Willow Grove Adolescent Unit, St Patrick's University Hospital

ID Number: AC0080

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Willow Grove Adolescent Unit, St Patrick's University Hospital
James's Street
Dublin 8

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
30 April 2016

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
N/a

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Martin McMenamin
Susan O'Neill

Inspection Date:
25 – 28 September 2018

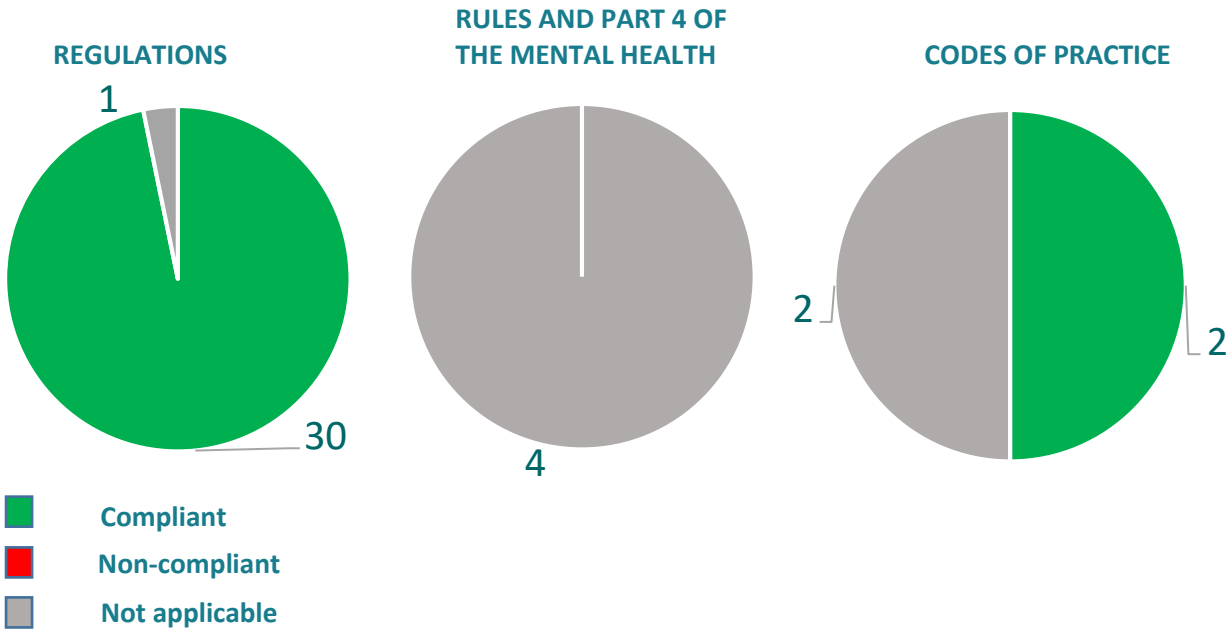
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
25 – 27 April 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
5 March 2019

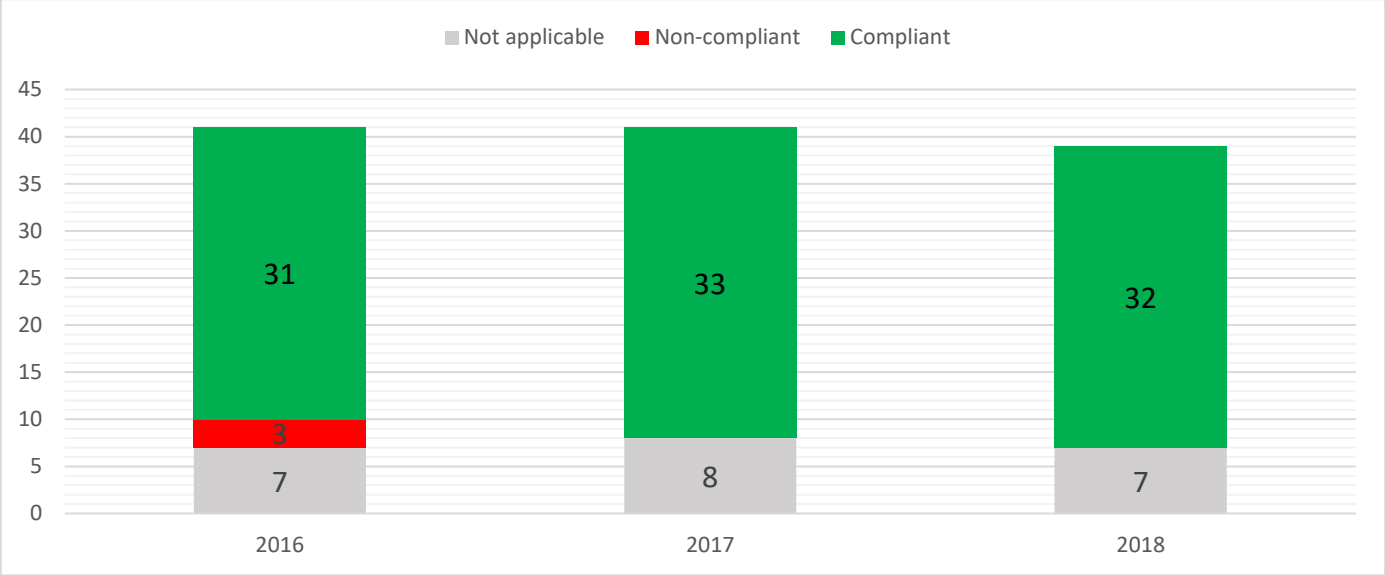
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

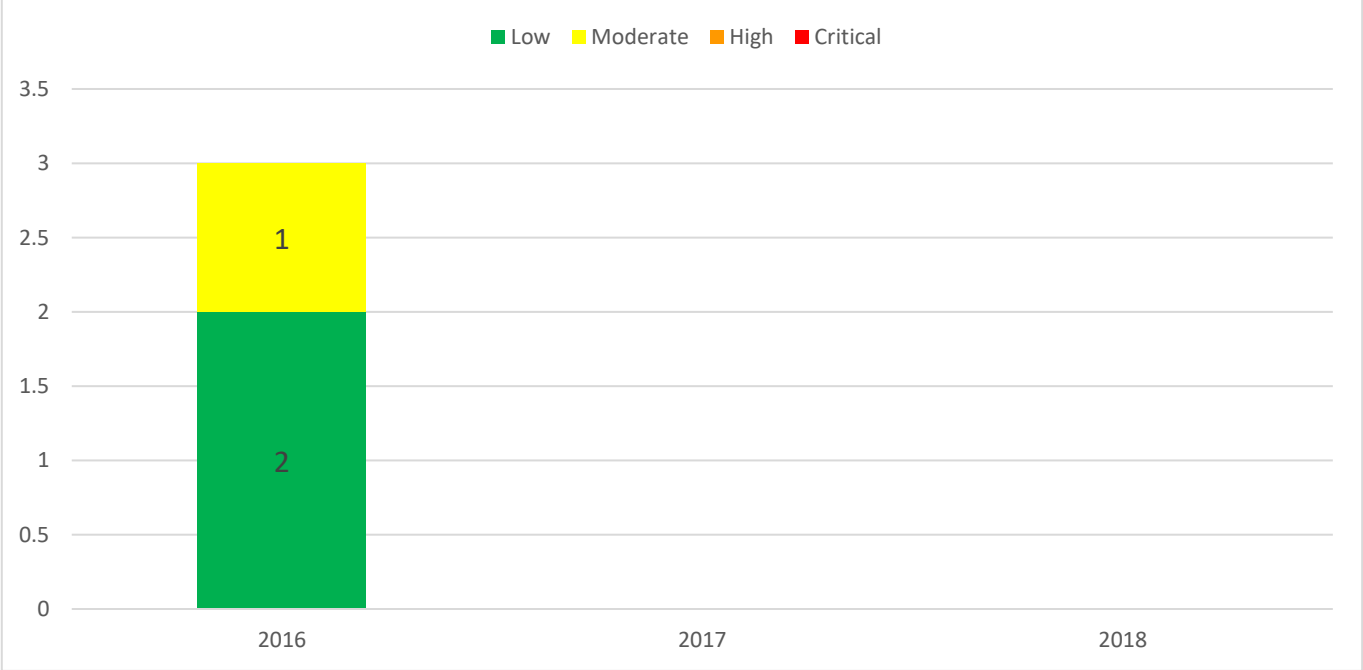
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018



Willow Grove had no areas of non-compliance in 2017 and in 2018 and, therefore, no associated risk ratings for those years.

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1.0 Introduction to the Inspection Process

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

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

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

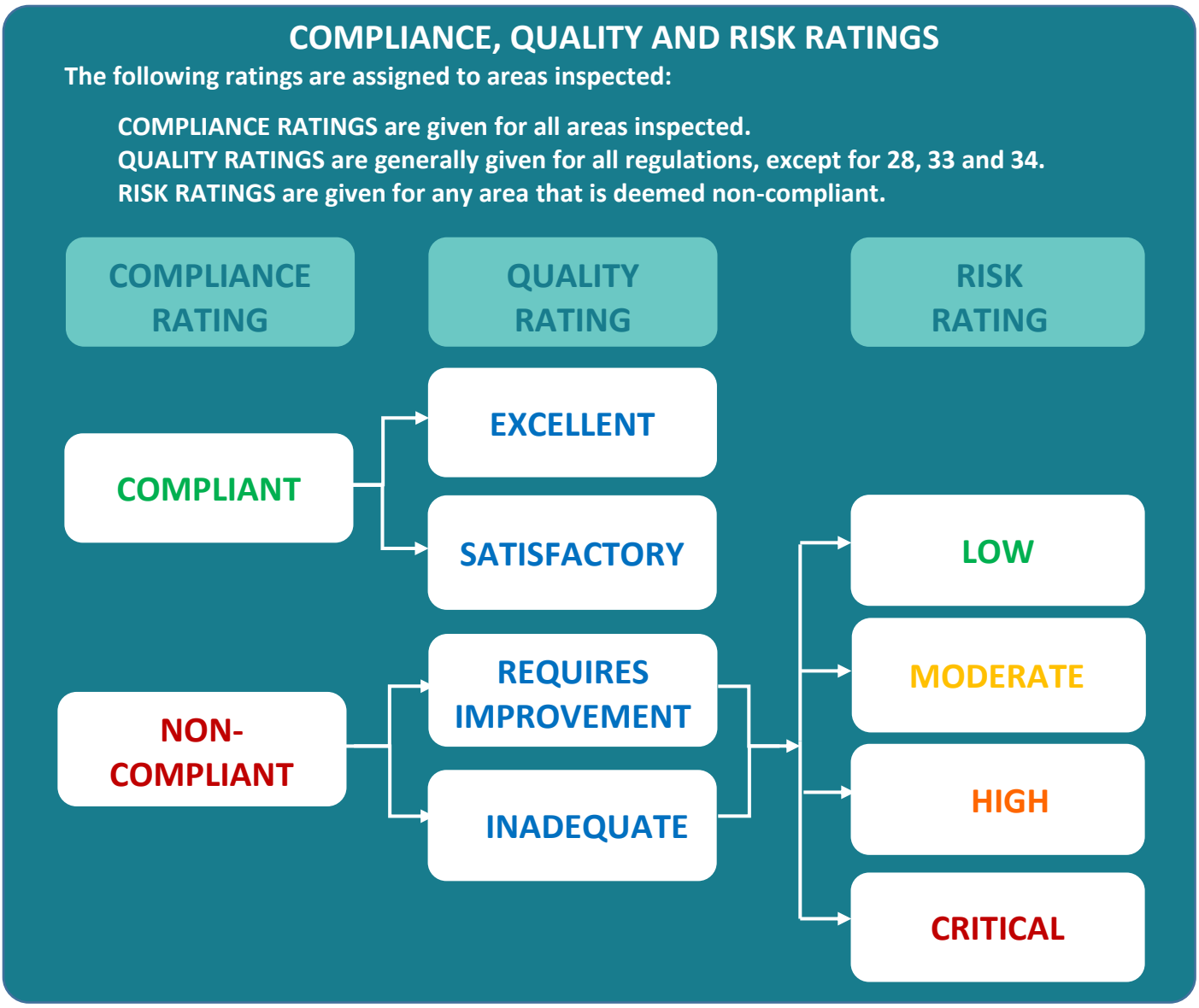
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

Willow Grove Adolescent Unit was a 14-bed independent facility located on the grounds of St. Patrick's University Hospital, Dublin, and was part of St. Patrick's Mental Health Services. It provided treatment to young people with mental illness between the ages of 12 and 17 nationally. All admissions to Willow Grove were planned and the criteria for admission were specific. There were adequate facilities and adequate staffing to support the treatment and recovery of young people receiving care and treatment in Willow Grove. All allied health care professionals working in the unit had training and experience specific to child and adolescent mental health.

The approved centre has been fully compliant with regulations, rules and codes of practice in 2017 and 2018. Twenty-four compliances with Regulations were rated excellent.

Safety in the approved centre

There were regular food safety audits and the kitchen areas were clean. Each young person had at least two personal identifiers for the purpose of administering medication and other interventions. Medication was ordered, prescribed, stored and administered in a safe manner. Ligature anchor points were minimised.

Appropriate care and treatment of residents

Each young person had a multi-disciplinary care plan which was developed and reviewed with the young person and their family. There were therapeutic services and programmes for residents which were evidence-based and based on assessed need. Each young person had access to appropriate medical care as required.

Respect for residents' privacy, dignity and autonomy

Each resident had a single en suite room. There was an age appropriate advocacy service in place.

Visitors could be met in private. The young people in Willow Grove had filtered Wi-Fi access via an internet hub located in the main reception area just outside the nursing office. Access was based on individual risk assessments. Residents were provided with a camera free mobile phone for their use whilst an in-patient in

Willow Grove. Parents signed consent for access to communication media such as internet access, mobile telephone usage.

Responsiveness to residents' needs

There was a wide range of recreational activities, both inside and outside and these were provided during the week and at weekends. The premises was well maintained and was clean. Age appropriate information was provided about the approved centre and there was information about medication and diagnoses as required. There was a robust complaints procedure in place.

Governance of the approved centre

The chief executive officer (CEO) of St. Patrick's Mental Health Services (SPMHS) was the registered proprietor for Willow Grove. There were clear, documented governance structures in place, as indicated in the organisational chart and in minutes of executive team and clinical governance team meetings.

There were systems in place to ensure that risk and incident reporting was escalated appropriately and there was a risk register in place that was reviewed regularly.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The implementation of the e-swift system into Willow Grove since the last inspection. This system provided access and shared clinical information in real time across departments and service locations, and improved the coordination of care and communication between clinicians and service users.

2. The launch of the Willow Grove Summer Programme for young people during the Summer school term. This included comprehensive therapeutic programmes to improve social functioning.

3. Further development of the Wellness Recovery Action Plan (WRAP) programme and the WRAP wall in Willow Grove Unit.

4. Young people's involvement in the "Take My Hand" report by the Ombudsman for Children's office (2018), which detailed young people's experiences of mental health services.

5. The Youth Advocacy Panel presented at the International Association for Youth Mental Health conference. This was a collaborative presentation between the young people and staff.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Willow Grove Adolescent Unit was located on the grounds of St. Patrick's University Hospital, Dublin, and was part of St. Patrick's Mental Health Services. It was on the ground floor of a three-storey building. Willow Grove had its own entrance, and day-to-day operations were independent of those of the main hospital campus. The unit opened in 2010 and since then has provided treatment to young people with mental illness between the ages of 12 and 17, from all over the Republic of Ireland. Willow Grove was easily accessible by public transport, by trains from Heuston Station and nearby trams and buses.

Willow Grove was a 14-bed unit with 10 young people resident on the first day of inspection. All admissions to Willow Grove were planned and the criteria for admission were specific. There were adequate facilities and adequate staffing to support the treatment and recovery of young people receiving care and treatment in Willow Grove. All allied health care professionals working in the unit had training and experience specific to child and adolescent mental health.

The unit was clean, bright, and well maintained. All bedrooms were single and had en suite toilet and shower facilities. There were communal areas with recreational activities for young people to engage in. Residents had access to a fully equipped gym and access to an outdoor tennis court. There was an outdoor garden area which was in need of maintenance; this was rectified at the time of inspection. Young people attended school on-site as appropriate to their needs and their fitness to engage. A Summer Programme had been put in place for residents during the Summer school term.

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

Resident Profile	
Number of registered beds	***14***
Total number of residents	**10**
Number of detained patients	0
Number of wards of court	0
Number of children	10
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

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 chief executive officer (CEO) of St. Patrick's Mental Health Services (SPMHS) was the registered proprietor for Willow Grove. There were clear, documented governance structures in place, as indicated in the organisational chart and in minutes of executive team and clinical governance team meetings. The CEO, clinical director, programme manager, director of services, director of nursing, and heads of department for all allied health care professionals were based in St. Patrick's University Hospital. Policy clearly outlined lines of responsibility as appropriate to individual roles. There was documentation throughout the service indicating evidence-based and best contemporary practice appropriate to child and adolescent mental health care.

There were systems in place to ensure that risk and incident reporting was escalated appropriately. There were also robust systems in place to manage the complaints process. As part of SPMHS, Willow Grove operated under the same governance structures. Management provided opportunity and supported staff to access further education.

Strict admission criteria ensured that Willow Grove operated within capacity, only offering in-patient care to young people whose needs could be met within the environment of Willow Grove and by the therapeutic programmes and services available.

4.5 Use of restrictive practices

The young people in Willow Grove had filtered Wi-Fi access via an internet hub located in the main reception area just outside the nursing office. Access was based on individual risk assessments. Residents were provided with a camera free mobile phone for their use whilst an in-patient in Willow Grove. Parents signed consent for access to communication media such as internet access, mobile telephone usage.

The decision to restrict service user access to communication facilities was made by the Multidisciplinary Team responsible for the service user's care and treatment and was based on assessment of risk.

5.0 Compliance

5.1 Non-compliant areas on this inspection

There were no areas rated non-compliant on this inspection.

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 15: Individual Care Plan
Regulation 16: Therapeutic Services and Programmes
Regulation 17: Children's Education
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 25: Use of Closed Circuit Television
Regulation 26: Staffing
Regulation 27: Maintenance of Records
Regulation 29: Operating Policies and Procedures
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

5.3 Areas that were not applicable on this inspection

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

6.0 Service-user Experience

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

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

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

The young people were generally complimentary of the Willow Grove staff. The residents expressed feeling safe in the approved centre and that overall it was a nice place. The approved centre had a young person's dress code which some felt was very strict. However, the young people understood that the dress code was necessary. Others felt communication was restricted as they could not access Wi-Fi through the mobile phones provided by the approved centre.

With regard to privacy, the young people expressed a wish to be able to lock their bedroom doors. Some residents did not like the restrictions on the storage of some of their personal items. Some residents expressed difficulty sleeping at night due to frequent checks by staff using flashlights.

All the young people agreed that the teacher in the approved centre's school was very helpful and focused on individual needs. The young people were happy that staff in the school regularly liaised with their individual schools.

7.0 Feedback Meeting

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

- Chief Executive Officer
- Medical Director
- Director of Services
- Director of Nursing
- Clinical Nurse Manager 3
- Programme Manager for Clinical Governance
- Occupational Therapy Manager
- Director of Psychology
- Head of Social Work
- Clinical Governance Department staff member
- Consultant, Child & Adolescent Psychiatrist

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.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Name, date of birth, photograph, and address were used. The photograph and name were used to identify residents before administering medications, undertaking medical investigations and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Identifiers were appropriate to the residents' communication abilities and were person specific. A system was in place to alert staff to residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in June 2016. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The head dietitian approved the menus to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food. Residents had at least two meal choices, including daily hot meals. There was access to safe, fresh water and hot and cold drinks were provided.

For residents with special dietary needs, nutritional and dietary needs were assessed and addressed in residents' individual care plans, if needed. These needs were regularly reviewed by a dietician. Residents and their representatives were educated about resident diets specifically in relation to any contraindications in medication. An evidence-based nutrition assessment tool (St. Andrew's Nutrition Screening Instrument) was used on admission and an on-going basis as need. Weight, input, and output charts were maintained where appropriate.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Food was prepared in a manner that reduced risk of contamination, spoilage, and infection. Hygiene was maintained to support food safety requirements. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Appropriate personal protective equipment was used during the catering process. Appropriate hand-washing areas were provided for catering services. Residents were provided with crockery and cutlery that addressed their specific 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 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 March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents had an adequate supply of individualised clothing, which was clean and appropriate to their needs. The supply of emergency clothing was kept in the main hospital, and was appropriate and took account of resident age, preferences, dignity, bodily integrity, religious, and cultural practices. Female and male clothing, underwear, and slippers were available. Residents changed out of nightclothes during daytime hours, unless indicated in their ICP.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written operational policies in relation to residents' personal property and possessions:

- Service users access to their clothing and personal property and possessions, last reviewed in March 2017.
- Processing Service Users Property, last reviewed in March 2017.

The policies 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 policies. Relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policies.

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

Evidence of Implementation: Residents were entitled to bring personal possessions into the approved centre with them. Where the approved centre assumed responsibility for a resident's personal property and possessions, they were safeguarded appropriately. All residents were allocated lockers in the unit for storage of items that they were not allowed to store within their bedrooms. Access to the lockers was available on request. There was a small property room which contained items unable to be stored in the bedrooms due to space limitation. Money or valuables were stored in a safe. All money and valuables were logged; however, this was an extremely rare occurrence as parents were advised to take home all significant sums of money or valuables. Residents generally kept small amounts of cash with them or stored it within their allocated ward lockers.

Parents were advised to take any object deemed inappropriate. Any possession (that was not taken away by parents) deemed to pose a risk was kept in an allocated locker, for example hair straighteners. A

resident property checklist was compiled on admission and updated as needed. The checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Access to and use of resident monies was overseen by two members of staff and the resident or their representative, though no resident money was being handled by staff at time of inspection.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities included: group activities, board games, puzzles, music, TV, relaxation, gym, football, basketball, table tennis, TV or computer based games, internet time, arts and crafts, cookery, community outings, educational and hands on visits to the zoo, and Dublin Society for Prevention of Cruelty to Animals visits and educational sessions. Activities were provided throughout the week, including opportunities for indoor and outdoor exercise. The recreational activities were appropriately resourced. Communal areas were provided that were suitable for recreational activities.

Information was provided to residents on the types and frequency of activities in an accessible format via a large A3 poster. Individual risk assessments were completed to help select activities. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. Residents were free to choose whether to participate and their decisions were respected and documented. Logs of participation were maintained for recreational activities in resident progress notes.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

Monitoring: The implementation of the policy to support residents' religious practices was reviewed to ensure that it reflected the identified needs of residents. This was documented.

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

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to visits, which was last reviewed in May 2018. The policy and procedures 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 visits, as set out in the policy.

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

Evidence of Implementation: Visiting times were appropriate and reasonable, and were publicly displayed in the foyer and throughout the approved centre. A separate visitors' area was provided where residents met visitors in private, if appropriate. The visiting area was suitable for visiting children. Children visiting were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly.

Restrictions on visiting individual residents were justified and documented where necessary. The clinical file documented the names of visitors the resident did not wish to see. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to resident communication, which sat alongside numerous supporting policies. The policy was last reviewed in March 2017. The policy and procedures 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 communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis, with the multi-disciplinary team constantly reviewing based on information gained from family and friends. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, e-mail, internet, and telephone, unless otherwise risk-assessed. Individual risk assessments were completed and documented in relation to any risks associated with their external communication. The clinical director, or senior staff member designated by the clinical director, only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Risk was assessed prior to a search of a resident or their property. Resident consent was sought prior to all searches, which was documented. Where consent was not received, the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents. Residents were informed by those implementing the search of what was happening during a search and why. Policy requirements were implemented when illicit substances were found as a result of a search.

At least two clinical staff were in attendance at all times when searches were conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched.

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

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying, which was last reviewed in August 2018. The policy and protocols 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 end of life care, as set out in the policy.

Only the processes and training and education pillars were inspected against as there had been no deaths since the last inspection.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Excellent**

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 two written policies in relation to the development, use, and review of individual care plans (ICPs):

- Multidisciplinary Service User/Young Person Care Plan, which was last reviewed in June 2018.
- Key Worker System, which was last reviewed in June 2018.

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

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policies. All multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: Ten ICPs were reviewed on inspection. Each resident was initially assessed at admission and an ICP was completed to address immediate needs of resident. An ICP was developed by the MDT following a comprehensive assessment, within seven days of admission. The comprehensive assessment included appropriate information and assessments.

Each ICP was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. The ICPs identified residents' goals, treatment, care, and the resources required to meet residents' needs. The ICP included a preliminary discharge plan, where deemed appropriate, and a risk management plan. The ICP of child residents included their educational requirements. A key worker was identified to ensure continuity in the implementation of each ICP. Evidence-based assessments were used where possible.

The ICPs were developed with the participation of residents and, where appropriate, their representatives. Residents completed a young person's care plan review sheet prior to each ICP meeting. The nurse and consultant also met with each resident twice a week on ward round, and these meetings informed ICPs. Residents did not attend ICP meetings, but the key worker went through ICPs with the resident the following day and received resident feedback. Families were contacted by members of the clinical team after each MDT meeting and on other occasions to discuss care and consent issues.

Each ICP was reviewed by the MDT in consultation with the resident at least every six months. The ICPs were updated following review and residents were kept informed of any changes. Residents were offered a copy of their ICP, including any reviews.

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 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to the provision of therapeutic services and programmes:

- Willow Grove Adolescent Unit Therapeutic Programme Service Plan, was last reviewed in March 2017.
- Protocol regarding therapy provided to in-patient of St Patrick's Mental Health Services by outside agencies, last reviewed in September 2018.

The policies combined included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Therapeutic programmes and services were appropriate and met the assessed needs of residents, as documented in their individual care plans (ICP). Programmes included psychotherapy, a skills group, sensory group, group outings, a Wellness Recovery Action Plan, card feedback, stress management, self-esteem, assertiveness, goal setting, and weekend planning groups. Programmes were run by a cognitive behavioural therapist, dietician, occupational therapist, social worker, psychologists, and the nursing team.

Programmes and services were aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Programmes and services were evidence-based. Adequate and appropriate resources and facilities were available, and were provided in separate dedicated rooms containing facilities and space for individual and group therapies. Rooms included a kitchen, group rooms, multipurpose rooms, sensory room, and a gym. Where no internal service existed, an appropriate external service with an approved, qualified health professional was found.

A list of services and programmes provided in the approved centre was available to residents. A record was maintained of participation, engagement, and outcomes achieved through the therapeutic programme in residents' ICPs or clinical files.

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

Regulation 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had been trained on the policy relating to children's education and its implementation throughout the approved centre. Individual providers of educational services on behalf of the approved centre were appropriately qualified in line with their roles and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs.

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

Evidence of Implementation: Child residents were assessed in relation to their educational requirements on admission, including linking with educational authorities and local education providers as appropriate. A single teacher taught all subjects. The teacher met with each resident when they were admitted. Appropriate facilities and personnel resources were available. Child residents were supported to access external education services. The education provided by the approved centre was reflective of the required educational curriculum, as appropriate to the individual. Where child residents are managing a transition, such as changing school or entering a higher level of education, they received additional support and appropriate assistance. The approved centre prepared each student socially and academically for the return to his or her own school in a planned and integrated manner.

The educational provisions available within the approved centre were effectively communicated, as was a daily activity timetable for schooling. Attendance by child residents at educational services was documented, including reasons for nonattendance. The approved centre maintained comprehensive records of each resident's educational history in the child's individual care plan.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: An assessment was completed and documented prior to transfers, including an individual risk assessment. Verbal communication and liaison took place between the approved centre and the receiving facility prior to transfers, and included a discussion of the reasons for transfer, care and treatment plans, and the resident's accompaniment requirements. Full and complete written information was sent to a named individual in advance and accompanied the resident upon transfer. Information included a letter of referral, medication requirements, and a transfer form. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred.

Copies of all records relevant to the resident transfer were retained in the resident's clinical file. Documented consent of resident to transfer was available, or justification as to why consent was not received. Communication records with receiving facility were documented and available on inspection.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in April 2018. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: Residents received appropriate general health care interventions in line with individual care plans. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as indicated by the residents' needs. As no residents were in the approved centre for longer than six months, six monthly general health assessments were not required.

Adequate arrangements were in place for residents to access general health services and referral to other health services. There was a localised policy on tobacco use and the approved centre had a trained smoking cessation advisor and had access to nicotine replacement therapy. The pharmacist spoke to the young people regularly with regard to nicotine replacement.

Medical emergencies, and the care provided, were recorded. Residents' completed general health checks and associated results were recorded. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator. Both were checked weekly.

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

Regulation 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 three written policies and procedures in relation to the provision of information to residents:

- Accessing interpreting and translation services, last reviewed in June 2017.
- Young person and family education journey, last reviewed in March 2017.
- Orientation to care setting, last reviewed in March 2016.

The policies and procedures 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 policies. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policies.

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

Evidence of Implementation: An information booklet was provided to residents and their representatives at admission in the required format. The booklet was clearly and simply written, and outlined the required information on care, services, and housekeeping practices, including arrangements for personal property, mealtimes, visiting times, and visiting arrangements, the complaints procedure, relevant advocacy and voluntary agencies, and details of the multi-disciplinary team. It also referenced where to find more information on residents' rights.

A variety of diagnosis and medication-related information, including risks and potential side effects, was available and provided to residents as appropriate. Information included evidence-based information about diagnosis, unless the provision of such information would be detrimental to a resident's health and well-being. Information was accessible and residents had access to interpretation and translation services as required. Information sheets regarding medication were obtained from the Choice and Medication

website, and diagnosis information was obtained from Orygen and Synergy websites. Documentation was appropriately reviewed and approved prior to implementation.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Staff had an appropriate demeanour and dressed appropriately. Staff communicated with residents appropriately, used discretion when discussing medical conditions or treatment, and used residents' preferred names. It was noted in a resident feedback meeting that whilst staff knock on doors, they do not always await resident permission before entering the room. All bathrooms, showers, toilets, and single bedrooms had locks with an override function on the inside of the door, unless there was an identified risk to a resident. All residents were wearing clothes that respected their privacy and dignity. Residents were facilitated to make private phone calls to pre-approved numbers, and were informed that their calls may be monitored.

All bedrooms and other rooms had opaque glass in the doors to protect privacy, all doors had blinds and external windows had curtains. Noticeboards did not display resident names or other identifiable information.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to its premises, which were all reviewed within an appropriate timeframe. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents had access to personal space and room to move about. There were suitable furnishings and supports to assist resident independence and comfort. Residents were encouraged to personalise their room. There were enough toilets and showers, which were appropriately placed and identified. There was a sluice room, cleaning room, dedicated therapy room, and laundry room.

Rooms were well heated and ventilated. Heating could be altered in individual resident rooms. Heating and water temperature was seasonally adjusted, with controls identified to allow individual residents to manually adjust temperature. The approved centre had adequate lighting, appropriate signage and sensory aids, and no excessive noise was noted. Hazards were not appropriately identified and minimised, as the stairs to the gym were partially obstructed by storage lockers on the lower landing. The clearance width barely facilitated the inspector passing between locker and wall. There was a cleaning schedule and the approved centre was clean and hygienic. Current national infection control guidelines were followed.

The approved centre was kept in a good state of repair; however, the gardens were poorly maintained. This was rectified during the inspection. Maintenance and faults were recorded and communicated appropriately. The approved centre had access to back-up power. Ligature points were minimised in line with individual risk assessments. Remote or isolated areas were monitored with CCTV.

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

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

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to the ordering, storing, prescribing, and administration of medication, which were last reviewed in an appropriate timeframe. The policies included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Ten MPARs were reviewed on inspection. All entries were legible, written in black, indelible ink, and had three appropriate identifiers. MPARs had dedicated space for routine, once-off, and "as-required" medications. A record of all medications administered to residents was kept, as well as the dose, frequency, administration route, date of initiation and discontinuation, generic and full name, as well as resident allergies. Micrograms were written in full. MPARs included the Medical Council Registration Number of every medical practitioner prescribing medication, and MPARs were electronically signed by the medical practitioner after each entry.

All medicines were administered by a registered nurse or medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber and pharmacist's advice. The expiration date of medication was checked prior to administration; expired medications were not administered. Good hand-hygiene techniques were implemented during the administration of medications. Schedule 2 controlled drugs were checked by two staff members, including one registered nurse, against the delivery form. Details were entered in the controlled drug book and the controlled drug balance corresponded with the balance recorded in the controlled drug book. Medications for self-administration were labelled individually and appropriately.

Medication was stored in an appropriate environment. Medication storage areas were clean, and free from damp, mould, litter, dust, pests, spillage, or breakage. Food and drink was not stored in areas used for medication storage. Medication storage areas were incorporated in the cleaning and housekeeping schedules. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit is taken daily.

Medication dispensed or supplied to residents was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication trolley and medication administration cupboard were locked at all times and secured in a locked room. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

Medication was reviewed and rewritten at least weekly, or more frequently as appropriate; this was documented in clinical files. Medical practitioners rewrote prescriptions where alteration was required. The pharmacist implemented a system of stock rotation and completed a monthly inventory of medications. Medications that were no longer required, which were past their expiry date, or have been dispensed to a resident but are no longer required, were stored in a secure manner, segregated from other medication, and returned to the pharmacy for disposal.

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written operational policies and procedures in relation to the health and safety of residents, staff, and visitors:

- Corporate Safety Statement, which was last reviewed in February 2018.
- Health & Safety Policy, which was last reviewed in June 2016.

The policies and the safety statement 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 policies. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in August 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre.

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

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

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras (or other monitoring systems) were located. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. CCTV was not used to monitor a resident if they start to act in a way that compromises their dignity. CCTV cameras were incapable of recording or storing a resident's image. CCTV cameras did not transmit images other than to a monitor that is viewed solely by the health professional responsible for the resident. The usage of CCTV was disclosed to the Mental Health Commission.

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

Regulation 26: Staffing

COMPLIANT

Quality Rating **Excellent**

(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 two written policies and procedures in relation to its staffing requirements:

- Staffing policy, which was last reviewed in September 2018.
- General recruitment policy, which was last reviewed in May 2016.

The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

Evidence of Implementation: The numbers and skill mix of staffing were sufficient to meet resident needs. Staff were recruited and vetted in accordance with the approved centre's policy and procedure. Staff had the appropriate qualifications to do their job. The required number of staff were on duty at night to ensure safety of residents in the event of a fire or other emergency. A planned and actual staff rota was maintained and an appropriately qualified staff member was on duty and in charge at all times; this was documented. There was an organisational chart to identify the leadership, management structure, and lines of authority and accountability.

There was a staffing plan that addressed the skill mix, competencies, number and qualifications of staff, and takes into account the size and layout of the approved centre and the assessed needs of the resident group profile. Annual staff training plans had been completed to identify required training and skills development. New staff completed orientation and induction training. All health care professionals were trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001, and Children First. Staff had also received a range of other training, including manual handling, infection control and prevention, resident rights, risk management, and recovery-centred approaches to mental health care and treatment.

Opportunities were made available and communicated to staff, and staff were supported to undertake further education. In-service training was completed by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training.

Staff training was documented and staff training logs were maintained. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Willow Grove	CNM1	1	0
	CNM2	1 Mon-Fri	0
	CNM3	1 Mon-Fri	0
	RPN	6 morning 5 evening	3
	Occupational Therapist	1	0
	Social Worker	By referral	0
	Psychologist	1	0
	Cognitive Behavioural Therapist	1 day a week	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN).

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 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to the maintenance of records, which were reviewed within the appropriate timeframes. The policies and procedures addressed all of the requirements *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 policies. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policies. All clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: All resident clinical files were online and information was easy to find. The approved centre maintained a record for every resident who was assessed or provided with care. Records had a unique identifier, were secure, up to date, in good order, and maintained in line with national guidelines and legislative requirements. Only authorised staff could access data and make new entries, and residents could access records in line with relevant legislation. Staff had access to the information needed to carry out their job.

Records were maintained appropriately, including being factual, consistent, reflecting the residents' current status, and used date and time (using the 24-hour clock). All entries made by student nurses or clinical training were validated by a registered nurse or clinical supervisor. Where errors were made, they were corrected appropriately. Where a member of staff made a referral, or consulted with a colleague,

this person was clearly identified by their full name and title. Information or advice was given over the phone was documented.

Documentation of food safety, health and safety, and fire inspections was maintained. Records were retained or destroyed in accordance with legislative requirements.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to the development and review of operating policies and procedures required by the regulations:

- Policy and Procedure Development and Approval, which was last reviewed in September 2018.
- Communication of New Policy or Policy Change, which was last reviewed in May 2017.

The policies 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. Policies were a standing item on the Clinical Governance group meeting. Each head of department was responsible for inputting into policy as they were reviewed. The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately formatted, approved, and communicated to all relevant staff. Policies were communicated to staff at induction and through line managers locally and signed off accordingly. Updates to policies were conveyed to all staff regularly with staff signatures updated accordingly. Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained but removed from access by staff.

Generic policies were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre has a written statement to this effect (adopting the generic policy).

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 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints, which was last reviewed in May 2017. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

Evidence of Implementation: Residents and their representatives were provided with information on the complaints process, with information being well publicised and accessible. Information regarding the complaints process was available throughout the approved centre, and there were suggestion boxes in the unit which were checked twice weekly. Residents and their representatives were assisted to make complaints using appropriate methods and were facilitated to access an advocate. There was a nominated complaints officer who was responsible for dealing with complaints, who was clearly identified. There was also a method for addressing minor complaints. The complaints officer dealt with minor complaints that could not be addressed locally. Where services, care, or treatment were provided on behalf of the approved centre by an external party, the nominated person was responsible for the full implementation of the approved centre’s complaints management process.

All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and informed promptly of the outcome and details of the appeals process. The complaints officer maintained a log for complaints they dealt with, including complete details of the complaint, investigation, outcomes, and the complainant's view of the outcome. This was kept distinct from the resident's individual care plan.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected because of the complaint being made. All information obtained in the complaints process was treated confidentially, consistent with relevant legislation.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to risk management and incident management procedures:

- Risk Management policy, which was last reviewed in March 2017.
- Safety Statement, which was last reviewed in 2018.

The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

Evidence of Implementation: The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in risk registers. Structural risks, including ligature points, were removed or effectively mitigated. A plan was implemented to reduce risks to residents while works to the premises were ongoing. The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management processes.

Individual risk assessments were completed prior to and during resident admission, transfer, discharge, physical restraint, and in conjunction with medication requirements or administration. Multi-disciplinary teams, residents, and their representatives were involved in the development, implementation, and review of individual risk management processes.

Incidents were recorded and risk-rated in a standardised format. The designated risk manager reviewed incidents for any trends or patterns occurring in the services, and clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of that review and recommended actions. The Mental Health Commission was provided with a six-monthly summary report of all incidents, with information anonymised at a resident level.

The requirements for the protection of children and vulnerable adults were appropriate and implemented. There was an emergency plan that specified responses by staff to possible emergencies, including evacuation procedures.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered 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 with no conditions to registration attached. The certificate was displayed prominently in the entrance to the improved centre.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

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

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of Mental Health Act 2001 was not applicable to this approved centre at the time of the inspection. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated March 2018. It addressed the following:

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

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

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

Evidence of Implementation: Physical restraint was used in relation to child residents. Child protection policies and procedures were in place. The policies addressed appropriate training for staff in relation to child protection.

Three episodes of physical restraint were reviewed on inspection. In all cases, physical restraint was used in rare, exceptional circumstances and in the best interests of the resident. Physical restraint was only exercised where a resident posed immediate threat of serious harm to self or others, after all alternative interventions had been considered, and based on a risk assessment. Orders for physical restraint did not last for longer than 30 minutes. Residents were informed of reasons for, likely duration of, or circumstances leading to discontinuation.

Physical restraint was initiated by an appropriate health professional in line with the physical restraint policy. A designated staff member was responsible for leading the physical restraint and monitoring the head and airway of the resident. The consultant psychiatrist or duty consultant psychiatrist was notified as soon as was practicable. This was documented. Cultural awareness and gender sensitivity was demonstrated. A same sex staff member was present at all times during physical restraint where practicable. Staff were aware of relevant considerations in individual care plan.

A registered medical professional completed a medical examination within three hours of the end of the episode, except in one case where the resident refused. As soon as practicable, the resident's parents or guardian were informed of the use of physical restraint; this was recorded. Residents were afforded an opportunity to discuss the episode with members of their multi-disciplinary team. Each episode of physical restraint was documented in a clinical file. A clinical practice form was completed by the initiator of physical restraint within three hours. That form was signed by a clinical psychiatrist within 24 hours and placed into the resident's clinical file. In one case, the episode was reviewed by members of the multi-disciplinary team (MDT) and documented within two working days, and the resident had the opportunity to speak with the MDT about the episode. In the other two cases, the residents were discharged within two working days.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge, which were last reviewed in June 2018, April 2018, and March 2018 respectively. Collectively they addressed all of the policy-related criteria for the codes of practice.

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

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

Evidence of Implementation:

Admission: All admissions were on the basis of mental illness or mental disorder. Admission assessments were completed and included an appropriate range of assessments. Resident's representatives were involved in the admission process, with the resident's consent. A key worker system was in place.

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

Discharge: The approved centre maintained discharge plans, which included documented communication with relevant health professionals, an estimated date of discharge, references to early warning signs of relapse and risks, and a follow-up plan.

Discharge meetings were attended by residents and their representatives, key worker, and relevant members of multi-disciplinary team. Discharge assessments addressed medical and informational needs. Discharges were coordinated by a key worker.

Comprehensive discharge summaries were issued within 14 days. Discharge summaries included details such as medical information, follow-up arrangements, and names and contact details of key people. Resident representatives were involved in discharge process. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.