Child & Adolescent Mental Health In-patient Unit
Merlin Park University Hospital

ID Number: AC0081

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital
Merlin Park
Galway

Approved Centre Type:
Child & Adolescent Mental Health Care

Most Recent Registration Date:
9 December 2016

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, CHO 2 - Mental Health Services

Inspection Team:
Sandra McGrath, Lead Inspector
Siobhán Dinan
Mary Connellan

Inspection Date:
23 – 26 October 2017

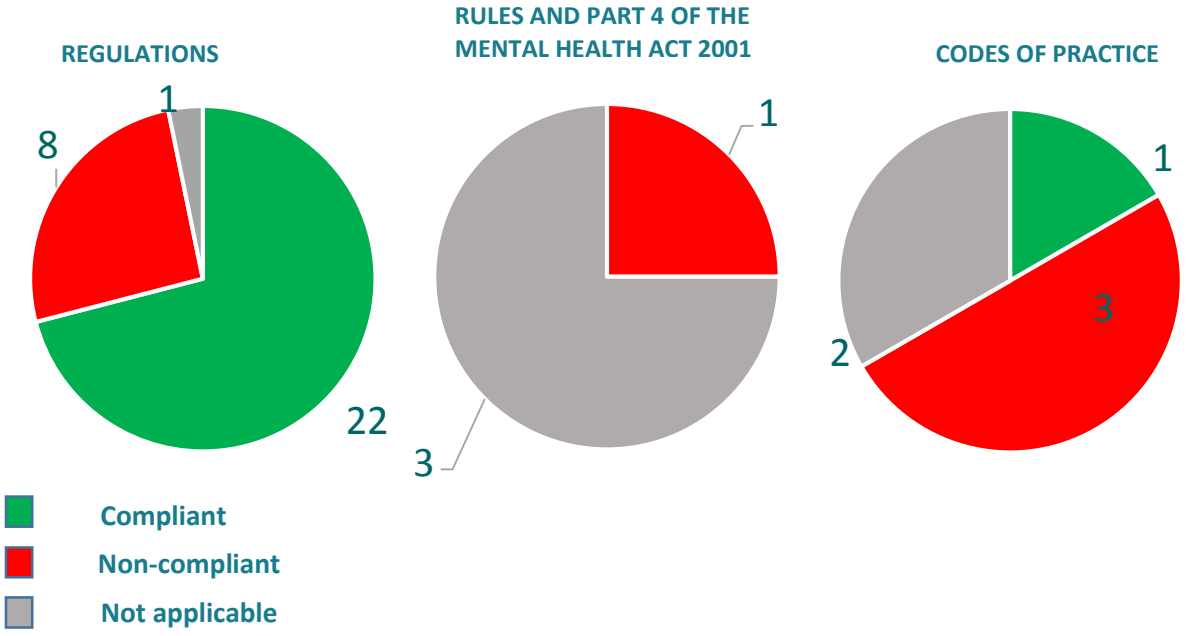
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
1 – 4 November 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
5 April 2018

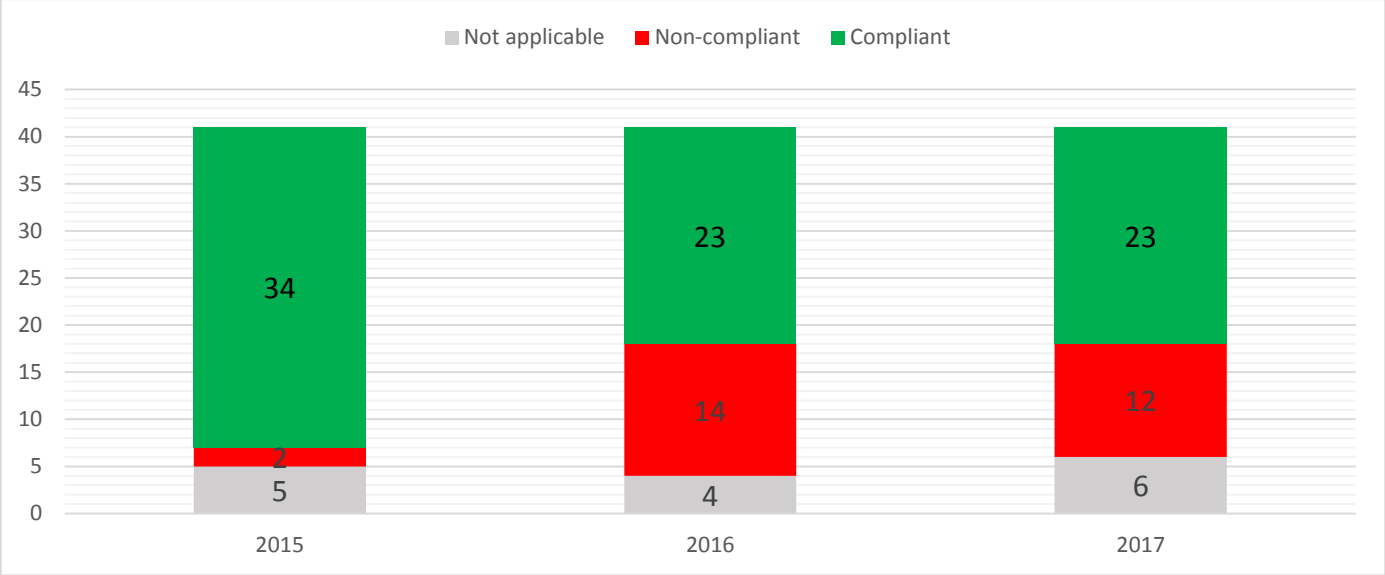
2017 COMPLIANCE RATINGS



RATINGS SUMMARY 2015 – 2017

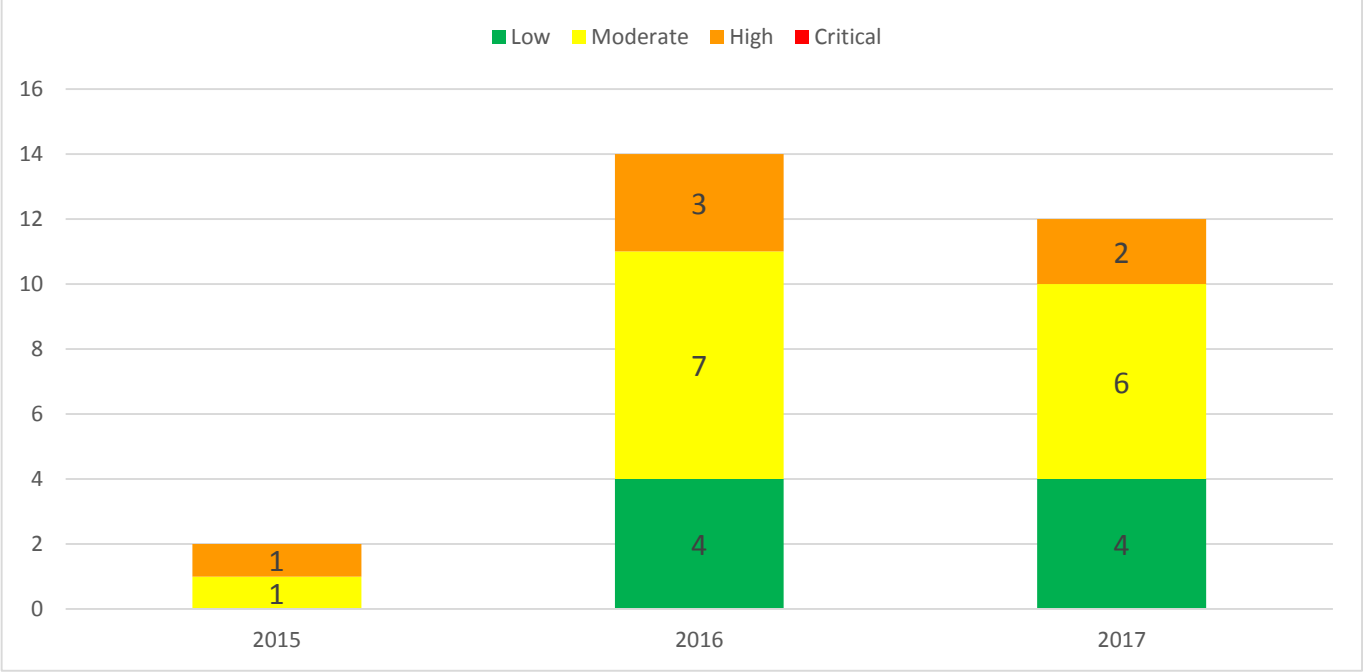
Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017



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

Chart 2 – Comparison of overall risk ratings 2015 – 2017



Contents

1.0 Introduction to the Inspection Process 5
2.0 Inspector of Mental Health Services – Summary of Findings 6
3.0 Quality Initiatives 11
4.0 Overview of the Approved Centre 12
4.1 Description of approved centre 12
4.2 Conditions to registration 12
4.3 Reporting on the National Clinical Guidelines 12
4.4 Governance 12
5.0 Compliance 14
5.1 Non-compliant areas from 2016 inspection 14
5.2 Non-compliant areas on this inspection 15
5.3 Areas of compliance rated Excellent on this inspection 15
6.0 Service-user Experience 16
7.0 Interviews with Heads of Discipline 16
8.0 Feedback Meeting 19
9.0 Inspection Findings – Regulations 20
10.0 Inspection Findings – Rules 63
11.0 Inspection Findings – Mental Health Act 2001 68
12.0 Inspection Findings – Codes of Practice 70
Appendix 1: Corrective and Preventative Action Plan Template - 2017 Inspection Report 79

1.0 Introduction to the Inspection Process

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

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

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

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

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

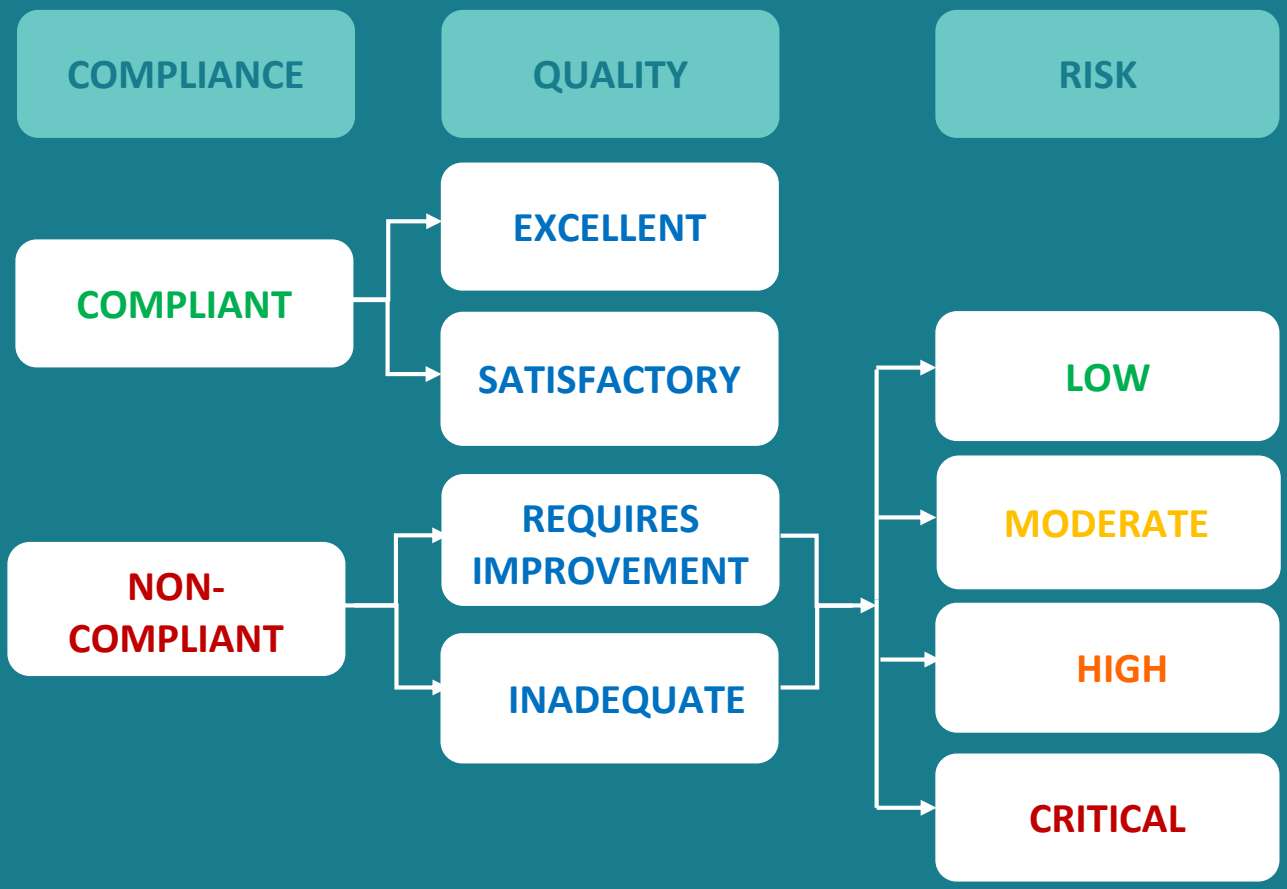
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

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

COMPLIANCE, QUALITY AND RISK RATINGS

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



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

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

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

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

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

Safety in the approved centre

The approved centre had a written policy in relation to health and safety, and a site-specific safety statement. It also had a written policy in relation to risk and incident management. Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. At the time of inspection, the person with responsibility for risk was not known by all staff in the approved centre. Whereas clinical and structural risks had been identified and reduced to the lowest practicable level, inspectors noted that not all categories of risk included in the approved centre's policy were being identified, assessed, or managed. The risk implications associated with operational changes within the approved centre were not being effectively identified by decision makers, or discussed within the forum of the quality and patient safety risk committee. The approved centre completed clinical risk assessments for all residents at admission to identify individual risk factors. Resident identifiers were person-specific and were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services.

Food safety audits were completed periodically and hygiene was maintained to support food safety, and catering areas and associated equipment were appropriately cleaned.

The special care unit was not fit for purpose. Only one of the three beds could be used at a given time due to lack of space in the unit. This had safety implications for both residents and staff.
Ordering, prescribing, storage and administration of medication was carried out in a safe manner.
Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staff were sufficient to address the assessed needs of residents at the time of inspection. Training records indicated that not all health care professionals had up-to-date mandatory training in Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act 2001. All 58 staff had up-to-date training in fire safety.

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

Appropriate care and treatment of residents

The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents' needs. The approved centre used the St. Andrew's Nutritional Screening Instrument, the Malnutrition Universal Screening Instrument, and the management of really sick patients with anorexia nervosa (MARSIPAN) refeeding guidelines. The needs of residents with special nutritional requirements were regularly reviewed by the dietitian who attended the approved centre two or three days a week.

Each resident had a multidisciplinary individual care plan (ICP). Residents had access to their ICPs and were kept informed of any changes. The range of therapeutic services and programmes available in the approved centre was appropriate for the assessed needs of residents. There were two consultant-led teams, and each had its own health and social care professionals, including nursing, psychology, occupational therapy, social work, teachers, and an activities nurse. Each team also had access to speech and language therapy and dietetics. Appropriate facilities and sufficient numbers of personnel were available for the provision of education to child residents. They attended a classroom on-site or the Child and Adolescent Mental Health Services primary and post-primary school, located close to the main entrance of the hospital campus.

At the time of inspection, three young people were identified as being resident in the approved centre for longer than six months. The interval between the admission assessment and the subsequent physical was longer than the required six months in two cases. Adequate arrangements were in place for residents to access general health services and for their referral to other health services. Residents' records were secure and up to date. However, some were incomplete as all they did not contain records of completed general health checks and associated results including records of clinical testing/lab results.

Apart from the use of recording TV, outlined below, the approved centre was compliant with the rule governing the use of seclusion. It was not compliant with the code of practice on the use of physical restraint.

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

Respect for residents' privacy and dignity

Residents could bring personal possessions into the approved centre, the extent of which was agreed at admission. There were storage areas for residents in each unit, including wardrobes and lockable bedside lockers. Residents had an adequate supply of individualised clothing which was observed to be clean and appropriate to their needs.
Searches were completed with due regard to the residents' dignity, privacy, and gender and residents' consent was sought. The residents were informed by those implementing the search of what was happening and why.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors, and all observation panels on doors of treatment rooms and bedrooms were appropriately screened. Residents were facilitated to make private phone calls. Bedrooms in both units of the approved centre could be viewed from the external courtyard areas accessed by residents, staff, and visitors. In addition, bedrooms in the Willows unit were overlooked from one meeting room in the nearby administration building.

The seclusion room was situated in the Willows unit and could only be accessed from Woodsend by bringing residents outside and through a courtyard, compromising the dignity of the young person and also having safety implications for both residents and staff in transferring a young person in a distressed state from one unit to another.

The approved centre's use of CCTV was confined to the seclusion room, and there was prominent signage to indicate camera locations. During the inspection, it was noted that the CCTV was set to continuously record. The company that installed the system and controlled the settings was contacted immediately and recording was stopped. The storage device was removed so that recordings could be destroyed in line with the approved centre's policy and data protection legislation.

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

Responsiveness to residents' needs

Residents were provided with a variety of wholesome and nutritious food choices within the approved centre's menus. Food was presented in an appealing manner. Recreational activities were available during the week and at weekends, but facilitation of activities was dependent on adequate staffing levels and on occasion activities outside of the units could not be facilitated. Residents were facilitated in the practice of their religion and a list of multi-faith chaplains was available.

Visiting times were appropriate and reasonable. Justifications for restricting visitors were put in place following a risk assessment, and they were implemented in the best interests of the residents concerned to ensure their safety. There was a designated room in each unit where residents could meet visitors in private, unless there was an identified risk to the resident or to others or a health and safety risk. There was also an apartment, a "parent flat", that visitors travelling long distances could be accommodated in overnight on a planned basis.

Residents had access to mail, fax, and phone, and to e-mail. Individual risk assessments were completed for residents in relation to any risks associated with their external communications.

Residents were provided with an information booklet at admission, which contained relevant information. Residents had access to written and verbal information regarding their diagnosis and medication. An established steering group has worked for a number of years and had secured funding to employ a professional youth advocate. The complaints procedure was satisfactory.

The approved centre was clean, hygienic, and free from offensive odours at the time of inspection. A cleaning schedule was implemented. Parts of the grounds around the approved centre were not well maintained. The external structure of the main administration building was worn, and the walls on the back corridors of the building required painting. The two in-patient units were well maintained externally and internally.

AREAS REFERRED TO

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

Governance of the approved centre

The approved centre was part of Community Healthcare Organisation (CHO) 2. The overall Governance of the Galway/Roscommon area within the CHO was well established and had representation from all disciplines. Child and Adolescent Mental Health Services (CAMHS) were represented within the relevant fora but not always discussed at meetings, based on the minutes provided for review. There was a clinical governance group, quality and patient safety committee, policy review group, and audit committee in place. Local governance of the CAMHS in-patient unit at the time of this inspection appeared imbalanced, with strong representation from psychiatry and nursing and less involvement from other health and social care professionals.

It was clear at local level that communication pathways were positive, open, and clear between all disciplines, but operational decisions were often made without full consultation or use of available professional resources. There was an open-door policy and open communication between staff which helped to build and sustain positive working relationships but interviews with senior staff indicated the lack of formality impacted negatively on consultation processes and full representation in decision making.

Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. They had been communicated to all relevant staff. All of the operating policies and procedures required by the regulations had been comprehensively reviewed since the last inspection.

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

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

The approved centre showed evidence of striving for continuous improvement, with a focus on developing processes that promote consistent and continuous care, as well as involvement of the young person and their family as appropriate. Since the last inspection, the approved centre had initiated the following:

1. A parent support group.

2. Wellness Recovery Action Plan (WRAP) groups for young people.

3. A mindfulness group.

4. Twice-weekly yoga classes.

5. The Child and Adolescent Mental Health Service (CAMHS) Merlin Park had been chosen to be part of Advanced Recovery in Ireland, which is a national mental health initiative that brings all stakeholders in mental health services together to work on making mental health services recovery-focused.

6. The service had successfully applied through the High Court to be able to, with District Court approval, initiate a process for nasogastric intubation and feeding for young people with eating disorders who previously would have had to be transferred to the general hospital when this intervention was required.

7. An established steering group has worked for a number of years and had secured funding to employ a professional youth advocate.

8. The approved centre had submitted applications for the HSE “Excellence Awards” for both the mindfulness group initiative and the nasogastric feeding initiative. Both applications had been accepted.

9. The young people had started a gardening project and were developing one of the enclosed gardens with support.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was a Child and Adolescent Mental Health Service (CAMHS) in-patient unit located on the grounds of Merlin Park Regional Hospital, Galway. There was a large wooden front to the main building, which housed a reception area, offices, conference rooms, a large gym, an occupational therapy kitchen, activity and therapy rooms, a classroom for young people who were not yet able to attend the school off-site, and the dining room where the young people ate meals. Two multi-disciplinary teams were responsible for the treatment and care of the young people admitted to the approved centre and were also based in this building. The residence was split into two units – the Willows, which was a 14-bed unit comprising two double bedrooms, seven single bedrooms, and three single bedrooms in a special care area, and Woodsend, which was a 6-bed unit comprising one double bedroom and four single bedrooms. There was a large, enclosed courtyard between the main building and the two units. There was also a "parent flat", which allowed a family to stay overnight when they had travelled to see one of the young residents.

The external structure of the main administration building was dark and worn. The external structure of the in-patient units were bright and in good condition. Internal areas were filled with artwork and bright furniture, and bedrooms were personalised by the young residents. The approved centre provided care and treatment to young people from age 12 to 18, inclusive, with mental illness. A nurse had been identified to support transitions for 18-year-old residents who required a move to adult in-patient services.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**17**
Number of detained patients	2
Number of Wards of Court	0
Number of children	17
Number of residents in the approved centre for more than 6 months	3

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre was part of Community Healthcare Organisation (CHO) 2. The overall Governance of the Galway/Roscommon area within the CHO was well established and had representation from all disciplines. Child and Adolescent Mental Health Services (CAMHS) were represented within the relevant fora but not always discussed at meetings, based on the minutes provided for review. Local governance of the CAMHS in-patient unit at the time of this inspection appeared imbalanced, with strong representation from psychiatry and nursing and less involvement from other health and social care professionals. It was clear at local level that communication pathways were positive, open, and clear between all disciplines, but operational decisions were often made without full consultation or use of available professional resources.

Staffing was noted as an ongoing challenge for management as recruiting nurses continues to impact services nationally. Maternity leave and sick leave within the approved centre added to the challenge. At the time of inspection, the approved centre was self-staffing and managing deficits with overtime. There was evidence in speaking to all management that there was a focus on staff support throughout the approved centre. Management capitalised on the skills of their staff, were supportive of ideas, and encouraged continuous professional development.

There were two psychologists and two social workers based in the approved centre – one on each of the two consultant-led teams. There were no ongoing challenges noted by management with regard to providing psychology or social work interventions to in-patients of Merlin Park. There was one occupational therapist (OT) within the approved centre. It was noted by management that working across two teams was impacting key performance indicators and the OT's ability to respond to all identified needs, in addition to completing assessments and summary reports. Speech and language therapy was spread across two teams on a half-time basis (0.25 for each team), making service delivery difficult.

Each person with management responsibility had good knowledge of operational aspects of the approved centre as appropriate to their role. There was a shared understanding of each other's roles and a shared goal for the approved centre, which influenced a relaxed and transparent way in which issues could be discussed. While an open-door policy and open communication between staff helped to build and sustain positive working relationships, interviews with senior staff indicated the lack of formality impacted negatively on consultation processes and full representation in decision making.

5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 1 – 4 November 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

Regulation/Rule/Act/Code	2017 Inspection Findings
Regulation 6: Food Safety	Compliant
Regulation 8: Residents' Personal Property and Possessions	Compliant
Regulation 13: Searches	Compliant
Regulation 21: Privacy	Non-Compliant
Regulation 22: Premises	Non-Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Compliant
Regulation 26: Staffing	Non-Compliant
Regulation 28: Register of Residents	Non-Complaint
Regulation 32: Risk Management Procedures	Non-Complaint
Rules Governing the Use of Seclusion	Non-Compliant
Code of Practice for Mental Health Services on Notification of Deaths and Incident reporting	Non-Compliant
Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities	Not Applicable
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Non-Compliant

5.2 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	2015 Compliance	2016 Compliance	2017 Compliance
Regulation 19: General Health	✓	✓	✗
Regulation 21: Privacy	✓	✗	✗
Regulation 22: Premises	✗	✗	✗
Regulation 25: Use of Closed Circuit Television	✓	✓	✗
Regulation 26: Staffing	✓	✗	✗
Regulation 27: Maintenance of Records	✓	✓	✗
Regulation 28: Register of Residents	✓	✗	✗
Regulation 32: Risk Management Procedures	✓	✗	✗
Rule Governing the Use of Seclusion	✗	✗	✗
Code of Practice on the Use of Physical Restraint in Approved Centres	✓	✓	✗
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	✓	✗	✗
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	✗	✗

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

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 7: Clothing
Regulation 17: Children's Education
Regulation 20: Provision of Information to Residents
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

6.0 Service-user Experience

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

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

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

Young people chose to meet inspectors as a group. Ten residents spoke to inspectors for approximately 30 minutes. Six questionnaires were also completed and received by the inspection team. Residents were mostly complimentary and positive about their experience of the approved centre. They reported that the food was good. They had input into the service and were able to voice concerns. They sometimes found that they got bored as activities, especially in the evenings and at weekends, were dependent on staff availability. Low staff numbers at times meant that residents could not get out or could not go to the gym, and outings on occasion had been cancelled.

The group enjoyed school and praised their teachers. They knew about and were involved in their individual care plans (ICPs) and knew the members of the multi-disciplinary team responsible for their care. Residents raised concerns about privacy and dignity, specifically being able to hear staff at handover talking about other young people. There was documented evidence that when young people had raised this with staff, they had responded, moved the handover meeting to another area, and piped light music through the ward to protect the privacy of young people. This was raised with management by the inspection team as an issue to continue to monitor.

Residents expressed they would like to be able to access the Internet as they currently had limited access to computers. Residents told inspectors about the suggestion box and knew how to make a complaint. It was stated that the "bars" on the external building could be intimidating. Young people commented during the meeting with inspectors that "staff are the best thing about here".

7.0 Interviews with Heads of Discipline

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

- Executive Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Principal Social Worker
- Occupational Therapy Manager
- Director of Psychology

Interviews with heads of discipline indicated clear reporting structures and consistent communication related to the approved centre. Open-door and ease of communication between senior staff was reported by all, although there was a lack of formal and planned multi-disciplinary review of the approved centre at this level.

There were robust systems in place for the reporting of adverse incidents to ensure immediate follow-up and effective incident management. There was a clinical governance group, quality and patient safety committee, policy review group, and audit committee in place. The move from local multi-disciplinary/management meetings to service-wide meetings was reported to have impacted the ability to represent in-patient Child and Adolescent Mental Health Service (CAMHS) issues comprehensively, considering all complexities as they apply to individual cases and to child and adolescent services overall.

Performance management was not implemented for any discipline within the service. Management supervision, individual clinical, and/or peer supervision was happening but not always formally or as frequently as would be expected for some disciplines. Each head of department was able to clearly articulate the processes in place within their own department and identify operational and management processes relevant to the staff within that department. The skill base of each staff member was capitalised on, encouraged, and developed, with further training and opportunities for continued professional development – for example, one staff member with an interest in eating disorders had developed skills in this area, two staff were training in Family Therapy, interested staff had completed courses in personal training to work with young people in the gym.

The in-patient service was part of the Advanced Recovery in Ireland programme and there was a clear commitment to the development and implementation of a recovery model of care and treatment. The imbalance of allied health care professionals between teams was identified during interviews as a challenge in this area.

Pregnancies, maternity leave, vacancies, supressed positions among allied health care professions, staff injury, and burn-out were identified as some of the challenges and risks within departments. The approved centre was carrying ongoing risks of deliberate self-harm and violence and aggression. Nursing management indicated risk of burn-out and/or injury was increased when treating particularly difficult presentations for prolonged periods.

Despite the challenges and complexities within the service, each head of discipline described committed staff with energy and passion for their work. There was evidence that significant work had been completed since the opening of the service in 2011 and of ongoing work to continuously improve the service.

8.0 Feedback Meeting

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

- Executive Clinical Director
- Business Manager
- Assistant Director of Nursing (CAMHS)
- Locum Consultant Psychiatrist (CAMHS)
- Director of Psychology
- Area Director of Nursing
- Quality and Patient Safety Advisor
- Senior Clinical Psychologist (2)
- Occupational Therapy Manager
- Senior Occupational Therapist
- Senior Social Worker
- Clinic Nurse Manager 3
- Clinic Nurse Manager 2
- Clinic Nurse Manager 1
- Section Officer

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. These are included in the body of the report.

9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **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 March 2016. It 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 identifying residents, as set out in the policy.

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

Evidence of Implementation: The approved centre used name, date of birth, and a photograph as identifiers, and an addressograph label with each resident's name and date of birth was used on documentation. The identifiers were person-specific and appropriate to the resident group profile and individual residents' needs. Two identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used to identify residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

(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 the provision of adequate food and nutrition to residents, which was last reviewed in March 2017. It 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 not been undertaken since the last inspection to ensure that residents received wholesome and nutritious food in accordance with their needs. Analysis had not been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food choices within the approved centre's menus. There was a three-week menu cycle for residents, and individual menu plans were developed for residents with an eating disorder.

Food was presented in an appealing manner, and hot meals were served daily. Residents were offered hot and cold drinks regularly, and they had access to a source of safe, fresh drinking water. Where necessary, nutritional and dietary needs were addressed in the residents' individual care plans.

The approved centre used a number of evidence-based nutrition assessment tools to evaluate residents' dietary requirements: the St. Andrew's Nutritional Screening Instrument, the Malnutrition Universal Screening Instrument, and the management of really sick patients with anorexia nervosa (MARSIPAN) refeeding guidelines. The needs of residents with special nutritional requirements were regularly reviewed by the dietitian who attended the approved centre two or three days a week. Residents, their representatives, family, and next of kin were educated about residents' diets, particularly those with an eating disorder.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written food safety policy, which was last reviewed in June 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date, documented training in the application of Hazard Analysis and Critical Control Point (HACCP).

Monitoring: Food safety audits were completed periodically. Food temperatures were recorded in line with food safety recommendations, and temperature log sheets were maintained and monitored. Documented analysis had been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: The approved centre had appropriate hand-washing areas for catering staff as well as suitable and sufficient catering equipment. Main meals were prepared in a kitchen off-site, in St. Francis Unit, Newcastle, Co. Galway, and transported to the approved centre in hot boxes. There were appropriate facilities in the approved centre's serving kitchen for the refrigeration, storage, and preparation, cooking, and serving of food.

Hygiene throughout the approved centre was maintained to support food safety, and catering areas and associated equipment were appropriately cleaned. Residents were provided with a supply of suitable crockery and cutlery.

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

Regulation 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 June 2017. It addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: An emergency supply of clothing was maintained and monitored. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, which was sent home to family for laundering, where possible. A laundry service was also provided by multi-task attendants, if necessary. Residents' clothing was observed to be clean and appropriate to their needs. Residents had an adequate supply of individualised clothing and a large wardrobe and bedside locker in which to store clothing and belongings.

An appropriate supply of emergency clothing was available that took account of residents' preferences, dignity, bodily integrity, and religious and cultural practices. At the time of inspection, no residents were wearing nightclothes during the day.

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 **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' personal property and possessions, which was last reviewed in March 2016. It addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Personal property logs were monitored in the approved centre. There was no documented analysis completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre, the extent of which was agreed at admission. There were storage areas for residents in each unit, including wardrobes and lockable bedside lockers. Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided on each unit for the safe-keeping of residents' monies, valuables, personal property, and possessions.

The approved centre maintained signed property checklists, which were recorded at admission, and these were kept separately to the residents' individual care plans. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by another staff, the resident, or their representative. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their individual care plans.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

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

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a record of resident uptake/attendance. Analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided a range of recreational activities appropriate to the resident group profile, including books, board games, baking, arts and crafts, library visits, music, yoga, a walking group, a gym, a newsletter group, and a creative group. Where appropriate, residents could participate in community outings.

Recreational activities were available during the week and at weekends, and a daily and weekly activities schedule was posted up on the noticeboard in each unit. Facilitation of activities was dependent on adequate staffing levels and on occasion activities outside of the units could not be facilitated. Recreational activities programmes were developed, implemented, and maintained with resident input. Residents' suggestions and requests in relation to activities were submitted at weekly community meetings, and efforts were made to incorporate these into the recreational programme. Where deemed appropriate, individual risk assessments were completed for residents in relation to the selection of activities, particularly outdoor activities. Records of resident attendance at activities were maintained in the clinical files.

Residents' decisions on whether or not to participate in activities were respected and documented in clinical files and/or the group records book. Opportunities were available for outdoor exercise and physical activity, including access to garden areas, a gym, and sports such as basketball, soccer, and boxing. Adequate communal areas suitable for recreational activities were provided, including activities rooms, occupational therapy rooms, and a relaxation room.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2016. It included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. Facilities were provided in the approved centre in support of residents' religious practices, and a list of multi-faith chaplains was available. Residents had access to local religious services if it was deemed appropriate, following a risk assessment.

The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes. Particular religious requirements relating to residents' care and treatment were clearly documented in the clinical files.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which was last reviewed in June 2017. It 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 relating to visits, as set out in the policy.

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis by nursing staff. Restrictions were documented in all clinical files, which also specified approved visitors. Analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in each unit and listed in the information booklet. Justifications for restricting visitors were put in place following a risk assessment, and they were implemented in the best interests of the residents concerned to ensure their safety. Visiting restrictions were documented in the clinical files.

There was a designated room in each unit where residents could meet visitors in private, unless there was an identified risk to the resident or to others or a health and safety risk. There was also an apartment, a "parent flat", that visitors travelling long distances could be accommodated in overnight on a planned basis. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children were welcome when accompanied by an adult to ensure their safety, and this was communicated to relevant individuals publicly. Visiting areas were suitable for children visiting.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents had access to mail, fax, and phone, and to e-mail at the nurses' stations and in the occupational therapy room. Individual risk assessments were completed for residents, as necessary, in relation to any risks associated with their external communications and documented in their clinical files, where applicable. The clinical director or a senior member of staff designated by the clinical director only examined incoming and outgoing resident communication when there was reasonable cause to believe that the communication may result in harm to the resident or others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in February 2017. It 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 was accommodated.
- The consent requirements of a resident regarding searches and the process for conducting searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

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

Monitoring: A log of searches was maintained. Each record was systematically reviewed to ensure the requirements of the regulation were complied with. Analysis had not been completed to identify opportunities for improving search processes.

Evidence of Implementation: The resident search policy was communicated to all residents. General written consent was sought for routine environmental searches. Three clinical files and search forms were examined. These indicated that a risk assessment was undertaken in advance of the searches and that the residents' consent was sought and received. The residents were informed by those implementing the search of what was happening and why.

A minimum of two clinical staff were in attendance at all times when the searches were being conducted, and the searches were completed with due regard to the residents' dignity, privacy, and gender. Search forms were completed for all of the searches, and these recorded the reason for each search, the names of the staff who undertook the search, and those in attendance during the search. A written record of all environmental searches was maintained.

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

- The supports available to other residents following the death of a resident.
- The process for ensuring that the approved centre is informed in the event of the death of a resident who had been transferred to another health care facility.

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

As there had been no deaths in the approved centre since the last inspection and no resident had required end of life care, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

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 March 2016. It 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 could articulate the processes relating to individual care planning, as set out in the policy. Multi-disciplinary team (MDT) members were not trained in individual care planning.

Monitoring: Resident ICPs were audited on a quarterly basis to assess compliance with the regulation. Analysis had not been completed to identify opportunities for improving the individual care planning process.

Evidence of Implementation: The ICPs of 12 residents in the approved centre were inspected. Each was a composite set of documents stored in the clinical file, was identifiable and uninterrupted, and was not amalgamated with progress notes.

Residents were assessed at admission and an initial care plan was put in place by the admitting clinician to address residents' immediate needs. The ICP was then developed by the MDT following a comprehensive assessment, within seven days of admission. The ICP was discussed, agreed where practicable, and developed with the involvement of residents, their representatives, family, or next of kin.

All of the ICPs inspected identified appropriate goals for residents. Each specified the care and treatment required to meet those goals, including named individuals with responsibility for care. The resources needed to provide the care and treatment identified were documented in all 12 ICPs. Not all of the ICPs inspected clearly included the residents' assessed needs. The template employed by the approved centre was not consistently completed. The front page, which was a pre-ICP review, was blank or had minimal information in all 12 ICPs inspected.

The ICPs were reviewed weekly, and re-written at least every three months or more often as indicated by residents' changing needs, by the MDT in consultation with the residents. Residents had access to their ICPs and were kept informed of any changes. Where residents declined or refused a copy of their ICP, this was documented. Educational requirements were documented for all residents.

None of the ICPs inspected contained an individual risk management plan. Risk assessments were completed using the Risk Assessment and Management Process (RAMP), but these were separate documents and details of the assessments were not included in the ICPs.

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

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was last reviewed in March 2017. It addressed requirements of the *Judgement Support Framework,* with the exception of the following:

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- The planning and provision of therapeutic services and programmes within the approved centre.
- The process for reviewing and evaluating therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.
- The provision of therapeutic services and programmes by external provider in external locations.

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 could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: Therapeutic services were monitored on an ongoing basis to ensure that residents' assessed needs were met. Documented analysis had not been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: The range of therapeutic services and programmes available in the approved centre was appropriate for the assessed needs of residents. There were two consultant-led teams, and each had its own range of health and social care professionals, including nursing, psychology, occupational therapy, social work, teachers, and an activities nurse. Each team also had access to speech and language therapy and dietetics.

The therapeutic services and programmes provided were evidence-based and directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A list of services and programmes provided in the approved centre was available to residents, and these included the following: mindfulness, anxiety management, decider skills training, Dialectical Behaviour Therapy, a Wellness Recovery Action Plan group, gardening, and therapeutic art. Activities such as rowing were facilitated outside of the approved centre.

Adequate and appropriate resources and facilities were available in the approved centre for the delivery of therapeutic services and programmes, including ample spaces for one-to-one and group work. Where residents required therapeutic services or programmes that were not provided internally, arrangements were in place for services to be provided by an approved, qualified health professional in a suitable location.

A record was maintained of resident participation and engagement in and outcomes achieved in therapeutic services or programmes.

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

Regulation 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 children's education, which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A record was maintained of resident attendance at internal and external educational services.

Evidence of Implementation: Residents were assessed in terms of their individual education requirements, with consideration of individual needs and age on admission, as indicated by their individual care plans. They were initially assessed by the multi-disciplinary team (MDT) and teachers attended the MDT meetings. Where appropriate, the approved centre liaised with educational authorities and local education providers to ensure that each resident was appropriately assessed in relation to education needs.

Where appropriate to the needs and age of the resident, the education provided by the approved centre was reflective of the required educational curriculum.

Appropriate facilities and sufficient numbers of personnel were available for the provision of education to child residents. They attended a classroom on-site or St. Anne's, the Child and Adolescent Mental Health Services primary and post-primary school, located close to the main entrance of the hospital campus. The school had five teachers, six special needs assistants, and a principal. The approved centre had two teachers, two special needs assistants, and a principal.

The educational provisions available within the approved centre were effectively communicated to residents and their representatives. A daily activity timetable was developed in line with residents' individual needs. Attendance by residents at educational services within the approved centre and outside was documented, including reasons for non-attendance. The approved centre maintained comprehensive records of residents' educational history.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

Monitoring: The approved centre maintained a transfer log, but each transfer record had not been systematically reviewed to ensure that all relevant information was provided to the receiving facility. Analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred to another approved centre was reviewed. The file contained documented consent to the transfer from the resident's parent. Communication records with the receiving facility were documented, including the reason for the transfer, the resident's care and treatment plan, and whether the resident required accompaniment on transfer.

A pre-transfer assessment of the resident was completed, including individual risk assessments relating to the transfer and the residents' needs. Full and complete information regarding the resident was transferred to the receiving facility, including a letter of referral with a list of current medications, a resident transfer form, and details of required medication for the resident during the transfer. The approved centre completed a checklist to ensure that comprehensive resident records were transferred. Copies of all records relevant to the transfer process were retained in the clinical file.

There had been no emergency transfer from the approved centre since the last inspection.

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

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in March 2017. It addressed requirements of the *Judgement Support Framework,* with the following exceptions:

- The staff training requirements in relation to Basic Life Support.
- The management of emergency response equipment, including the resuscitation trolley and Automated External Defibrillator (AED).
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The referral process for residents' general health needs.

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 could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policy.

Monitoring: National screening programmes were not applicable to the resident group at the time of this inspection. A systematic review had not 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, and a new system for flagging six-monthly physicals had been introduced.

Evidence of Implementation: The approved centre did not have an emergency trolley. It had an AED pack stored in the clinical room in each unit. It also had access to the crash team in Merlin Park Hospital and had a policy of calling emergency services in the event of an emergency. There was no evidence that weekly checks were completed on emergency equipment in the approved centre. There had been no medical emergencies in the approved centre since the last inspection.

A registered medical practitioner assessed residents' general health needs at admission and on an ongoing basis, as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with their individual care plans. It was found that results of phlebotomy, and other medical investigations were not consistently placed in the residents' clinical files.

At the time of inspection, three young people were identified as being resident in the approved centre for longer than six months. Their clinical files were inspected. Two files indicated that the gap between the admission assessment and the subsequent physical was longer than the required six months. The third

file indicated that a physical examination had been completed within the six-month time frame, but two six-monthly examinations were included on the same form, which was poor practice.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services. Records were maintained of general health checks and the associated results, but copies of these were not evidenced in all of the clinical files.

The approved centre was non-compliant with this regulation because not all residents' general health checks had been completed within the required six-month time frame, 19(1)(b).

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 in relation to the provision of information to residents, which was last reviewed in June 2017. It addressed 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 interviewed could articulate the processes for providing information to residents, as set out in the policy.

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

Evidence of Implementation: Residents were provided with an information booklet at admission, which contained information on housekeeping arrangements, visiting times and arrangements, the complaints procedure, relevant voluntary agencies, residents' rights, and their multi-disciplinary team. Residents were not provided with information on relevant advocacy agencies because, currently, there are no child advocacy services available nationally.

Residents had access to written and verbal information regarding their diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition. A folder containing all relevant medication and diagnosis information was available to residents. Verbal and written information was provided on the likely adverse effects of treatments, including risks and other potential side-effects. Information was available on indications for the use of all medications administered to the residents. Medication information sheets and verbal information were provided in a format that was appropriate to resident needs.

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

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in April 2017. It 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 interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

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

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were dressed in a manner that convened respect for the residents, and they sought permission before entering residents' rooms. Staff were discreet when discussing residents' condition or treatment. Residents wore clothing that respected their privacy and dignity.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors, and these had an override facility. All observation panels on doors of treatment rooms and bedrooms were appropriately screened. Residents were facilitated to make private phone calls. Noticeboards in public view detailed residents' first names.

There were two double rooms on the Willows unit, and neither had bed screening in place to prevent resident privacy from being compromised. In one room, there was a rail but no curtain; in the other room, the rail had been removed. Appropriate bed screening was in place in the double bedroom in the Woodsend unit.

Bedrooms in both units of the approved centre could be viewed from the external courtyard areas accessed by residents, staff, and visitors. In addition, bedrooms in the Willows unit were overlooked from one meeting room in the nearby administration building. The room was used by nonclinical staff, residents, and visitors.

The approved centre was non-compliant with this regulation because the register proprietor did not ensure that residents' privacy and dignity were appropriately respected, as indicated by the following:

a) **Appropriate bed screening was not in place in two of the three double bedrooms in the approved centre, which was not conducive to resident privacy.**
b) **Bedrooms in both units were overlooked from external areas.**

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 the premises, which was last reviewed in June 2017. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The approved centre had completed a hygiene audit and a ligature audit. Each audit had an associated action plan in which opportunities were identified for improving the premises.

Evidence of Implementation: Residents had access to personal space and to appropriately sized communal areas. The approved centre provided accommodation for residents that assured their comfort and met their assessed needs. Sufficient spaces were available for residents to move about, including spacious corridors, adequate communal areas, a large garden area, and smaller garden spaces.

The approved centre was comfortably heated, and heating could be safely controlled in residents' rooms. Communal areas were adequately lit to facilitate reading and other activities. Rooms in the approved centre were ventilated. Appropriate signage and sensory aids were in place to support resident orientation needs. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, had been minimised. Anti-ligature fixture and fittings were in place in bedrooms and bathrooms.

Parts of the grounds around the approved centre were not well maintained. Although the main garden area was well maintained, at the time of inspection, all other gardens were overgrown and pathways needed cleaning. There was one on-site staff member who had multiple responsibilities; driving, garden maintenance and general maintenance issues, but it was not possible for one person to effectively meet

the requirements of the many different roles, and driving took priority. Routine maintenance of external garden areas was required. The external structure of the main administration building was worn, and the walls on the back corridors of the building would benefit from painting. The two in-patient units were well maintained externally and internally.

The physical structure of the approved centre did not meet the specific needs of residents because the special care unit was not fit for purpose. Only one of the three beds could be used at a given time due to lack of space in the unit. This had safety implications for both residents and staff as a young person requiring special care in a distressed state requires the option of full separation from others for that period. In addition, the seclusion room was situated in the Willows unit and could only be accessed from Woodsend by bringing residents outside and through a courtyard, compromising the dignity of the young person and also having safety implications for both residents and staff transferring a young person in a distressed state from one unit to another.

The approved centre had a system for reporting maintenance issues, and records of this were maintained. However, there was no schedule of decorative or general maintenance.

The approved centre was clean, hygienic, and free from offensive odours at the time of inspection. A cleaning schedule was implemented, and current national infection control guidelines were followed. There was a sufficient number of toilets and showers, including accessible facilities, for residents. Wheelchair accessible facilities were available for use by visitors who required them. The lift was broken at the time of inspection and was reported to have been broken for over a month.

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

a) **There was no programme of routine maintenance in the approved centre, 22(1)(c).**
b) **The physical structure of the approved centre did not meet the specific needs of residents as per 22(3) for the following reasons:**
    - **Only one of the three beds in the special care unit could be used at a given time due to lack of space, which had safety implications.**
    - **The seclusion room was in an area that could only be accessed from Woodsend by bringing residents outside and through a courtyard.**
    - **The gardens were overgrown and pathways were in need of cleaning.**
    - **The lift was broken at the time of inspection.**

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

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: An MPAR was maintained for each resident, and 15 of these were inspected. Two appropriate resident identifiers were used on each MPAR. Names of medications were written in full, all medications administered to residents were recorded, and the Medical Council Registration Number of every medical practitioner prescribing medication to residents was included.

Where there was an alteration in a medication order, the prescription was rewritten by the medical practitioner. All medicines were appropriately administered by a registered nurse or registered medical practitioner. The expiry dates of medications were checked prior to their administration, and good hand-hygiene and cross-infection control techniques were observed during the dispensing of medications. Where a resident's medication was withheld, this was documented in the MPAR and clinical file.

At the time of inspection, no medication had been refused by a resident, no resident was prescribed crushed medication, and no resident was prescribed controlled drugs.

Medication arriving from the pharmacist was verified against the order by the pharmacy technician to ensure that it was correct and accompanied by appropriate directions for use. Medication was appropriately stored, and medication storage areas were clean and tidy. Food was not stored in areas used for the storage of medication.

Medication was stored securely in a locked trolley in a secure room. A system of stock rotation was implemented, and an inventory of medications was completed on a weekly basis.

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety, which was last reviewed in March 2017. It also had a site-specific safety statement, a fire policy, and infection control guidelines, and it used the HSE's corporate statement. Together, the policies and safety statements addressed requirements of the *Judgement Support Framework,* with the following exceptions:

- Falls prevention initiatives (as relevant to in-patient CAMHS service).
- Vehicle controls.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating LOW

(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 in relation to the use of CCTV, which was last reviewed in January 2017. It included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre's use of CCTV was confined to the seclusion room, and there was prominent signage to indicate camera locations. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The CCTV cameras did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. The Mental Health Commission and the Inspector of Mental Health Services had been informed about the approved centre's use of CCTV.

During the inspection, it was noted that the CCTV was set to continuously record. The company that installed the system and controlled the settings was contacted immediately and recording was stopped. The storage device was removed so that recordings could be destroyed in line with the approved centre's policy and data protection legislation. The CCTV had been serviced since the last inspection, and staff said they were unaware that the system was capable of recording or that it was set to record.

The approved centre was non-compliant with this regulation because the CCTV system was capable of recording a resident's image, 25(1)(d).

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the recruitment, selection, and vetting of staff, which was last reviewed in June 2017. It addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The staff performance and evaluation requirements.
- The required qualifications of training personnel.
- The evaluation of training programmes.

The process for reassigning staff in response to changing resident needs or staff shortages was included in the staffing policy but not in an overall staffing plan.

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

Monitoring: The implementation and effectiveness of the staff training plan had been reviewed annually, and this was documented. The numbers and skill mix of staff were assessed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart which identified the leadership and management structure and lines of authority and accountability of staff in the approved centre. A planned and actual staff rota was in place. Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times.

The numbers and skill mix of staff were sufficient to address the assessed needs of residents at the time of inspection. Senior management drew on the skills and interests of frontline staff to run an effective service. Staff were recruited and selected in accordance with the approved centre's policy and procedures.

The approved centre did not provide a written staffing plan that addressed the following:

- The skill mix, competencies, number, and qualifications of staff.

- The assessed needs of the resident group profile.

Annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training had been completed by staff. Training records indicated that not all health care professionals had up-to-date mandatory training in Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act 2001. All 58 staff had up-to-date training in fire safety.

All relevant staff were trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training completed in manual handling, infection control and prevention, care for residents with an intellectual disability, resident rights, risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults.

Staff training was documented, and staff training logs were maintained. The Mental Health Act 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available throughout the approved centre.

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

Note: Allied health care professionals were allocated across two teams and were not allocated to one unit or the other.

Ward or Unit	*Staff Grade*	*Day*	*Night*
The Willows	ADON	1 (across both units)	-
	CNM3	1 (across both units)	-
	CNM2/CNM1	1	1
	RPN	3	2
	HCA	1	-
	Night porter	-	1
Team 1	Occupational Therapist	0.5	
	Social Worker	1	
	Psychologist	1	
	Speech and Language Therapist	0.25	

Ward or Unit	*Staff Grade*	*Day*	*Night*
Woodsend	CNM2/CNM1	1	1
	RPN	2	2
	HCA	1	-
	Night porter	-	1
Team 2	Occupational Therapist	0.5	
	Social Worker	1	
	Psychologist	1	
	Speech and Language Therapist	0.25	

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

The approved centre was non-compliant with this regulation because not all staff had up-to-date mandatory training in BLS, the management of aggression and violence, 26(4), and the Mental Health Act 2001, 26(5).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in March 2017. It 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.
- The required resident record creation and content.
- Those authorised to access and make entries in residents' records.
- Record retention periods.
- The destruction of records.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. Clinical staff and other relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records, as set out in the policy. Not all clinical staff had received training in best-practice record keeping.

Monitoring: Resident records had not been audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had been completed to identify opportunities for improving processes relating to the maintenance of records.

Evidence of Implementation: Residents' records were secure, up to date, and constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and relevant legislative requirements. Resident records were stored together in the locked offices on both units and were appropriately secured from loss or destruction, tampering, and unauthorised access or use.

A record had been initiated for every resident in the approved centre, and these were reflective of residents' current status and the care and treatment being provided, but were incomplete as all files did not contain records of completed general health checks and associated results including records of clinical testing/lab results. Resident records were maintained through the use of a person-specific identifier.

Resident records were developed and maintained in a logical sequence and in good order, with no loose pages.

Entries in resident records were not always written in black ink to make them readable when they were photocopied, blue ink was used in some entries. It was found that where an error was made, entries were not scored out with a single line and accompanied by the correction, including the date, time, and initials.

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

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

a) Records were not complete to include all information regarding physical examinations, 27 (1).

Regulation 28: Register of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 hard-copy register of residents, which was made available to the inspection team. It contained headings for all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006 but it was not up to date. Specifically, residents' diagnosis on admission and diagnosis on discharge were not recorded appropriately using official diagnostic codes. The register was completed by nursing staff. There was no named person with responsibility for the maintenance of the register.

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

a) **The register of residents did not appropriately record all of the required information listed in schedule 1, namely residents' diagnosis on admission or diagnosis on discharge, 28(2).**

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures, which was last reviewed in March 2016. It addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had received training 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 for developing and reviewing policies.

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved by the policy review committee before being implemented. The operating policies and procedures of the approved centre had been communicated to all relevant staff.

All of the operating policies and procedures required by the regulations had been comprehensively reviewed since the last inspection. All of the policies in use in the approved centre had been specifically developed for Child and Adolescent Mental Health Services. Generic policies in use were appropriate to the approved centre and the resident group profile.

Policies were presented in a standardised format. Not all obsolete versions of operating policies and procedures had been removed from possible access by staff; some were observed in the policy folder provided to the inspection team.

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 30: Mental Health Tribunals

NOT APPLICABLE

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

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

INSPECTION FINDINGS

As Mental Health Tribunals were not held in the approved centre, this regulation was not applicable.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in June 2017. It also used the HSE's *Your Service, Your Say* complaints procedure. The policies addressed requirements of the *Judgement Support Framework,* but did not include up-to-date details for the external complaints officer.

Training and Education: Not all relevant staff had received training in complaints management processes. All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policies.

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

Evidence of Implementation: There was a nominated complaints officer in the approved centre who was responsible for dealing with all complaints. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy, on posters throughout the approved centre, and in the resident information booklet. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. Insofar as was practicable, the registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

A consistent and standardised approach was implemented for the management of all complaints, and all complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints, which were lodged verbally at community meetings or in writing via the suggestion box, were addressed locally by the activities nurse and documented in a log. Where minor

complaints could not be addressed locally, they were escalated to the nominated person and documented. Since the last inspection, no complaint had required escalation to the external complaints officer.

Details of complaints and of subsequent investigations and outcomes were fully recorded and kept distinct from the resident's individual care plan.

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

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 and incident management, which was last reviewed in March 2017. It addressed requirements of the *Judgement Support Framework*, including the following:

- The process of identification, assessment, treatment, reporting, and monitoring of risks, including
  - Structural risks such as ligature points.
  - Health and safety risks to the residents, staff, and visitors.
  - Risks to the resident group during the provision of general care and services.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The policy did not reference the following:

- The responsibilities of the registered proprietor.
- The named person responsible for completing six-monthly incident summary reports.
- The process of identification, assessment, treatment, reporting, and monitoring of
  - Organisational risks.
  - Capacity risks relating to the number of residents in the approved centre.
  - Risks to individual residents during the delivery of individualised care.
- The roles and responsibilities in relation to the incident reporting process.

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 had received training in individual risk management processes. Managerial staff had not been 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. Not 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 audited at least quarterly to determine compliance with the approved centre's risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: Responsibilities were allocated at management level to ensure the effective implementation of risk management processes. At the time of inspection, the person with responsibility for risk was not known by all staff in the approved centre.

Whereas clinical and structural risks had been identified and reduced to the lowest practicable level, inspectors noted that not all categories of risk included in the approved centre's policy were being identified, assessed, or managed. The risk implications associated with operational changes within the approved centre were not being effectively identified by decision makers, or discussed within the forum of the quality and patient safety risk committee.

The approved centre completed clinical risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, before and during the use of resident seclusion and physical restraint, and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes, and MDTs reviewed all clinical incidents at their regular meeting. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents in the approved centre were recorded and risk-rated using the National Incident Management System. A six-monthly summary report of all incidents occurring in the approved centre was sent to the Mental Health Commission in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. The approved centre had an emergency plan that incorporated a fire evacuation plan.

There was no evidence that the individual with responsibility for risk management had reviewed incidents for trends or patterns occurring in the service.

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

a) **The risk management policy was not being fully implemented throughout the approved centre, 32(1), specifically in relation to the identification and assessment of risk, in all relevant risk categories throughout the approved centre.**

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 insured under the auspices of 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 reception area.

The approved centre was compliant with this regulation.

10.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

NOT APPLICABLE

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

INSPECTION FINDINGS

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating **LOW**

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 in relation to the use of seclusion, dated February 2017. The policy, which had been reviewed annually, identified those who were authorised to initiate seclusion and referenced the provision of information to the resident in seclusion. It identified staff training requirements in relation to the use of seclusion and addressed ways of reducing the rates of seclusion. There was a policy on the use of closed circuit television (CCTV).

Training and Education: All staff involved in the use of seclusion had signed the signature log to indicate that they had read and understood the policy. Records were maintained of staff attendance at training.

Monitoring: An annual report on the use of seclusion was completed and was available for inspection.

Evidence of Implementation: The clinical file of one resident was inspected in relation to four episodes of seclusion. The seclusion register was also examined. The resident in seclusion had access to adequate toilet and bathroom facilities. The seclusion room was furnished, maintained, and cleaned to ensure resident dignity and privacy. Furnishings and fittings in the seclusion room were of a design and quality so as not to endanger resident safety.

All episodes of seclusion were initiated by a registered medical practitioner, and the consultant psychiatrist was notified of the use of seclusion as soon as was practicable. A comprehensive assessment, including a risk assessment, was completed in advance of the use of seclusion. The resident's next of kin were notified in each instance and a copy of each episode was placed in the clinical file.

During the course of the inspection, it was noted that the CCTV in the seclusion room was set to continuously record. The company that installed the system and controlled the settings was contacted immediately and recording was stopped. Until then, it had not been possible to stop using the CCTV if the dignity of the resident in seclusion had been compromised.

Seclusion was used in rare, exceptional circumstances and best interests, when the resident posed an immediate and serious threat of harm to self or others and after all other interventions to manage unsafe behaviour had been first considered. In each case, the use of seclusion was recorded in the clinical file and

the seclusion register and the registered medical practitioner indicated the duration of the seclusion order.

Nursing staff directly observed the resident for the first hour of seclusion. An external courtyard was used for direct observation if required, to overcome a blind spot in the seclusion room. Staff remained outside the door of the seclusion room for the full period of seclusion. Following a risk assessment, a nursing review took place every two hours. A medical review of the resident occurred every four hours. The resident was informed of the reasons for, duration of, and circumstances leading to the discontinuation of seclusion. All episodes of seclusion were reviewed by the multi-disciplinary team.

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

a) **The CCTV used in the seclusion room was set to continuously record, 12.2(c).**
b) **As the CCTV was continuously recording, it was not possible to stop using it if the dignity of the resident in seclusion was compromised, 12.2(d).**

Section 69: The Use of Mechanical Restraint

NOT APPLICABLE

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

INSPECTION FINDINGS

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

11.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NOT APPLICABLE

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

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

a) the patient gives his or her consent in writing to the continued administration of that medicine, or

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

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

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

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

INSPECTION FINDINGS

During this inspection, inspectors were informed that no child had been detained in the approved centre for a consecutive period of three months. Eight of the section 25 court orders processed since the last inspection were reviewed, and Part 4 of the Mental Health Act 2001: Consent to Treatment was deemed not applicable on this inspection. The processes required under section 61 of the Mental Health Act (2001) were included in the approved centres medication management policy.

12.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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, dated February 2017. The policy, which had been reviewed annually, addressed the following:

- The provision of information to residents regarding the use of physical restraint.
- The individuals authorised to initiate physical restraint.
- The training requirements relating to the physical restraint of a child.
- The child protection process in the event of a child being restrained.
- Staff training procedures in relation to the use of physical restraint.

While the policy specified the individuals authorised to initiate physical restraint, it did not specify all staff who could be involved in an episode of physical restraint.

Training and Education: All staff involved in the use of physical restraint had signed the signature log to indicate that they had read and understood the policy. A record of attendance at training was maintained. All relevant staff did not have up to date training in physical restraint. Physical restraint was never used to ameliorate staff shortages.

Monitoring: An annual report had been completed in relation to physical restraint.

Evidence of Implementation: The clinical files of two residents and the relevant clinical practice forms were examined in relation to four episodes of physical restraint. These indicated that physical restraint was initiated by a registered nurse, in rare and exceptional circumstances, where the residents posed an immediate and serious threat of harm to themselves or others. In each case, physical restraint was initiated following a risk assessment and after staff had first tried other interventions. A designated staff member was the lead in all episodes. Not all staff involved in episodes of physical restraint had awareness of the residents care plan or specific requirements in relation to the use of physical restraint.

Cultural awareness and gender sensitivity were demonstrated during the use of physical restraint. In each case, the consultant psychiatrist was notified of the use of physical restraint as soon as was practicable and signed the clinical practice form within 24 hours. Next of kin were informed as soon as was possible. A registered medical practitioner completed a medical examination of the residents within three hours of the start of physical restraint. Members of the multi-disciplinary team reviewed the episodes and documented them in the clinical files within two working days.

In one of the episodes of restraint, it was not documented that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **In one episode, it was not documented that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint, 5.8.**
b) **The policy did not specify all staff in the approved centre who may carry out physical restraint, 9.2(a).**
c) **Not all staff involved in physical restraint were aware of the resident's care and treatment plan in relation to the use of physical restraint, 6.1.**

Admission of Children

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had policies and protocols in place in relation to the admission of a child.

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

Evidence of Implementation: The approved centre was a Child and Adolescent Mental Health Service (CAMHS) and complied in full with this code of practice. Age-appropriate facilities and a programme of activities appropriate to age and ability were provided.

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

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

Appropriate visiting times for families, including children, were available. Families who travelled to see a child could book to stay overnight in appropriate facilities on site. Consent for treatment was obtained from at least one parent.

The approved centre was compliant with this code of practice.

Notification of Deaths and Incident Reporting

NON-COMPLIANT

Risk Rating **LOW**

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

INSPECTION FINDINGS

Processes: The approved centre's risk management policy, dated March 2016, addressed the notification of deaths and incident reporting to the Mental Health Commission (MHC). The policy identified the risk manager and specified the roles and responsibilities of staff in relation to the following:

- The reporting of deaths and incidents.
- The completion of death notification forms.
- The submission of forms to the MHC.

The policy did not reference the named person responsible for completing six-monthly incident summary reports.

Monitoring: There had been no deaths in the approved centre since the last inspection. Incidents were reviewed to identify and correct any problems as they arose and to improve quality.

Evidence of Implementation: The approved centre did not comply with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

The approved centre used the National Incident Management System to report incidents, and the standard incident report form was available to inspectors. A six-monthly summary of all incidents was sent to the MHC.

The approved centre was non-compliant with this code of practice because it did not comply with Regulation 32: Risk Management Procedures, 3.1.

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

NOT APPLICABLE

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

INSPECTION FINDINGS

As no resident of the approved centre had a diagnosis of intellectual disability, this code of practice was not applicable on this inspection.

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

NOT APPLICABLE

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

INSPECTION FINDINGS

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

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was dated March 2016, included a procedure for involuntary admission and protocols for urgent referrals, self-presenting individuals, and planned admission. It also included a protocol for timely communication with primary care and community mental health teams. The approved centre had a policy on privacy and confidentiality.

Transfer: The transfer policy, which was dated July 2017, included procedures for involuntary transfer and outlined the roles and responsibilities of staff in relation to the transfer of residents. It detailed how a transfer was arranged, addressed the safety of the resident and staff during a transfer, and contained provisions for emergency transfer and transfer abroad.

Discharge: The discharge policy, which was dated June 2017, included procedures for the discharge of involuntary patients and the management of discharge against medical advice. It contained protocols for discharging homeless people, and people with intellectual disability. The policy referenced prescriptions and supply of medication on discharge. The approved centre also had a post-discharge follow-up policy.

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

Monitoring: Audits had not been completed on the implementation of and adherence to the admission and discharge policies.

Evidence of Implementation:

The approved centre was non-compliant with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

Admission: One clinical file was reviewed in relation to admission. The approved centre had a key worker system in place and the entire multi-disciplinary team record was contained in a single clinical file. The decision to admit was taken by the registered medical practitioner (RMP) and made on the basis of a mental illness or disorder. The resident was admitted to the unit most appropriate to their needs. The resident was assessed at admission, and details of all assessments were documented in the clinical file. The clinical file contained evidence of the involvement of family/carer in the admission process.

The approved centre's admission process was compliant under the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Residents' Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, and Regulation 27: Maintenance of Records.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical file of one resident who had been transferred to another approved centre was inspected. The decision to transfer was made by the RMP in consultation with the resident's parents and documented. A pre-transfer clinical assessment, including a risk assessment, was recorded. An effort was made to respect the resident's wishes and obtain consent for the transfer. The clinical file contained a copy of the referral letter.

Discharge: Three clinical files were inspected in relation to discharge. In each case, the decision to discharge was taken by the RMP, and a discharge plan was in place as part of the residents' individual care plans. The residents were comprehensively assessed prior to discharge. Efforts were made to inform primary care/community mental health teams of the discharges within 24 hours. In each case, a preliminary discharge summary was issued within three days and a comprehensive discharge summary followed within two weeks.

The approved centre was non-complaint with this code of practice for the following reasons:

a) **There was no evidence that an audit had been undertaken in relation to the implementation of and adherence to the admission or discharge policies, 4.19.**
b) **The approved centre was non-compliant with Regulation 32: Risk Management Procedures, which is associated with this code of practice, 7.1.**

Appendix 1: Corrective and Preventative Action Plan Template - 2017 Inspection Report

Regulation 19: General Health

Report reference: Page 38-39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. Not all residents' general health checks had been completed within the required six-month time frame.	*New*	Corrective Action(s): Post-Holder(s) responsible:	We have since added the general health check list to a weekly checklist- staff check that the general health checks are completed on a weekly basis CNM's responsible for implementation	Currently in place	Completed
		Preventative Action(s): Post-Holder(s) responsible:	Audit	Bi-annualy	Bi-Annually – next due in May 2018

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

Regulation 21: Privacy

Report reference: Page 41

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
2. Appropriate bed screening was not in place in two of the three double bedrooms in the approved centre, which was not conducive to resident privacy.	*Reoccurring*	Corrective Action(s): Post-Holder(s) responsible:	Curtains have been put back up in the rooms as screens between the beds in sharing rooms	Achieved	Completed at time of inspection
		Preventative Action(s): Post-Holder(s) responsible:	Curtains are not to be removed in future unless young person is on their own in the room and request same to be removed. This request to be sought in writing.To be discussed with CNM2's and recorded in minutes of same. CNM's responsible for action.	Achieved	Completed
3. Bedrooms in both units were overlooked from external areas.	*New*	Corrective Action(s): Post-Holder(s) responsible:	Apply privacy window screen to all bedrooms that are overlooked	Achieved	Completed on 19th of December 2017
		Preventative Action(s): Post-Holder(s) responsible:	Apply privacy window screen to all bedrooms that are overlooked	Achieved	Completed on 19th of December 2017

Regulation 22: Premises

Report reference: Page 42-43

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
4. There was no programme of routine maintenance in the approved centre.	*New*	Corrective Action(s): Post-Holder(s) responsible:	Introduction of regular review of local issues log with maintenance (at least, fortnightly) to prioritize and record plan for, and resolution of, issues raised. This to be combined with quarterly physical review of premises, and drafting/update of maintenance plan. This will be monitored by use of log, and the joint ownership involvement of maintenance and unit staff.	Funding. Higher Priorities elsewhere and the availability of limited maintenance personnel resource with a wide remit. Maintenance person employed to carry out routine maintenance to visit units twice a week, to review maintenance log.Maintenance foreman to attend units quarterly.	Planning and prioritization to begin Quarter 1 ; effective ongoing thereafter.
		Preventative Action(s): Post-Holder(s) responsible:	As Above	As above	As above
5. The physical structure of the approved centre did not meet the specific needs of residents as per 22(3) for the following reasons: – Only one of the three beds in the special care unit could be used at a given time due to lack	*Reoccurring (seclusion room)*	Corrective Action(s): Post-Holder(s) responsible:	-during time when a young person requires low stimulus environment, there can only be one bed used. However outside of this time all 3 beds can be utilised -There are plans submitted for works to build a new seclusion room in a more appropriate location, as well as a link corrider between woodsend and willows to rectify this concern. Management will Continue to submit reminders to clinical governance meetings	-achievable when Special Care Area is not in use. - Achievable pending funding Achievable	-When not being used to nurse a patient requiring low stimulus 20 beds can be used, dependant on the needs of inpatients. 12-18months

of space, which had safety implications. – The seclusion room was in an area that could only be accessed from Woodsend by bringing residents outside and through a courtyard. – The gardens were overgrown and pathways were in need of cleaning. – The lift was broken at the time of inspection.			re importance of seclusion room and outline risks involved -In relation to gardens and pathways –Plans suggested for initial clean up of grounds ie gardens and pathways and a maintenance contract going forward by specialist landscaping company. - Lift has been repaired , awaiting insurance certificate.	Achievable Achieved	4-8months 5th of March 2018 Activated within 2 weeks.
		Preventative Action(s): Post-Holder(s) responsible:	-during time when a young person requires low stimulus environment, there can only be one bed used. However outside of this time all 3 beds can be utilised -There are plans submitted for works to build a new seclusion room in a more appropriate location, as well as a link corrider between woodsend and willows to rectify this concern. -As above As above	-achievable when Special Care Area is not in use. - Achievable pending funding Achievable Achievable	When not being used to nurse a patient requiring low stimulus 20 beds can be used, dependant on the needs of inpatients. 12-18months 5th of March 2018

Regulation 25: Use of Closed Circuit Television

Report reference: Page 47

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
6. The CCTV system was capable of recording a resident's image.	*New*	Corrective Action(s): Post-Holder(s) responsible:	At time of inspection the hard drive was removed, and recording function removed. Audit	Achieved	Completed at time of inspection
		Preventative Action(s): Post-Holder(s) responsible:	At time of inspection the hard drive was removed, and recording function removed.	Achieved	Completed at time of inspection

Regulation 26: Staffing

Report reference: Page 48-50

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
7. Not all staff had up-to-date mandatory training in BLS, the management of aggression and violence and the Mental Health Act 2001.	*Reoccurring*	Corrective Action(s): Post-Holder(s) responsible:	Management have put together a 1 day mandatory training day for all staff to attend, it includes TMV, Manual Handling and BLS, Other mandatory training can be completed on-line there will be a greater emphasis this year put on training by Management Assign nurse manager Roisin Callanan to oversee training Register to highlight attendance of mandatory training .	Shortage of staff to be released for training . General business of the unit. Training being cancelled due to instructors being asked to return to work on the units.	9 months to cover all staff
		Preventative Action(s): Post-Holder(s) responsible:	Continually highlight importance of attending mandatory trainiig	Shortage of staff to be released for training . General business of the unit. Training being cancelled due to instructors being asked to return to work on the units.	9 months to cover all staff

Regulation 27: Maintenance of Records

Report reference: Page 51-52

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
8. Records were not complete to include all information regarding physical examinations.	*New*	Corrective Action(s): Post-Holder(s) responsible:	We have since added the general health check list to a weekly checklist- staff check that the general health checks are completed on a weekly basis Monitor via audit	Achieved	Completed at time of inspection
		Preventative Action(s): Post-Holder(s) responsible:	We have since added the general health check list to a weekly checklist- staff check that the general health checks are completed on a weekly basis Monitor via audit	Achieved	Completed at time of inspection

Regulation 28: Register of Residents

Report reference: Page 53

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
9. The register of residents did not appropriately record all of the required information listed in schedule 1, namely residents' diagnosis on admission or diagnosis on discharge.	*Reoccurring*	Corrective Action(s): Post-Holder(s) responsible:	ICD Codes on Admission and Dischargs have been added to the Register of Inpatients since inspection	Achieved	Completed
		Preventative Action(s): Post-Holder(s) responsible:	Audit	Achieved	Completed

Regulation 32: Risk Management Procedures (and Code of Practice: Notification of Deaths and Incident Reporting)

Report reference: Page 58-59

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
10. The risk management policy was not being fully implemented throughout the approved centre, specifically in relation to the identification and assessment of risk, in all relevant risk categories throughout the approved centre.	*Reoccurring*	Corrective Action(s): Post-Holder(s) responsible:	Niamh Lane Health and Saftey Representative and Paul Mc Loughlin CAMHS internal risk manager have attended a train the trainer course on Feb 14th and 15th , titled Positive Risk Programme. They will roll out training to all staff to get them all actively involved in identifying risk in all risk categories through out the approved centre	Achievable	2-6months
		Preventative Action(s): Post-Holder(s) responsible:	Niamh Lane Health and Saftey Representative and Paul Mc Loughlin CAMHS internal risk managaer have attended a train the trainer course on Feb 14th and 15th , titled Positive Risk Programme. They will roll out training to all staff to get them all actively involved in identifying risk in all risk categories through out the approved centre	Achievable	2-6months

Section 69: The Use of Seclusion

Report reference: Page 64-65

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
11. The CCTV used in the seclusion room was set to continuously record. 12. As the CCTV was continuously recording, it was not possible to stop using it if the dignity of the resident in seclusion was compromised.	*New*	Corrective Action(s): Post-Holder(s) responsible:	At time of inspection the hard drive was removed, and recording function removed. Audit	Achieved	Completed
		Preventative Action(s): Post-Holder(s) responsible:	At time of inspection the hard drive was removed, and recording function removed. Audit	Achieved	Completed

Code of Practice: The Use of Physical Restraint

Report reference: Page 70-71

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
13. In one episode, it was not documented that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.	*Reoccurring*	Corrective Action(s): Post-Holder(s) responsible:	Training to be provided for all staff by Anthony Fitzpatrick on the use of seclusion and restraint and in particular documentation	Achievable	4 months-6 months to capture all appropriate staff
		Preventative Action(s): Post-Holder(s) responsible:	Training to be provide for all staff by Anthony Fitzpatrick on the use of seclusion and restraint and in particular documentation	Achievable	4 months-6 months to capture all appropriate staff
14. The policy did not specify all staff in the approved centre who may carry out physical restraint.	*New*	Corrective Action(s): Post-Holder(s) responsible:	Policy currently being amended to reflect that all staff who are employed within CAMHS inpatient unit and are fully TMV trained (5 days) can carry out physical reastraint, which will always be led by a registered nurse. Annual Audit	Achievable	1 – 2 month to go through policies and procdures committee, and cleanrance and Clinical Governance Meeting
		Preventative Action(s): Post-Holder(s) responsible:	As above	Achievable	1 – 2 month to go through policies and procdures committee, and cleanrance and Clinical Governance Meeting

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
15. Not all staff involved in physical restraint were aware of the resident's care and treatment plan in relation to the use of physical restraint.	*New*	Corrective Action(s): Post-Holder(s) responsible:	All members of the MDT inclusive of night porters and MTA's attend handover each morning and night and are made aware of the residents care and treatment plan, and are also made aware of any potential plans for restraint	Achieved	Completed
		Preventative Action(s): Post-Holder(s) responsible:	As above	Achieved	Completed

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 76-77

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
16. There was no evidence that an audit had been undertaken in relation to the implementation of and adherence to the admission or discharge policies.	*Reoccurring*	Corrective Action(s): Post-Holder(s) responsible:	Audit to be completed by Senior Registrars as agreed by consultants	Achievable	2 months
		Preventative Action(s): Post-Holder(s) responsible:	Audit to be completed by Senior Registrars as agreed by consultants	Achievable	2 months