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

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

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

Cherry Orchard Hospital Campus, Ballyfermot Road, Ballyfermot, Dublin 10

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2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child & Adolescent Mental Health Care

Most Recent Registration Date:
10 December 2018

Conditions Attached:
None

Registered Proprietor:
HSE

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

Inspection Team:
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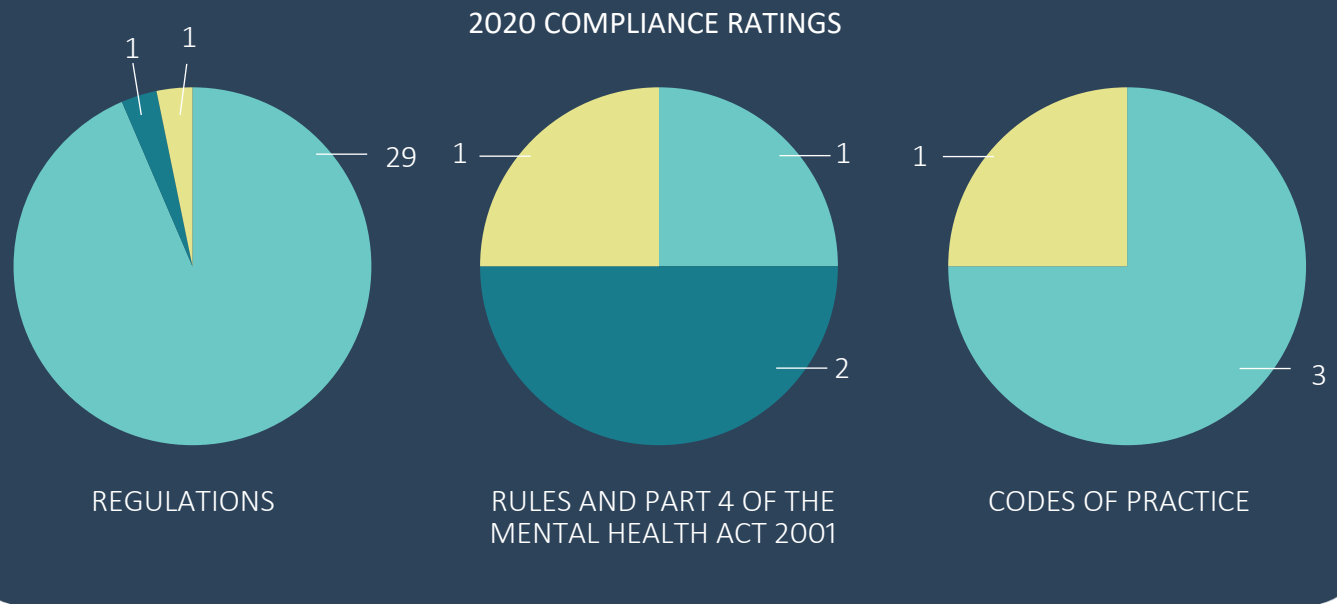
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
14 – 17 July 2020
21 July 2020

Previous Inspection Date:
22 – 24 October 2019

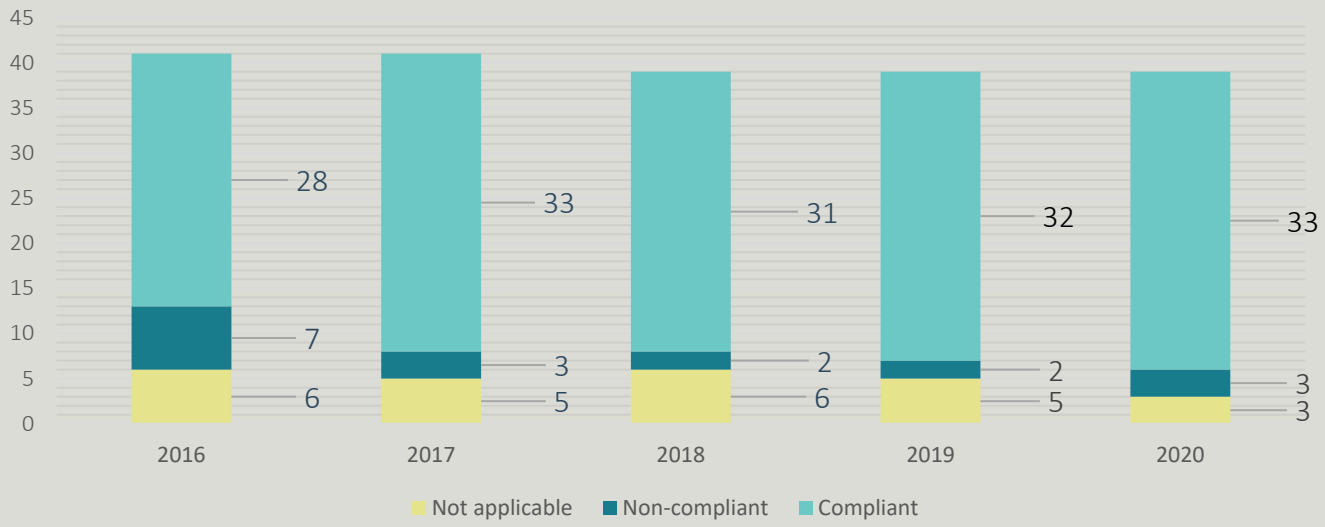
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2016 – 2020

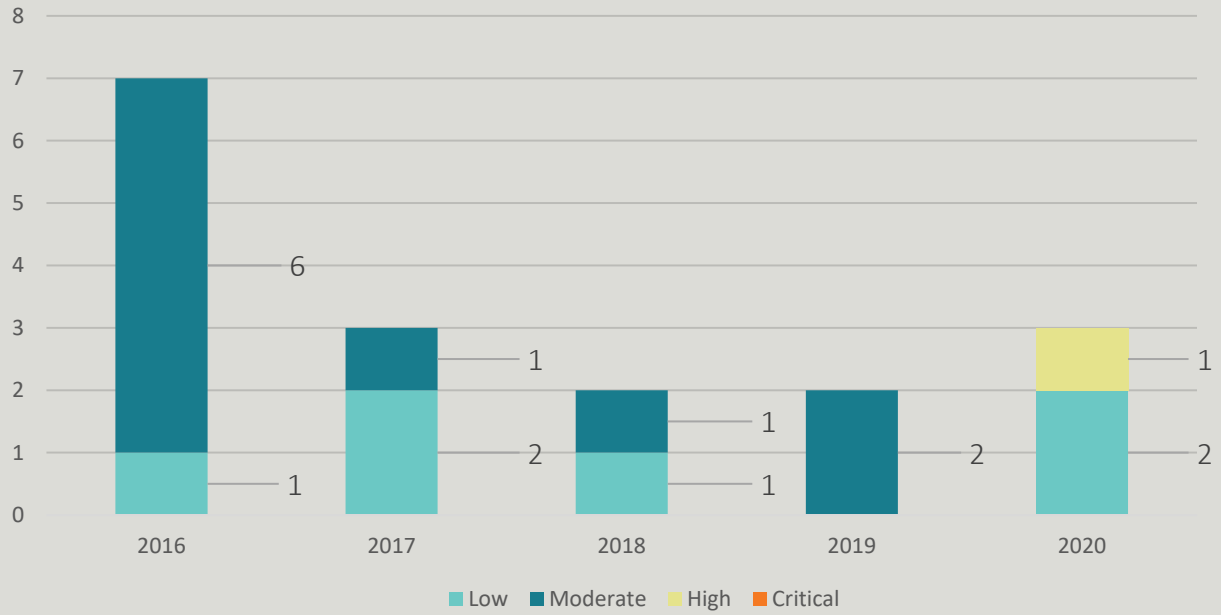
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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 – 2020



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with regulations rules and codes of practice.

In line with Public Health guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

Linn Dara Child and Adolescent Mental Health Service (CAMHS) in-patient unit was located on the Cherry Orchard Hospital campus in Ballyfermot, Dublin 10. The facility catered for young people under the age of 18 and had a total capacity of 24. It consisted of two 11-bed units; Hazel which predominantly accommodated younger residents under the age of 16, and Rowan which accommodated older adolescents, together with a two-bed high observation area (Oak). All bedroom accommodation was in single, en suite bedrooms.

The approved centre had a high level of compliance with regulations, rules and codes of practice over the past four years.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	80%	92%	94%	94%	92%
Regulations Rated Excellent	6	16	7	20	N/A

Conditions to registration

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

Safety in the approved centre

- Regular food safety audits are completed and kitchen areas were clean.

- Ligature anchor points were minimised and regular individual risk assessments were completed.
- The ordering, prescribing, storing, and administration of medication was completed in a safe manner.
- Hazards were minimised.
- A comprehensive COVID 19 infection prevention and control was in place.

Appropriate care and treatment of residents

- Each resident had an individual care plan.
- Technology Enabled Care Services (TECS) were introduced to support care and service delivery during the pandemic. TECS is a range of health and care technologies such as teleconsultations and telecoaching delivered by remote telephone or video.
- There was a separate dedicated room containing facilities and space for individual and group therapies. The therapeutic services and programmes provided by the approved centre were evidence-based, and included art psychotherapy, play therapy, and drama therapy.
- Each young person had access to physical health care as indicated by their needs.
- A dietician assessed the nutritional needs of young people as indicated and provided part of the programme for eating disorders.

However:

- Two ICPs did not identify appropriate goals for the young person, while one of the ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.

Respect for residents' privacy, dignity and autonomy

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

However:

- One young person was mechanically restrained for extended periods of time using arm and leg cuffs in order to protect others from injury.
    - It was used at night even when the young person was asleep which meant that it was not only used in exceptional circumstances.
    - The consultant psychiatrist responsible for the care of the young person was not notified of the use of mechanical restraint as soon as was practicable on three separate occasions.
    - A risk assessment was not completed prior to the initiation of mechanical restraint.
    - The MDT did not develop a plan of care for mechanical restraint for the young person.

- Seclusion facilities were not maintained and cleaned to ensure respect for the young person's dignity and privacy, as there were fluid stains on the walls and the bathroom floor of the seclusion room was worn and beginning to come away.

Responsiveness to residents' needs

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

Governance of the approved centre

- Linn Dara in-patient unit was part of the Linn Dara CAMHS providing a service to Area 7: Dublin South West, Kildare, and West Wicklow Community Healthcare. The in-patient unit also provided a catchment area service to sections of Area 8 (specifically counties Laois, Offaly, Westmeath, and Longford).
- A specific Approved Centre Governance Group had charge of compliance with the various requirements of the Mental Health Act 2001, evaluated activity levels within the centre, promoted quality improvement, and ensured standardisation of service delivery in line with best practice. It also had a role in financial oversight within the approved centre and in monitoring service user feedback
- A COVID-19 preparedness plan was developed and implemented which promoted infection control and ensured there was reduced footfall.
- Staff had access to regular clinical supervision. Documented training plans were in place to address identified deficits and to promote staff development.
- An independent youth advocacy service was in place and provided a report to the inspectors that included recurring themes, and common emerging themes.

- An active audit process had been developed within the approved centre to identify and address any deficits in the provision of services. Audits involved various disciplines and were updated in a timely manner.
- It was evident from the information provided that an active governance process involving both clinical and operational staff was in place to monitor operational, staffing, and clinical risks affecting the approved centre.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Enhanced infection and prevention control measures were implemented in response to COVID-19 Pandemic.

2. Technology Enabled Care Services (TECS) were introduced to support care and service delivery during the pandemic. TECS is a range of health and care technologies such as teleconsultations and telecoaching delivered by remote telephone or video. These technologies complement services and are appropriate for some young people and offer an alternative to a traditional face to face appointment.

3. A Youth Advocate was introduced in all units.

4. The seclusion core care plan was updated.

5. The young person information booklet was updated.

6. New tablet computers were introduced to assist young people in communicating with family, friends, advocates and legal representatives.

7. Two specialist treatment rooms were dedicated to support Specialist Eating Disorder programme.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

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

All bedroom accommodation was in single, en suite bedrooms. There was a school attached to the unit. In addition, there was a range of communal recreational and therapeutic facilities available, including a sports hall, gymnasium, and outdoor gardens. The unit was appropriately decorated and furnished with age-appropriate furniture and artwork.

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

Resident Profile	
Number of registered beds	***24***
Total number of residents	**20**
Number of detained patients (s.25)	9
Number of wards of court	1
Number of children	20
Number of residents in the approved centre for more than 6 months	3
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

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

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

The inspection team was provided with a variety of documents outlining the governance process and associated meeting minutes, which incorporated the approved centre. These included the Linn Dara CAMHS

Management Group, the Operations Group, the Policy Group, the Governance Group, and the Quality and Patient Safety (QPS) group.

In addition, a specific Approved Centre Governance Group, comprising representatives of multi-disciplinary management within the approved centre met at two monthly intervals. This group oversaw the functioning of the approved centre to ensure compliance with the various requirements of the Mental Health Act 2001, to evaluate activity levels within the centre, promote quality improvement, and ensure standardisation of service delivery in line with best practice. It also had a role in financial oversight within the approved centre and in monitoring service user feedback. It sought to embed an advocacy forum, review quality indicators, and to foster a culture of continuous professional development for staff. An approved centre Quality and Safety group met at approximately six-weekly intervals.

Governance questionnaires were completed by the heads of clinical disciplines. To update this information the inspection team spoke to heads of clinical disciplines operating within the approved centre. This process clarified the current roles of theses disciplines in the overall governance of the approved centre, specific and generic risks, and processes to manage the risks identified. Twelve operational risks associated with a pandemic had been added to the risk register. A COVID-19 preparedness plan was developed and implemented. Two teams, working seven days on and seven days off were established. These teams were led by a Consultant Psychiatrist and Nurse Managers. Further divided into sub-teams, each worked four long days with three days off. A speech and language therapist and a psychologist from the community mental health teams joined the teams in the approved centre, to ensure continuous service and equity on both multi-disciplinary teams. These measures promoted infection control and ensured there was reduced footfall.

Staff working within the approved centre had access to regular clinical supervision, either directly within the centre or involving staff working within the broader service. Documented training plans were in place to address identified deficits and to promote staff development. An independent youth advocacy service was in place and provided a report to the inspectors that included recurring themes, and common emerging themes.

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

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

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 15: Individual Care Plan	✗	Moderate	✓		✓		✓		✗	Low
Rules Governing the Use of Seclusion	✓		✓		✓		✓		✗	Low
Rules Governing the Use of Mechanical Means of Bodily Restraint	✓		✓		✓		✓		✗	High

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

4.2 Areas 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.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents, their parents or guardians could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- The Independent Advocacy Service that visit residents in Linn Dara were contacted to obtain residents' feedback about the approved centre and a report was provided.

Fourteen young people returned questionnaires and the majority of comments were very complimentary of the staff and the care and treatment they received. Three young people did not feel able to give feedback to staff and nine said there was not enough activities during the day.

6.0 Feedback Meeting

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

- Clinical Director
- The Registered Proprietor
- The Area Director of Nursing
- The Assistant Director of Nursing
- The Inspector of Mental Health Services

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(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

Young persons were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Young persons had at least two choices for meals and a source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre. For young persons with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in the young person's individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(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

There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements and young persons were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

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

The young people were provided with emergency personal clothing that was appropriate and considered the young peoples' preferences, dignity, bodily integrity, and religious and cultural practices. No young persons wore nightclothes during the day.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

(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

The approved centre had a written operational policy and procedures relating to young persons' personal property and possessions. The policy was last reviewed in February 2018. A young person's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the young person's monies, valuables, personal property, and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each young person of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the young person's individual care plan (ICP) and was available to the young person. The young people were supported to manage their own property, unless this posed a danger to the young person or others, as indicated in their ICP or in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the young person group profile. Activities included board games, DVDs, a gym for exercise and games. There was an arts and crafts room, which was well resourced. The young people had access to a horticulturist for gardening activities. There are various games consoles was in the approved centre for young persons' use. There was relaxation group time and movie nights. The approved centre provided access to recreational activities on weekdays and during the weekend.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

The young peoples' rights to practice religion were facilitated within the approved centre insofar as was practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

(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

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2019. Visiting times were appropriate and reasonable, though they were restricted due to pandemic events and infection control measures; parents and guardians could visit twice weekly. Justifications for visiting restrictions implemented for a young person were documented in the clinical file. Separate visitors' rooms were provided where young persons could meet visitors in private, unless there was an identified risk to the young person, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of young persons and visitors during visits. Visiting rooms were suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

(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

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in July 2019. The young people had access to a phone and internet unless otherwise risk-assessed with due regard to the young persons' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing young person communication if there was reasonable cause to believe the communication would result in harm to the young person or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

(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

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in February 2019 and included all requirements related to:

- 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.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

Risk was assessed prior to the search of the young person, their property, or the environment, appropriate to the type of search being undertaken. The parent or guardian consent was sought prior to all searches and the request for consent and the received consent were documented for every search. The resident search policy and procedure was communicated to all young persons.

The young people were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the young person’s dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the young person being searched. A written record of every search of a young person and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. Policy requirements were implemented when

illicit substances were found as a result of a search. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

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

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in February 2018. No young person had died in the approved centre since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating LOW

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the young person and their representative, family, and next of kin, as appropriate.

Two ICPs did not identify appropriate goals for the young person, while one of the ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICPs inspected identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT weekly, in consultation with the young person. ICPs were updated following review, as indicated by the young person's changing needs, condition, circumstances, and goals.

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

a) **Two ICPs did not identify appropriate goals for the young person.**
b) **One of the ICPs did not identify the treatment required to meet the identified goals.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

(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

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the young persons as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of young persons. There was attachment-based family therapy and group interventions included body image, mindfulness, and a dialectical behaviour therapy (DBT) skills group. Speech and language therapy ran groups on social communication, assertive communication, and functional communication. Occupational therapy, for example, arranged activity based groups, such as baking, self-care, engaging in leisure activities. There was a wide variety of nurse led activity groups provided weekly. Where a young person required a therapeutic service or programme that was not provided internally, the approved centre normally arranged for the service to be provided by an approved, qualified health professional in an appropriate location; however, due to the COVID-19 pandemic events and the closure of external services, this was limited.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

Child residents were assessed in relation to their educational requirements, with consideration of their individual needs and age on admission. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities were available for the provision of education, as were sufficient personnel resources. Due to pandemic events, virtual classrooms were established and all young people were provided with tablets. An individual plan was arranged by the key teacher and nurses supported young persons and assisted them with their work.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

(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

The approved centre had an operational policy and procedures relating to the transfer of young people. The policy was last reviewed in February 2018. The clinical file of one young person who had been transferred was examined. Full and complete written information for the young person was transferred when they were moved from the approved centre. Information accompanied the young person upon transfer, to a named individual, including a letter of referral that contained a list of current medications, a young person transfer form, and the required medication for the young person during the transfer process.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(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

The approved centre had a medical emergencies policy, which was last reviewed in February 2018. The approved centre had an emergency trolley and staff had access at all times to an AED, both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Three clinical files were examined in relation to provision of general health services during the inspection process. Registered medical practitioners assessed the young person's general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Young people received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the young person's specific needs, but not less than every six months. The six monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, body mass-index, and weight. For young persons on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, prolactin levels, and an electrocardiogram was undertaken.

Adequate arrangements were in place for young persons to access general health services and for their referral to other health services as required. Records were available demonstrating young peoples' completed general health checks and associated results, including records of any clinical testing, e.g. laboratory results.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

(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

The approved centre had a written operational policy and procedures on the provision of information to young persons. The policy was last reviewed in February 2018. The required information was provided to young persons and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required format to support young peoples' needs and information was clearly and simply written. It contained details of: housekeeping arrangement, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and; their rights.

Young people were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the young person's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to young peoples' needs. The content of the medication information sheets included information on indications for use of all medications to be administered to the young person, including any possible side effects. The young people had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Young people were called by their preferred name and the general demeanour of staff and the way in which they dressed and communicated with young persons was respectful. Staff were discrete when discussing the young person's condition or treatment needs and sought the young person's permission before entering their room, as appropriate.

The layout and furnishings of the approved centre were conducive to young peoples' privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a young person. Observation panels on bedrooms had a frosted blind mechanism for the service user to manage and there was an override system for staff. Treatment rooms also had privacy observation panels. Where rooms were overlooked by public areas, opaque glass was fitted to protect the young person's privacy. Notice boards within the units only included the first names of young persons and key workers; no other identifiable information was located on notice boards.

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(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

Young people had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics and the lighting in communal rooms suited the needs of young persons and staff. Appropriate signage and sensory aids were provided to support young person orientation needs and sufficient spaces were provided for young people to move about, including outdoor spaces.

Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre. There was a minimisation of ligature points to the lowest practicable level, based on risk assessment.

There was a sufficient number of toilets and showers for young people in the approved centre and there was at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room. All young persons' bedrooms were appropriately sized to address the young persons' needs. The approved centre provided assisted devices and equipment to address young persons' needs, as well as suitable furnishings to support young person independence and comfort.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Though the approved centre was generally clean, hygienic, and free from offensive odours, the seclusion room had fluid stains on the walls and the bathroom floor was worn and beginning to bubble

and come away from the wall. Rooms were centrally heated with overhead radiant panels. Current national infection control guidelines were followed.

The approved centre was compliant with this regulation.

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

COMPLIANT

(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

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in February 2018 and included:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing resident medication.
- The process for the administration of resident medication, including routes of medication.

A Medication Prescription and Administration Record (MPAR) was maintained for each young person, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the young person had no allergies; the administration route for the medication; a record of all medications administered to the young person, and; a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the young person and the signature of the medical practitioner for each entry. However, three MPARs did not have the minimum dose intervals recorded.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently, where there was a significant change in the young person's care or condition: this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the young person was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

The approved centre was compliant with this regulation.

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

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in February 2018.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

(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

The approved centre had a written operational policy and procedure on the use of CCTV. The policy was last reviewed in February 2019. The policy included the purpose and function of using CCTV for observing young persons in the approved centre.

There were clear signs in prominent positions where CCTV cameras or other monitoring systems were located throughout the approved centre. A young person was monitored solely for the purposes of ensuring the health, safety, and welfare of that young person. The use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras used to observe a young person were incapable of recording or storing a young person's image on a tape, disc, hard drive, or in any other form, and did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the young person. CCTV was not used to monitor a young person if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

(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

The approved centre had a written operational policy and procedures in relation to staffing. The policy was last reviewed in February 2018. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staffing were sufficient to meet young persons' needs and an appropriately qualified staff member was on duty and in charge at all times. This was documented. 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. As part of the COVID-19 pandemic plan three staff were deployed from the community mental health teams to work in the approved centre. Young people in the approved centre had access to a Speech and Language therapist, a Dietitian and a Psychologist.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) & 26(5) have been deferred until 2021.

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

Staff in Approved Centre		
Staff Grade	Day	Night
Consultant Psychiatrist	2	
Non consultant Hospital Doctor	2	
Assistant Director of Nursing	1	1 ADON or CNM3 on call
Clinical Nurse Manager 3	1	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Hazel	Clinical Nurse Manager 2	1	
	Clinical Nurse Manager 1	1	
	Registered Psychiatric Nurse	3	
	Occupation Therapist	1	
	Social Worker	1	
	Psychologist	1	
	Dietitian	1	
	Speech and Language Therapist	1	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Rowan	Clinical Nurse Manager 2	1	
	Clinical Nurse manager 1	1	
	Registered Psychiatric Nurse	3	3
	Occupation Therapist	1	
	Social Worker	1	
	Psychologist	1	
	Dietitian	1	
	Speech and Language Therapist	1	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Oak Ward	Clinical Nurse Manager 2	1	
	Registered Psychiatric Nurse	2	2
	Healthcare Assistant	1	1
	Occupational Therapist	As required	
	Social Worker	As required	
	Psychologist	As required	
	Dietitian	As required	
	Speech and Language Therapist	As required	

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

(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

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in February 2018. The young peoples' records were secure, up-to-date, and in good order, and were physically stored together in a secure office on each ward. All young person records were reflective of the young person's current status and the care and treatment being provided.

Young peoples' records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

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 young people, 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

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

All operating policies and procedures requiring a three-yearly review were reviewed appropriately.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(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

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in February 2018 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaints procedure to young persons and their representatives at admission or soon thereafter. This information was available within the young person information booklet and noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Young people, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a young person was not adversely affected by reason of the complaint being made. Minor complaints were documented and details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the young person’s ICP. No formal complaints had been escalated since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

(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

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed and dated February 2018, and it addressed all requirements.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated

Individual risk assessments were completed prior to and during seclusion, physical restraint, mechanical restraint, specialised treatments, in conjunction with medication requirements or administration, transfer and discharge, as well as at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Young people and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Health and safety risks were identified, assessed, treated, reported, monitored and documented within the risk register as appropriate. Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was

maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with three conditions to registration attached. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion, which was last reviewed in February 2020. The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

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

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: Seclusion facilities were not maintained and cleaned to ensure respect for the young person's dignity and privacy, as there were food stains, on the walls. The bathroom floor of the seclusion room was worn and beginning to come away. Young people in seclusion had access to adequate toilet and washing facilities. The seclusion room's furniture and fittings were of a design and quality so as not to endanger patient safety. The seclusion room was not used as a bedroom.

One episode of seclusion was reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in young person's best interests, when the young person posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage the young person's unsafe behaviour were considered.

Seclusion was initiated by a registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion. The young person's next of kin or family were also informed of the use of seclusion. The seclusion order did not last longer than eight hours and the young person was informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless detrimental to the young person. The young person was informed of the ending of an episode of seclusion and cultural awareness and gender sensitivity was demonstrated. Young persons' clothing respected their right to dignity, bodily integrity, and privacy.

A registered nurse undertook direct observation for the first hour following the initiation of a seclusion episode, with continuous observation thereafter. A written record of the young person's well-being was made by a nurse every 15 minutes, including the level of distress and behaviour displayed by the young person. Following risk assessment, a nursing review took place every two hours. During this review, at least two staff entered the seclusion room. A medical review of the patient was undertaken no later than four hours after the commencement of the episode of seclusion and reviewed every four hours.

The seclusion initiation was recorded in a clinical file and seclusion register by the person who initiated seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of the episode. A copy of the seclusion register was placed in the clinical file. The episode was reviewed by members of the multi-disciplinary team and documented in clinical file within two working days.

The approved centre was non-compliant with this rule because the seclusion facilities were not appropriately cleaned to ensure resident dignity 8.2.

Section 69: The Use of Mechanical Restraint

NON-COMPLIANT

Risk Rating **High**

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

INSPECTION FINDINGS

Evidence of Implementation: Part four of the Rule on the Use of Mechanical Restraint was inspected. Mechanical restraint was not used to ameliorate operational difficulties, including staff shortages. The approved centre had a written policy in relation to the use of mechanical restraint. The policy identified who may carry out mechanical means of bodily restraint and included a section regarding the provision of information to the patient, as well as a section that detailed how the approved centre was attempting to reduce the use of mechanical restraint. The written policy on mechanical restraint also specified how the approved centre reviewed cases of the use of mechanical restraint. A record was maintained that indicated all staff involved in mechanical restraint had read and understood the policy. The approved centre reviewed its policy on mechanical restraint at least yearly and reviewed all cases of mechanical restraint at least quarterly.

The approved centre had a policy and procedure for the training of staff in relation to mechanical restraint, which included, but was not limited to: who received training based on the identified needs of young people and staff; the areas addressed within the training programme, including training in alternative to mechanical restraint; an identification of appropriately qualified person(s) to give the training, and; the mandatory nature of training for those involved in the use of mechanical restraint.

The clinical file of one young person who was mechanically restrained for a period beyond one month was reviewed on inspection. The mechanical restraint was used as the young person posed a threat of serious harm to others. The service demonstrated that they attempted to reduce the use of mechanical restraint, including all other interventions to manage the patient's unsafe behaviour.

Mechanical means of bodily restraint was prolonged beyond the period strictly necessary, as the patient was mechanically restrained at night to prevent them from becoming violent if they woke up.

Mechanical restraint was used within legal frameworks. Cultural awareness and gender sensitivity was demonstrated by staff involved in the use of mechanical restraint.

The mechanical restraint was initiated by a registered nurse and a registered medical practitioner on each instance.

On three separate occasions, the consultant psychiatrist responsible for the care of the patient was not notified of the use of mechanical restraint as soon as was practicable. Where the use of mechanical restraint was initiated by a registered medical practitioner, it did not occur following an assessment of the patient, including a risk assessment, nor was the matter always recorded in the clinical file.

A medical review of the young person was completed no later than four hours after the commencement of each episode of mechanical restraint. After the medical review, the registered medical practitioner ordered the continuation of the mechanical restraint following a discussion with nursing staff and this was recorded in the Register for Mechanical Means of Bodily Restraint, indicating the duration of the continuation order. The duration of the order of mechanical restraint was recorded on the register, which was signed by the consultant psychiatrist responsible for the care of the young person, within 24 hours of the episode.

The patient was informed of the reasons for, likely duration of, and the circumstances that would lead to the discontinuation of mechanical restraint. The patient's parent or guardian was informed of the use of mechanical restraint as soon as was practicable and were in regular contact with the approved centre; this communication was recorded in the clinical file. Both a male and female staff member were involved in the patient's mechanical restraint and was under constant nurse observation throughout the episode. Devices intended to deliberately inflict pain were not used.

All uses of mechanical restraint were clearly recorded in the patient's clinical file and in the Register for Mechanical Means of Bodily Restraint. The MDT did not develop a plan of care relating to mechanical restraint and how to reduce it for the patient. As the patient had been mechanically restrained for a period beyond one month, an independent review by a consultant psychiatrist from outside the approved centre and not involved in the care of the patient was completed.

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

a) **The policy on staff training in relation to mechanical restraint did not include the frequency of training 19.1 (c).**
b) **Mechanical means of bodily restraint was prolonged beyond the period strictly necessary 1.3.**
c) **The consultant psychiatrist responsible for the care of the patient was not notified of the use of mechanical restraint as soon as was practicable on three separate occasions 14.2.**
d) **A formal assessment of the patient, including a risk assessment was not completed prior to the initiation of mechanical restraint by a registered nurse or registered medical practitioner 14.4 (a).**

e) The MDT did not develop a plan of care for mechanical restraint for the patient 18.3.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had assessed the patients' capacity to consent to receive treatment and that the patients were unable to consent. The administration of medication only continued following the approval and authorisation by two consultant psychiatrists as set out in form 18.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.

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.

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

Evidence of Implementation: The clinical file of a young person that had been physically restrained was examined on inspection. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the young person. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated. The child's parent or guardian was informed of the use of physical restraint as soon as was practicable, and the approved centre had child protection policies and procedures in place, including for appropriate training for staff in relation to child protection.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the young person. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the young person had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the young person had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the young person's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Completed clinical practice forms had been placed in the young person's clinical file.

The approved centre was compliant with this code of practice.

Admission of Children

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in February 2018. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: Age-appropriate facilities and a programme of activities appropriate to age and ability were provided. Provisions were in place to ensure the safety of a child, to respond to a child's special needs as a young person in an adult setting, and to ensure the right of the child to have their views heard.

Staff that had contact with a child had undergone Garda vetting and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated, including age and gender-segregated sleeping and bathroom areas. Staff observation acknowledged gender sensitivity and observation arrangements, including assignment of designated staff member, were provided as considered clinically appropriate. Children had access to age-appropriate advocacy services at the time of inspection. Children had their rights explained to them and information about the ward and facilities were provided in a form and language they could understand: the clinical file recorded the child's understanding of the explanation given. Appropriate visiting arrangements for families were available, including for visiting children. The consent for treatment was obtained from one or both parents.

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.

Admission: The admission policy, which was last reviewed in February 2018, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in February 2018, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in February 2018, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one young person who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication, and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the young person's family member was involved in the admission process.

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

Discharge: The clinical file of a young person who had been discharged evidenced a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the young person and relevant members of the multi-disciplinary team. A comprehensive discharge summary was sent to the relevant mental health team within 14 days and detailed the young person's diagnosis, prognosis, medication, their mental state at discharge, outstanding

health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues. A parent or guardian was involved in the discharge process and a follow-up appointment had been arranged for the young person.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001816		**Two ICPs did not identify appropriate goals for the young person. One of the ICPs did not identify the treatment required to meet the identified goals.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The two ICP's were reviewed and amended with the two residents within 24 hours of inspection	Weekly review of ICP	Achievable and realistic	15/07/2020	Consultant Psychiatrist,
Preventative Action	Further briefing sessions with MDT members on the ICP process as part of CPD sesions occured and are part of rolling CPD sessions	Attendance records at briefing sessions to be maintained ,. Weekly monitoring of ICP's at MDT meeting Ongiong audit of ICP	achievable and realistic	12/03/2021	CNM3, Consultant Psychiatrist

Rules Governing the Use of Seclusion					
Reason ID : 10001815		**Seclusion facilities were not appropriately cleaned to ensure resident dignity 8.2**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The wall in the seclusion suite was cleaned immediately	Cleaning records	Achieved	15/07/2020	CNM 2 & Household staff
Preventative Action	Monitoring of seclusion facilities are included in the daily environmental checks	Daily environmental checklist by Nursing staff Monitoring of CAPA's remains a standing item on the Approved Centre Governance Meeting.	achievable and realistic	12/03/2021	CNM2 Rowan unit

Rules Governing the Use of Mechanical Means of Bodily Restraint					
Reason ID : 10001810		**The policy on staff training in relation to mechanical restraint did not include the frequency of training 19.1 (c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The policy was reviewed and the section on training was made more explicit in terms of frequency of training	Completed- see revised policy	Completed	12/03/2021	Chair of Policy Group
Preventative Action	A coordinated training plan has been developed to ensure that all staff in the Approved Centre have up-to-date training commensurate with their role/ involvement with Mechanical Restraint and in line with the policy timeframe	Ongoing monitoring of the training database by the CNM III in the Approved Centre.Training will remain a standing item on the Approved Centre Governance Meeting. Monitoring of CAPA's remains a standing item on the Approved Centre Governance Meeting.	Achievable and realistic	12/03/2021	Named Consultant, CNM 3
Reason ID : 10001811		**Mechanical means of bodily restraint was prolonged beyond the period strictly necessary 1.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It is not possible to retrospectively, implement a corrective action in relation to this as the period of Mechanical Means of Bodily	Staff training log	Achieved	12/03/2021	Consultant Psychiatrist, Nurse in Charge

	restraint had elapsed. However risk assessment and risk management was discussed with staff as part of CPD sesson on Mechanical Means of Bodily Restraint.				
Preventative Action	Further briefing sessions with Nursing and Medical staff on the updated Mehanical Restraint Policy and associated documentation to occur as part of rolling CPD sessions/ Policy awarness sessions. Where there is a clinical indicaiton that Mechanical Restraint needs to be used - on site briefing with staff will occur in advance,	Attendance records at briefing sessions to be maintained	achievable and realistic	12/03/2021	Consultant Psychiatrist, CNM/ Nurse in charge
Reason ID : 10001812		**The consultant psychiatrist responsible for the care of the patient was not notified of the use of mechanical restraint as soon as was practicable on three separate occasions 14.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It is not possible to retrospectively, implement a corrective action in relation to this as the	training sessions occured with staff as part of CPD	achieved	12/03/2021	CNM3, Consultant Psychiatrist

	period of Mechanical Means of Bodily restraint had elapsed . However briefing sessions with staff on the policy of Mechanical restraint risk and need to notify consultant in keeping with policy occured				
Preventative Action	Further briefing sessions with Nursing and Medical staff on the Policy and associated documentation to occur as part of CPD In the event Mechanical Restaint is required in future, staff will be refreshed on site regarding the policy and the need to notify Consultant Psychiatrist as soon as is practicable. A daily review will occur if Mechanical means of restraint are used,	Documentation of training , Date/ Time of contact with Consultatnt will be recorded in approved documentation on Mechnical Means of Bodily Restraint	Achievable and reallistic	12/03/2021	CNM3, CNM2 Consultant Psychiatrist
Reason ID : 10001813		**A formal assessment of the patient, including a risk assessment was not completed prior to the initiation of mechanical restraint by a registered nurse or registered medical practitioner 14.4 (a). The MDT did not develop a plan of care for mechanical restraint for the patient 18.3.**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	It is not possible to retrospectively, implement a corrective action in relation to this as the period of Mechanical Means of Bodily restraint had elapsed , however staff training occured on the updated policy on Mechanical Means of Bodily Restraint . Training also occured on Individual care planning as part of CPD sessions	staff training, attendance at CPD sessions	achieved	12/03/2021	CNM3, Consultant Psychiatrist
Preventative Action	A documented risk assessment must be completed prior to the initiation of an episode of Mechanical Restraint. Prior discussion and agreement must be obtained by the Clinical Director re any further use of Mechanical Restraint. All other options used must be recorded and exausted.	Attendance records at briefing sessions to be maintained Weekly audit of ICP and associated Mechanical Restraint documentation when in use	achievable and realistic	12/03/2021	Consultant Psychiatrist CNM2 MDT staff involved in care and Treatment

	Documentation must occur of risk assessment and risk management strategies used as required by 14.4(a). A detailed MDT care plan needs to be developed which may incorporate any postive behavioural support plan. MDT staff are aware that the sole reliance of a PBSP does not substitue a documented Plan of care as required by 18.3				

Appendix 2: Background to the inspection process

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

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

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

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

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

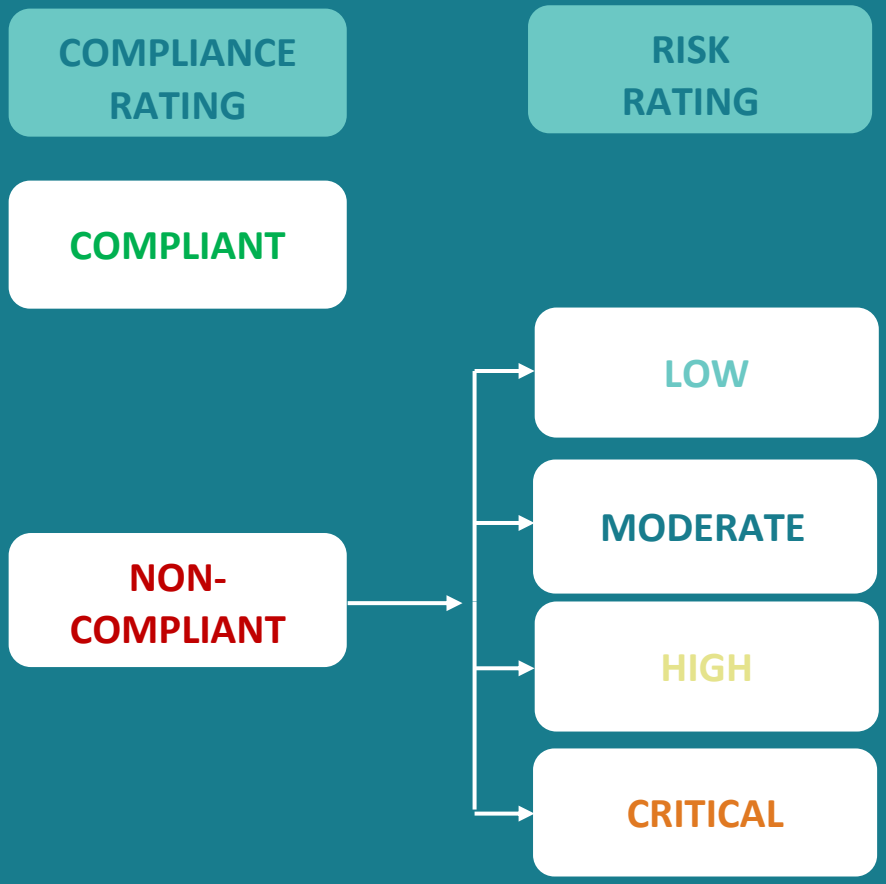
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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 and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



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

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, 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.