assistance provided. Where child residents were managing a transition, such as changing school or moving to a higher level of education, they were provided with additional support and appropriate assistance from the approved centre, as necessary and required.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in February 2018 and included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Communication records relating to the transfer of a resident with the receiving facility were documented and available on inspection, including the agreement pertaining to resident receipt prior to transfer. Verbal communication took place between the approved centre and the receiving facility, including on the reasons for transfer, the resident's care and treatment plan, and the resident's accompaniment requirements on transfer. Where available, the resident's consent to transfer, or justification as to why consent was not received, was documented. An assessment of the resident was completed prior to transfer, and included an individual risk assessment relating to the resident's specific needs.

A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility, and included: a medical transfer letter; a nursing transfer form; an individual care plan; a risk assessment, and; a medication, prescription, and administration record. Copies of each document in the resident's records were retained by 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 19: General Health

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. Both the general health and medical emergencies policies were last reviewed in February 2019. The policies and procedures included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Residents' take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: In order to respond to medical emergencies, the approved centre had an emergency resuscitation trolley and AED which were available at all times to staff and were checked weekly. Records of all medical emergencies within the approved centre, and the care provided to mitigate those emergencies, were available. Residents were provided with information on, and assisted to access, national screening programmes that were available, appropriate according to their age and gender: in the case of the approved centre, the only applicable screening programme was that for retina checks for diabetic child residents; however, there had been no uptake since the previous inspection.

Five clinical files were reviewed in the course of the approved centre's inspection. Residents received appropriate general health care interventions in line with their individual care plans, and records of the associated results were available. Adequate arrangements were in place for residents' referral to other health services, as required. In all cases, registered medical practitioners assessed the residents' general health needs at admission, and on an ongoing basis as part of the approved centre's provision of care, at least every six months. The six-monthly general health assessment included: a physical examination; personal history; BMI, weight and circumference measurements; blood pressure; smoking status; nutritional status; medication review, and; dental health. None of these residents were on anti-psychotics medication where specific assessment of glucose, lipid levels, prolactin, and ECGs were required.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in February 2018, and included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre's information booklet outlining the care and services provided, and details of their multi-disciplinary team. The information booklet and Linn Dara's website were being updated at the time of inspection. The residents and their advocates were involved in the updating process. The information booklet included: housekeeping arrangements, arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and; the rights of residents.

Residents were provided with written and verbal information, in formats appropriate to the resident's needs, outlining their diagnosis, unless, in the treating psychiatrist's opinion, the provision of such information would be prejudicial to their physical or mental health, well-being, or emotional condition. The justification for any such restriction of information was documented in the resident's clinical file and individual care plan. Medication information sheets included details of the likely side effects of treatments and medications, including risks and potential adverse effects. The information in the documents provided by or within the approved centre was evidence-based and was appropriately reviewed and approved prior to use.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy relating to resident privacy, which was last reviewed in February 2019, and which addressed all of the requirements of the *Judgement Support Framework.*

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

Monitoring: A documented annual review, in the form of a regular walkthrough by the Operations Group, had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis, which had been discussed by the approved centre's Governance Group, had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Approved centre residents were called by their preferred name. The general demeanour, dress and appearance of staff was appropriate, as was the manner in which staff communicated with residents. Staff used discretion when discussing residents' conditions or treatment needs. Residents were facilitated to make private phone calls using either a phone booth or using their mobile phone.

All bathrooms, showers, toilets, and single bedrooms had locks, which had an override function on the inside of the door, unless there was an identified risk. When entering a resident's room, staff sought permission. All observation panels on the doors of treatment rooms were fitted with opaque glass, and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display residents' names, or any other identifiable information.

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: The approved centre had a written policy in relation to premises, which was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: The approved centre had completed a hygiene audit, and had completed a ligature audit using the Queensland Audit Tool. Documented analysis, including governance and operational meeting minutes, had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre had appropriately sized communal rooms and outdoor areas, sufficiently large bedrooms also provided ample personal space for residents. Rooms were ventilated, suitably and sufficiently heated, and heating could safely be controlled in the resident's own room. Private and communal areas were suitably sized and furnished to remove excess noise; additional acoustic panels had been installed in double height spaces. The lighting in communal rooms suited the needs of residents and staff, being sufficiently bright and positioned to facilitate reading and other activities. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, had been minimised, while ligature points were mitigated to the lowest practicable level.

The approved centre was in a good state of repair, both internally and externally, and had a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment. Records were kept in a maintenance log. Suitable furnishings to support resident independence and comfort were in place, and the approved centre provided assistive equipment to address resident needs, where indicated in their individual care plan. There was a cleaning schedule implemented, and the approved centre was clean,

hygienic, and free from offensive odours. Where problems were identified in relation to the premises, they were communicated through the appropriate maintenance reporting process.

There was a sufficient number of toilets and showers for the number of residents; the toilets were accessible, clearly marked, and were close to day and dining areas. Wheelchair accessible toilet facilities were located in the reception, and there were five assisted toilets in each unit, along with one in the schooling facility. There were designated sluice, cleaning, and laundry rooms, as well as therapy and examination rooms, and there were appropriately sized lifts for patient access to the approved centre. Remote or isolated areas of the approved centre were monitored. Where the premises was in need of substantial changes, an appropriate assessment as to the possible impact on current residents and staff was undertaken prior to implementation, and the Mental Health Commission was notified prior to the commencement of works.

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 **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication which was last reviewed in September 2019. The policy addressed requirements of the *Judgement Support Framework*, but did not include the approved centre's process for medication reconciliation.

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

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

Evidence of Implementation: Nine MPARs were reviewed as part of the inspection process. All included the following: two appropriate resident identifiers; a record of any allergies or sensitivities to medications; the generic name of the medication and preparation, where applicable, written in full; dedicated spaces for routine medications, once-off medications, and "as required" medications; the frequency, dose, and route of administration; a record of all medications both administered and refused by the resident; a clear record of the date of initiation and discontinuation, as relevant, of each medication; the Medical Council Registration Number of every registered medical practitioner (RMP) prescribing medication to the resident, and; the signature of the RMP responsible for each entry.

Every MPAR entry was legible, and was written in black, indelible ink. Medication was reviewed and rewritten at least twice a year, or more frequently where there was a significant change to the resident's condition or care and treatment. Medicinal products were administered in accordance with the directions of the prescriber, and any advice provided by the resident's pharmacist regarding appropriate use of the product. All medications were administered by a registered nurse or RMP.

Good hand hygiene techniques were implemented while medications were being dispensed, and the expiration date of medications were checked prior to administration. When a resident's medication was withheld or refused, the respective justification and reason was documented in the relevant clinical file and MPAR.

Medications were stored in the relevant appropriate environment, free from damp and mould, clean, free from litter, dust and pests, and free from spillage; food and drink were not stored in the same areas, and; where medication required refrigeration, a daily log of the temperature of refrigerated storage was maintained. Medication storage areas were incorporated into the cleaning and housekeeping schedules. The medication trolley and medication administration cupboard remained locked at all times. A system of stock rotation was implemented, and an inventory of medications was conducted on a monthly basis, whereby the name, dose, and quantity of each medication was checked; however, the medications' expiry dates were not. Medications that were no longer required, which were past their expiry date, or which were dispensed and were subsequently no longer required, were segregated from the other medication and returned to the pharmacy for safe disposal.

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 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in June 2019. The policy addressed all requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre.

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

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

Evidence of Implementation: Clear signs in prominent positions throughout the approved centre indicated where CCTV cameras or other monitoring systems were located. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare, and CCTV was not used to monitor residents if they started to act in a way that compromised their dignity. The CCTV cameras used were incapable of recording or storing a resident's image in any form, and could not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to its staffing requirements, which were last reviewed in February 2018. The policies and procedures addressed requirements of the *Judgement Support Framework,* but did not include the following:

- The roles and responsibilities in relation to staff training processes within the approved centre.
- The required qualifications of training personnel.
- The evaluation of training programmes.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies and procedures. 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 numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: The approved centre had an organisational chart to identify the leadership and management structure, and lines of authority and accountability of its staff. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained. Staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment, and references for each member of staff were sought and documented; however, the lack of adequate numbers of both Occupational Therapy and Social Work staff meant that the number and skill mix of staff was not appropriate for the assessed needs of residents. Staff were appropriately qualified to do their job, and an appropriately qualified member of staff was on duty and in charge at all times, which was documented within the staffing roster. Where agency staff were used, a comprehensive contract between the approved centre and the licensed staffing agency outlined the agency's responsibilities in relation to staff, and these responsibilities were consistently carried out.

There was a written staffing plan for the approved centre which addressed the skill mix, competencies, number, and qualification of the staff, taking into account: the size and layout of the centre; the level of

the cohort's acuity of psychiatric illness; the age profile and physical care needs of residents; challenging behaviours exhibited by residents; the level of dependency and need for supervision, and; the number of beds available. The plan also included the number of staff on duty required to ensure the safety of residents in the event of a fire or other emergency.

All health care professionals were trained in Children First, the Mental Health Act, Basic Life Support, and in the management of violence and aggression. All staff training was documented. Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. Staff training logs were maintained, and opportunities were made available to staff by the approved centre for further education. The Mental Health Act 2001, and the associated regulation (S.I. No. 551 of 2006) and the Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance, were available in the nurse's station.

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (22)	22	100%	22	100%	22	100%	22	100%	22	100%
Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Medical (6)	6	100%	6	100%	6	100%	6	100%	6	100%
Occupational Therapist (0.2)	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (0.2)	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1.8)	2	100%	2	100%	2	100%	2	100%	2	100%
Speech & Language Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian (1)	1	100%	1	100%	1	100%	1	100%	1	100%

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

Ward or Unit	Staff Grade	Day	Night
Hazel	CNM2	1	-
	CNM1	1	-
	RPN	3	2
	SCW	-	1
	Occupational Therapist	-	-
	Social Worker	-	-
	Psychologist	1	-

Ward or Unit	Staff Grade	Day	Night
Rowan	CNM2	1	-
	CNM1	1	-
	RPN	3	2
	Occupational Therapist	-	-
	Social Worker	-	-
	Psychologist	1	-

Ward or Unit	Staff Grade	Day	Night
Oak (staff assigned when a resident is transferred)	CNM2	1	-
	RPN	2	2
	HCA	1	1
	Occupational Therapist	-	-
	Social Worker	-	-
	Psychologist	-	-

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

The approved centre was non-compliant with this regulation because the lack of adequate numbers of both Occupational Therapy and Social Work staff meant that the number and skill mix of staff was not appropriate for the assessed needs of residents, 26(2).

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures relating to the maintenance of records, which were last reviewed in February 2018. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- Record retention periods.
- The destruction of records.

Training and Education: All clinical and other relevant staff had signed the policy acknowledgment form to indicate that they had read and understood the policy. All clinical and other relevant staff interviewed could articulate the processes relating to the creation of, access to, retention, and destruction of records, as set out in the policy.

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

Evidence of Implementation: All resident records were secure, up-to-date, and in good order, physically stored together, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Residents' records were reflective of their current status, and of the treatment and care being provided to them. Records were developed and maintained in a logical sequence, and each record had a unique identifier. Only authorised staff had access to and could make entries in residents' records, and staff only had access to the data and information needed to carry out their job responsibilities.

Records were written clearly and legibly in black, indelible ink, and were readable when photocopied. Entries to records: were factual, consistent, and accurate; included the date; used the 24-hour clock; were followed by a signature, and; included two appropriate resident identifiers. Documentation of food safety, health and safety, and fire inspections was maintained. Records were appropriately secured throughout the approved centre from loss or destruction, tampering, and unauthorised use or access, and records were retained and destroyed in accordance with legislative requirements, as appropriate.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in February 2018. It included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff as part of the Audit Committee, and in consultation with all relevant stakeholders, including service users, as appropriate. The operating policies and procedures of the approved centre were appropriately approved, incorporated relevant legislation, were evidence-based, and were communicated to all relevant staff.

Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. The format of policies and procedures was standardised, including: the names of the document owners and reviewers, as applicable; the name of the policy and procedure; the reference number and revision; the scope of the policy and procedure; the date of implementation; the scheduled review date, and; the total number of pages in the policy and procedure. Any 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 rated excellent and not rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented, and the findings acted upon. Complaints data was analysed, and details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: The approved centre had a nominated person who was responsible for dealing with all complaints, both major and minor, and a consistent and standardised approach was implemented for the management of all complaints. Minor complaints were documented. Residents and their representatives were facilitated to make complaints using the following methods: verbally; in written form; electronically by email; by telephone, and; through complaint, feedback, or suggestion forms.

The complaints procedure was provided to residents and their representatives in the resident information booklet, as well as being publicly displayed in the approved centre. All complaints, whether oral or written, were investigated promptly, and handled sensitively and appropriately. The registered proprietor ensured that the quality of care, treatment, and service of a resident would not be adversely affected following the making of a complaint.

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, together with associated policies relating to self-harm, assault, residents being absent without leave, accidental injury, and safeguarding, which were last reviewed in February 2018. The policy addressed requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for risk management and the implementation of the risk management policy within the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The policy did not address the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre, in relation to: organisational risks; structural risks, including ligature points; and capacity risks relating to the number of residents in the approved centre.
- The process for responding to emergencies, including: the roles and responsibilities of key staff; the sequence of required actions; the process for communication; and the escalation of emergencies to management.

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that

they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

Evidence of Implementation: Responsibilities were allocated at a management level and throughout the approved centre to ensure their effective implementation, and the person with responsibility for risk was identified and known by all staff. The approved centre was purpose designed, and, as a result, structural risks, including ligature points were excluded or mitigated at the time of building. Corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register.

Individual risk assessments were completed prior to and during: resident seclusion; physical restraint; at admission, in order to identify individual risk factors; during resident transfer, and; in conjunction with medication administration or requirements. Multi-disciplinary teams (MDTs), residents, and their representatives, as appropriate, were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children were appropriate.

Incidents were recorded in the National Incident Management System and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT, who recommended actions, a record of which was maintained and documented in individual clinical files. A six-monthly summary report of all incidents was sent to the Mental Health Commission, and the information provided was anonymous at resident level. There was no emergency plan, including evacuation procedures and specifying responses by approved centre staff to possible emergencies.

The approved centre was non-compliant with this regulation because the Risk Management policy did not clearly cover arrangements for responding to emergencies, such as fire, flooding, or significant structural damage, 32(2).

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

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: The approved centre had a written policy on the use of seclusion, which had been reviewed annually and was dated January 2019. The policy addressed the following:

- Who may implement seclusion.
- The provision of information to the resident being secluded.
- Methods for reducing rates of seclusion use.

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

Monitoring: Residents in seclusion had access to adequate toilet and washing facilities, and all furniture and fittings were of a design and quality so as not to endanger patient safety. An annual report on the use of seclusion had been completed.

Evidence of Implementation: The records of three episodes of seclusion were reviewed on inspection. Seclusion was only used in rare and exceptional circumstances, and in the best interests of the resident, when they posed an immediate threat of serious harm to themselves or others. In all cases, the service had first considered all other interventions to manage the resident's unsafe behaviour before deciding to use seclusion. Cultural awareness and gender sensitivity were demonstrated. Each resident was informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of seclusion, unless this was deemed to be detrimental to the resident. The resident's next of kin or representative was informed, and this was recorded in the resident's clinical file.

Clothing worn by residents, and any bodily searches undertaken, respected their right to dignity, bodily integrity, and privacy. Direct observation by a registered nurse (RN) occurred for the first hour following the initiation of an episode of seclusion, followed by continuous observation thereafter. A written record was made by the RN every fifteen minutes, detailing the resident's level of distress and behaviour. Following a risk assessment, a nursing review took place every two hours, during the course of which at least two staff were present in the seclusion room. A medical review of the secluded resident was conducted by a registered medical practitioner every four hours.

All uses of seclusion were reviewed by the multi-disciplinary team and clearly recorded in the clinical file within two working days, and also on the seclusion register. A copy of the seclusion register entry was placed in the clinical file. Residents and their representatives were informed of the ending of an episode of seclusion, and the reason for the episode's cessation was recorded in each clinical file.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. After a three month period, the administration of medication was only continued after being approved and authorised by two consultant psychiatrists, as set out in the Form 18 completed on 29 August 2018.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: The clinical files of three residents who had been physically restrained were reviewed. The use of physical restraint was based on documented risk assessment and was only utilised after all less restrictive approaches had been considered. A designated member of staff was responsible for leading the restraint and there was documented evidence that the responsible consultant was notified as soon as practicable.

In all cases a physical examination was documented within three hours of the episode. Parents or guardians were informed in all cases. There was documentary evidence that the resident was informed of reasons for, and likely duration of, the episode. The episode was discussed with the resident by members of the MDT. In all cases a copy of the relevant Clinical Practice Form (CPF) was placed in the clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge, all of which were last reviewed in February 2018. Each of the three policies included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. The resident had been admitted on the basis of a mental illness or mental disorder. The approved centre had a key worker system in place, and a family member, carer, or advocate had been involved in the admission process. An admission assessment had been completed, including: the resident's presenting and any past psychiatric problems, and current mental state; family and medical history; current and historic medication; a risk assessment, and; any other relevant information. The resident had undergone a full physical examination.

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

Discharge: The discharge plan of one resident was reviewed during the inspection process, and included documented communication with the relevant Community Mental Health Team (CMHT). The discharge plan included risks and early warning signs of relapse. The discharge was coordinated by a key worker, and a timely follow-up appointment was confirmed before the resident left the approved centre. A preliminary discharge summary was sent to the CMHT responsible for the resident's care within three days.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 26: Staffing					
Reason ID : 10001018		**The lack of adequate numbers of both Occupational Therapy and Social Work staff meant that the number and skill mix of staff was not appropriate for the assessed needs of residents, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Two Occupational Therapist vacanices in approved centre Two social work vacancies in the approved centre	One Occupational Therapist is now in post. Second has accepted and on maternity leave. Request for agency maternity leave cover has been submitted for derogation Two professional qualified social workers now in post. Principal Social worker continues to provide input during induction process.	One post fully staffed since 18/11/2019 - OT Occupational Therapy manager continues to provide advice and consultation to approved centre	18/11/2019	Occupational Therapy Manager Principal Social Worker
Preventative Action	Two Occupational Therapist vacancies in approved centre Two social work vacancies in the approved centre	One Occupational Therapist is now in post. Second has accepted and on maternity leave. Request for agency maternity leave cover has been submitted for derogation Two professional qualified social workers now in post. Principal Social worker continues to provide input during induction process	Achieved First social worker on 29th October 2019 Second social worker started 03/02/2020 One post fully staffed since 18/11/2019 Occupational Therapy manager continues to provide advice and consultation to approved centre	18/11/2019	Occupational Therapy Manager Principal Social Worker

Regulation 32: Risk Management Procedures					
Reason ID : 10001017		**The Risk Management policy did not clearly cover arrangements for responding to emergencies, such as fire, flooding, or significant structural damage, 32(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Policy review undertaken in conjunction with Safety Statement for Approved Centre	New policy commissioned to address specific area of non compliance in 32(2) [non clinical emergency- fire, flooding or significant structural damage] Evacuation card updated and extended beyond evacuation in event of fire.	Policy completed 7th November 2019	07/11/2019	Chair of Policy Group
Preventative Action	Educational sessions incorporated into rolling CPD programme for 2020 this includes new policy and amended Evacuation Card Each staff to read Policy and having done so sign policy acknowledgment form	Attendance list at CPD session Policy acknowledgment form	Q 1 2020	31/03/2020	CNM111 & Chair of Policy group

Appendix 2: Background to the inspection process

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

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

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

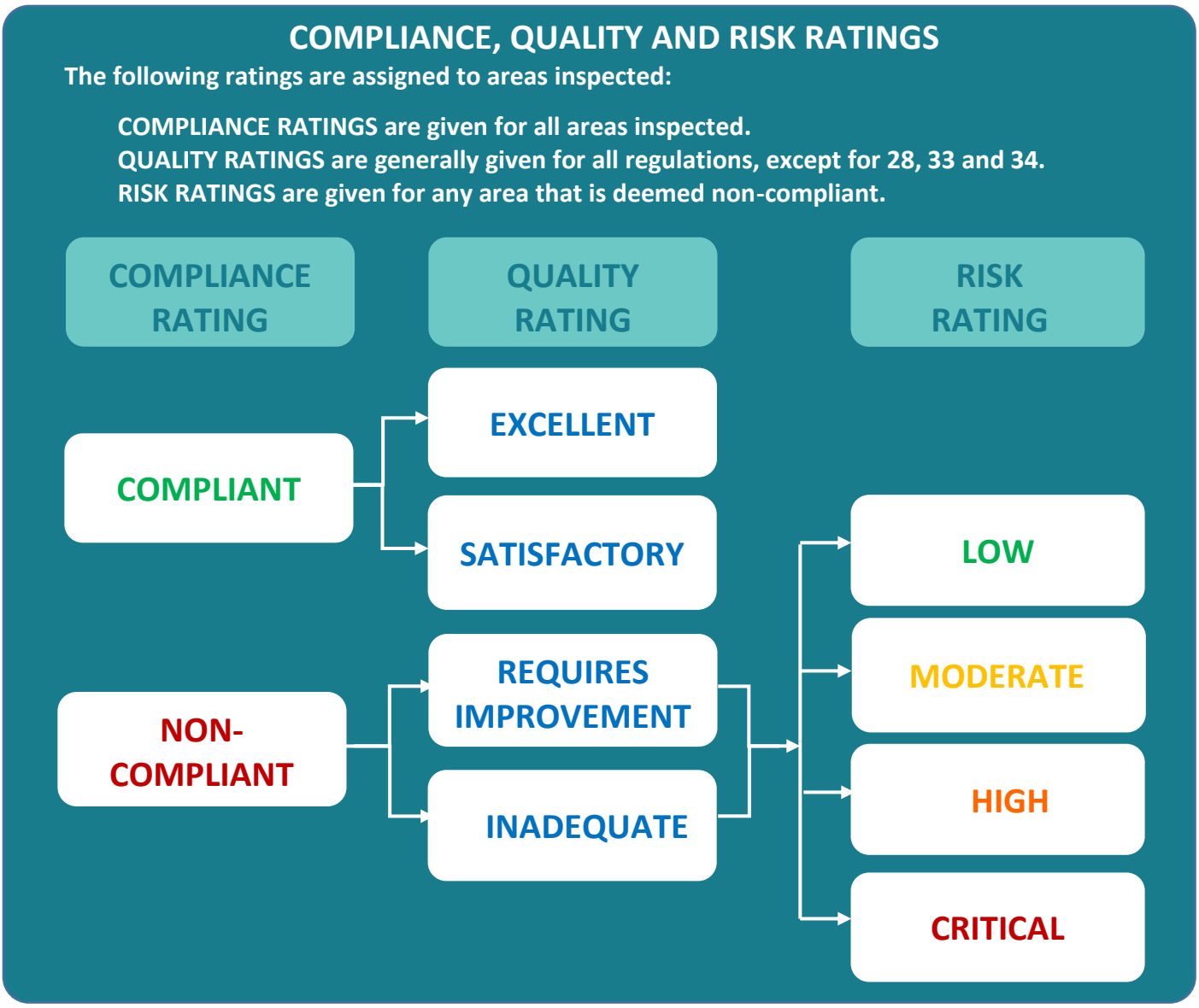
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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