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

Annual Inspection Report 2021

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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2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child & Adolescent Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
10 December 2018

Registered Proprietor:
HSE

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

Inspection Team:
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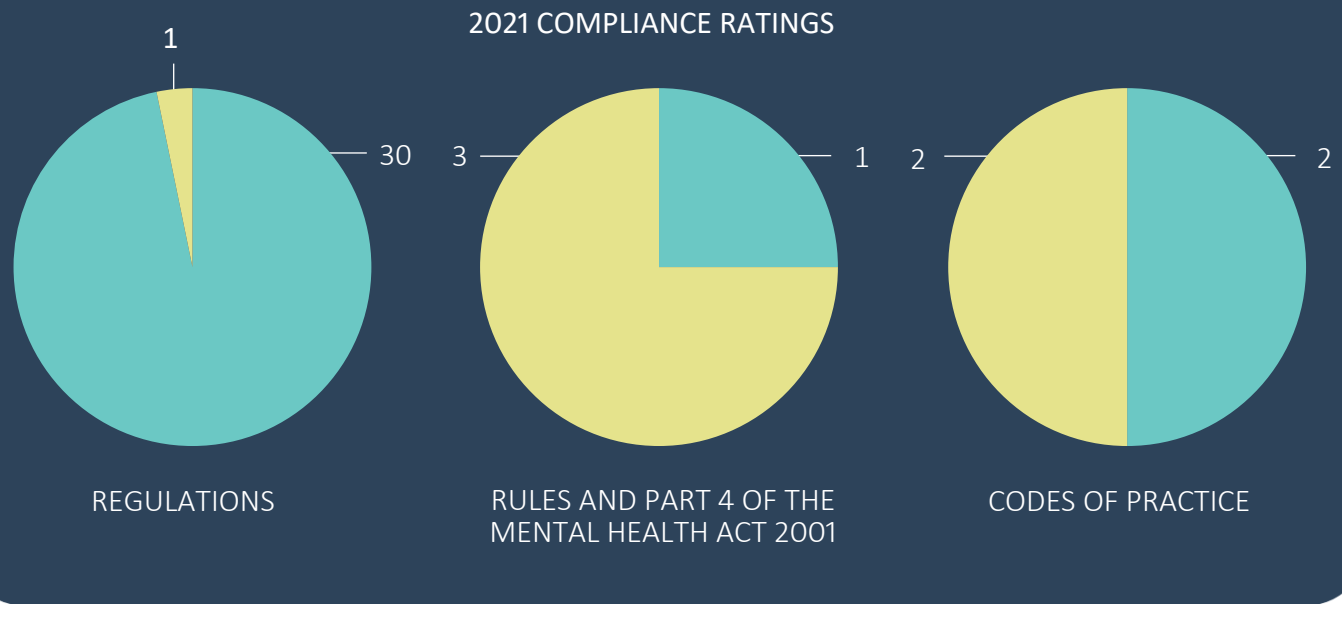
Inspection Date:
27 - 30 April 2021

Previous Inspection date:
14 – 17 July 2020
21 July 2020

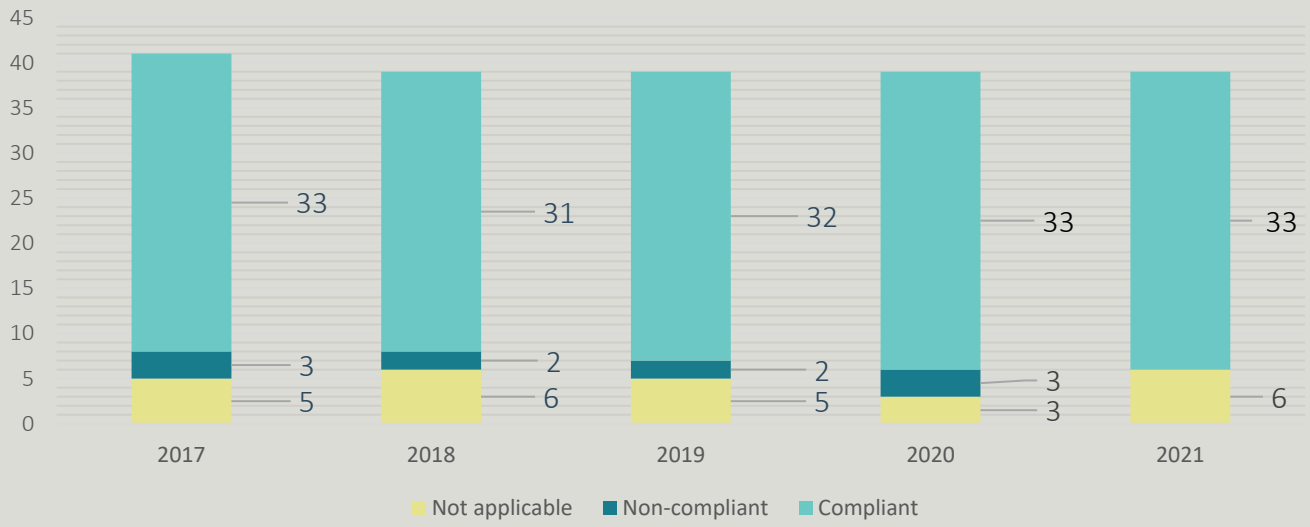
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2017 – 2021

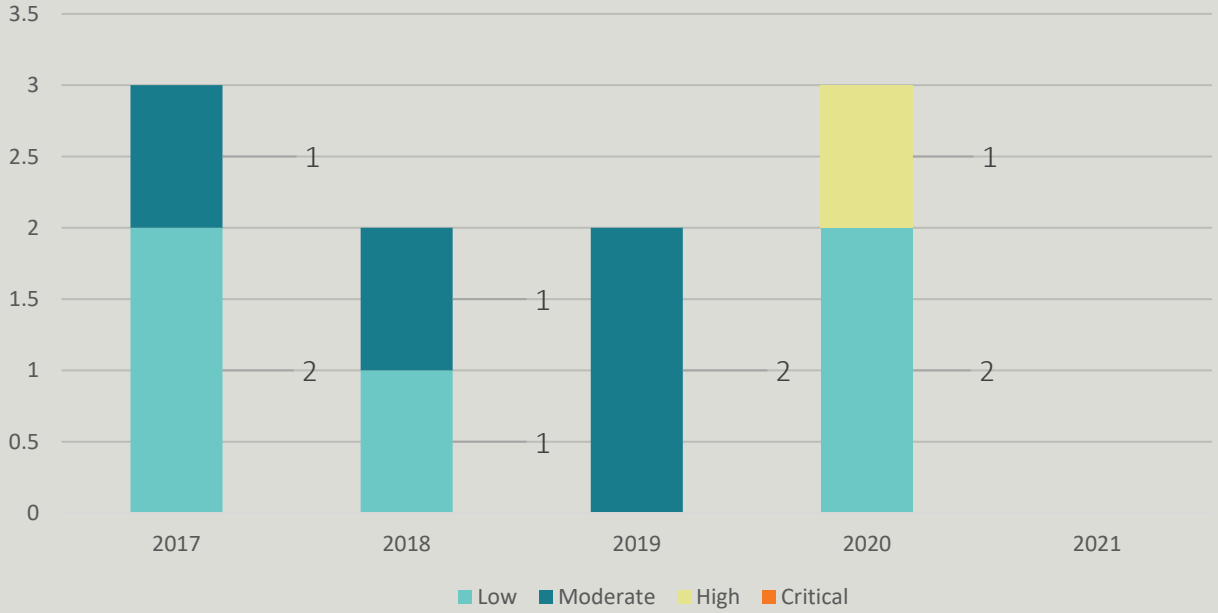
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2017 – 2021



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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 Services (CAMHS) was located on the Cherry Orchard Hospital Campus in Ballyfermot, Dublin 10. The approved centre was registered for 24 beds and catered for residents aged from 10 to 18; the younger children residing on Hazel Ward and older adolescents cared for on Rowan Ward. The approved centre had a separate school building located adjacent to its in-patient facilities. There were two multi-disciplinary teams (MDT) based onsite in Linn Dara – one each on Hazel and Rowan ward. These teams were fully staffed with required MDT members.

The approved centre was part of the national CAMHS network and took referrals predominantly from the east and north of the country. At times young people from other areas were also referred into the approved centre for treatment.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	92%	94%	94%	92%	100%
Regulations Rated Excellent	16	7	20	N/A	N/A

The average rate of compliance across all approved centres in 2020 was 87%.

Conditions to registration

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

Escalation and enforcement actions since last inspection

There were no escalation or enforcement actions since the last inspection in 2020.

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm and that effective systems were in place to safeguard young people.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- There was a minimisation of ligature points to the lowest practicable level.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- Staff held a 'Safety Pause each day; this was a morning meeting of all clinical staff working with the young people used to discuss any current and updated risk issues pertaining to the residents.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to needs of young people.

- Each young person had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The occupational therapy programme changed themes each week and included; assertiveness, friendship, expressing emotions, non-verbal communication, and conversation skills groups. Social work programmes included a new four-week parent group which was facilitated remotely and aimed to support parents' communication skills with the young person. Play therapy and art therapy were also available in the approved centre.
- Staff were trained to deliver specialist clinical services in the area of eating disorder treatment.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre provided services in a way that met the needs of young people.

- All bedroom accommodation was single and en suite.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.
- Noticeboards did not display resident names or other identifiable information.
- Young people were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where young people could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that was responsive to the needs of young people.

- Recreational activities included baking groups, art groups, table-football, ping pong, computers, DVDs, board games, jigsaws, and a garden for exercise. Two computers with supervised internet access were available to the young people. Recreational activities were provided on weekdays and weekends.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

We found that the approved centre had robust governance structures and processes in place.

- The approved centre was part of Community Healthcare Organisation 7 (CHO7) encompassing Dublin South West, Kildare and West Wicklow. The in-patient unit also provided a catchment area service to Laois, Offaly, Westmeath and Longford.
- The Linn Dara Management dealt with issues including the staff vaccination roll out and recruitment for vacant positions, the COVID-19 returning the business plan and financial planning for approved centre renovations as well as the approved centre risk register.
- The Quality and Patient Safety and Health and Safety (QPSHS) meeting took place on a two-monthly basis. Quality indicators and outcome measures, audit reports and the implementation of national and local quality and safety initiatives were discussed by the QPSHS committee.

- The approved centre had a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register.
- All Heads of Discipline had received training in the area of risk management and each discipline each fostered a system of staff supervision and performance appraisal within their respective departments.
- Recruitment and retention presented a potential challenge in the running of the approved centre.
- Resident community meetings took place on a weekly basis and feedback from these meetings was discussed at the staff team meetings. The advocate visited the approved centre each week and was also contactable by phone and video link.
- Complaints were managed in adherence with the Your Service Your Say protocol.

COVID-19 response

- The approved centre followed all public health advice in regard to the COVID-19 outbreak. Contingency planning included the potential risks posed by the COVID-19 virus. The roll out and review of infection and prevention control measures featured upon the QPSHS agenda for discussion.
- The reintroduction of nurse-led Carer groups in response to the COVID-19 restrictions on visiting included six online carer support and information sharing sessions for parents, guardians and carers.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had recently undertaken extensive horticultural works including the upgrade of garden areas with Astroturf and replanting. The internal gardens on both units had also been upgraded. The project was co-produced with the young people and each internal garden had a complimentary horticulturally theme.

2. The approved centre had introduced 'Multi-disciplinary team Complex Case Supervision' including sessions that focused on case of a specific resident each week. All professionals involved in the care and treatment of this resident were invited to join in this supervision. Sessions occurred fortnightly and the aim was to facilitate a supervision space for each team once a month. This method of team supervision provided a therapeutic space for team members based around a case.

3. The reintroduction of nurse-led Carer groups in response to the COVID-19 restrictions on visiting included six online carer support and information sharing sessions for parents, guardians and carers. The sessions give carers a space to reflect, share information, ask questions and listen to carers in similar situations to themselves. These sessions were facilitated by the Linn Dara nursing team.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Linn Dara Child and Adolescent Mental Health Services (CAMHS) was located on the Cherry Orchard Hospital Campus in Ballyfermot, Dublin 10. The approved centre was registered for 24 beds, however at the time of the inspection 2 beds were out of commission. This was due to the ongoing refurbishment and upgrade of the 2-bedded high observation area, the Oak Ward. The remaining beds were located in Hazel Ward (11) and Rowan Ward (11). The approved centre catered for residents aged from 10 to 18, with younger children residing on Hazel Ward and older adolescents cared for on Rowan Ward. All bedroom accommodation was single and en suite. Rowan and Hazel Wards each contained numerous seating areas, visiting rooms, therapy rooms, a prayer room, a games room, a large and small TV room, and resident kitchen and dining facilities.

Linn Dara had recently upgraded all of its garden areas to include Astroturf lawns. The approved centre had a separate school building located adjacent to its in-patient facilities. The garden between the approved centre and the school had been extensively developed to include a water feature and a large shrub. The innovative design of the Linn Dara approved centre had won prizes for its use of light and space. All rooms looked out upon a green space. The approved centre had two multi-disciplinary teams (MDT) based onsite in Linn Dara – one each on Hazel and Rowan ward. These teams were fully staffed with required MDT members.

The approved centre was part of the national CAMHS network and took referrals predominantly from the east and north of the country. At times young people from other areas were also referred into the approved centre for treatment.

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

Resident Profile	
Number of registered beds	***22***
Total number of residents	**19**
Number of detained patients	1
Number of wards of court	0
Number of children	19
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	NA

3.2 Governance

The approved centre was part of Community Healthcare Organisation 7 (CHO7) encompassing: Dublin South West, Kildare and West Wicklow. The in-patient unit also provided a catchment area service to Laois, Offaly,

Westmeath and Longford. Linn Dara was one of four approved centres within CHO7 and the only one registered to provide Child and Adolescent Mental Health services. Linn Dara had established governance structures in place and a number of senior management meetings took place within the approved centre on a regular basis in order to deliver the governance processes.

The Linn Dara Management meeting discussed human resources issues including the staff vaccination roll out and recruitment for vacant positions, the COVID-19 returning the business plan and financial planning for approved centre renovations. The management team also discussed the approved centre risk register at their meetings which took place every month.

The Linn Dara Governance meeting discussed the approved centre compliance with the Mental Health Act including Corrective and Preventative Actions plans that had been developed for the approved centre, the use of restrictive practices within the approved centre, staff training and development and building related issues. The Linn Dara governance meeting took place every two months.

The Quality and Patient Safety and Health and Safety meeting also took place on a two-monthly basis. Quality indicators and outcome measures, audit reports and the implementation of national and local quality and safety initiatives were each discussed by the QPSHS committee. The members completed an overview of the incidents reported within the approved centre and reviewed any issues identified as part of their risk management strategy.

Linn Dara was also represented at the overarching CHO7 Management Group which met on a monthly basis. Issues pertaining to Linn Dara that required escalation to area management level were brought to this meeting for discussion.

The person in the approved centre with responsibility for risk management was identified and known by staff. This role was supported by an assistant director of nursing who was the risk advisor. The approved centre had a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register.

There was an organizational chart defining key personnel and lines of responsibility and accountability. At the time of the inspection all positions were filled as required. Staffing was in line with the approved centres registration details.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, psychology, speech and language therapy (SLT), and dietetics. Risks highlighted within these questionnaires included: the lack of opportunity to offer face to face consultations with parents and carers due to COVID-19 restrictions, ongoing recruitment challenges in terms of medical and nursing personnel, the reduction in collaborative working due to the pandemic and the impact of the pandemic on training. In the case of both dietetics and SLT one of the two respective SLT and dietitian posts was a temporary contract and not a permanent one. This posed a challenge to service continuity. The identified risks were effectively mitigated by the use of technology for collaboration with peers and contact with family carers, escalating potential staffing issues to senior management meetings and via the risk management process.

The goals and aims of the departments included: the provision of holistic and individualised supports to young people, a recovery oriented multi-disciplinary approach to treatment, continuous service improvement informed by innovative approaches and service user feedback, a focus upon recovery through activity and the reduction of restrictive practices. The re-opening of the High Dependency unit was also cited as a strategic goal for the approved centre. All Heads of Discipline had received training in the area of risk management and each discipline each fostered a system of staff supervision and performance appraisal within their respective departments. The Registered Proprietor nominee reiterated that staff recruitment and retention presented a potential challenge in the running of the approved centre.

The approved centre had an established culture of quality improvement. This was evident by the ongoing refurbishment of the approved centre including the refurbishment of the Oak ward and the garden works. Similarly, staff were trained to deliver specialist clinical services in the area of eating disorder treatment. Staff held a 'Safety Pause each day; this was a morning meeting of all clinical staff working with the young people used to discuss any current and updated risk issues pertaining to the residents.

Resident community meetings took place on a weekly basis and feedback from these meetings was discussed at the staff team meetings. The advocate visited the approved centre each week and was also contactable by phone and video link. Complaints were managed in adherence with the Your Service Your Say protocol.

The approved centre followed all public health advice in regard to the COVID-19 outbreak. Contingency planning included the potential risks posed by the COVID-19 virus. The roll out and review of infection and prevention control measures featured upon the QPSHS agenda for discussion.

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

No areas were found to be non-compliant on this inspection.

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.
Rules Governing the Use of Mechanical Means of Bodily Restraint.	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment.	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001.	As the approved centre was a child and adolescent mental health facility, this Code of Practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients.	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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:

- Posters were displayed inviting the residents to talk to the inspection team.
- 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 could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.

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

Seventeen service user questionnaires were completed by the residents and returned to the inspection team.

- In response to the question: 'How often are you able to discuss your worries or concerns with a member of staff as you need to?' Six respondents stated 'always', nine ticked 'sometimes' one 'never' and one 'I do not have worries or concerns.' All residents indicated that they understood what their care plan was.
- When asked 'Are there enough activities to do during the day?' 10 stated 'yes' and 7 indicted 'no'.
- Four responded to the question 'I have space for privacy' with 'no' whereas the remaining 13 stating 'yes.'
- In answer to the question 'I can communicate freely with my family / friends / advocate' 4 responded 'no' with 13 stating 'yes'.
- Comments detailed in the questionnaire reflected mixed feedback in terms of the approachability of the nursing staff.

The inspection team spoke with four residents and three parents. This feedback indicated that:

- Staff were generally nice and approachable although some were reported to be cold in their manner.
- Residents knew their keyworkers and were informed about their individual care plans.
- The quality of the Linn Dara building was satisfactory, and the bedrooms were comfortable and kept clean.
- Some residents felt that more activities during the day would be welcomed.

- The COVID-19 restrictions limiting visiting times was reported as a difficulty by both residents and parents.
- Residents felt that communication with their families was facilitated adequately in terms of phone calls and access to an electronic tablet.
- Communication to parents could be enhanced with written reports on how the young person was progressing in terms of their recovery.

5.2 Advocacy

The approved centre did have an advocacy service, the Youth Advocacy Programme. The advocate visited the approved centre on a weekly basis (alternating Rowan and Hazel wards each week) and was available for consultations via Skype on a weekly basis to the ward that was not visited in person.

The inspection team spoke with a representative from the advocacy service who furnished the inspectors a report detailing advocacy activity within Linn Dara in 2021. Themes emerging from this report included:

- The young people expressed desire for more activities over the weekends.
- The young people frequently sought clarification on the availability of home Leave and visits in the context of the COVID-19 restrictions. The advocacy sessions gave space to the young people to discuss their uncertainty around the timeframes for lifting COVID-19 restrictions.
- Discussions about the rules and regulations within the approved centre.
- Young people received support in communicating with the treating team around specific topics as part of the advocacy service.

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 Nurse Manager 3
- Area Director of Nursing
- Dietitian Manager
- Area Manager
- Occupational Therapy Manager
- Speech and Language Therapy Manager
- Clinical Director
- Consultant Psychiatrist
- Clinical Nurse Manager 2
- Principal Psychologist
- Registered Proprietor
- Social Work Manager
- Linn Dara School Principal

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans (ICP); the approved centre used its own bespoke nutritional screening tool which was completed for each resident. Required referrals to the dietitian were made as required. Dietitians attended the multi-disciplinary team meetings and had input into the ICP of each resident regarding required dietetic input.

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. There were proper facilities for the refrigeration, storage, preparation, cooking and serving of food. Hygiene was maintained to support food safety requirements. Residents 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

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Emergency clothing and an emergency fund to buy clothing were available, if the emergency supply was unsuitable for specific individual needs. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

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 January 2021. 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 them. The young people were supported to manage their own property, unless this posed a danger to themselves 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 a wide range of recreational activities appropriate to the resident group profile. Recreational activities included baking groups, art groups, table-football, ping pong, computers, DVDs, board games, jigsaws, and a garden for exercise. Two computers with supervised internet access were available to the young people. Recreational activities were provided on weekdays and weekends.

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 January 2021. Visiting times were appropriate and reasonable. 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. Visitors were required to wear full personal protective equipment (PPE). 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 January 2021.

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. On admission, each young person was provided with a mobile phone and each ward had three electronic tablets available for family contact. 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 January 2021 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 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 January 2021. 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

COMPLIANT

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 clinic 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.

The ICPs identified appropriate goals for the young person and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICP was 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 compliant with this regulation.

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. The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of young persons. The occupational therapy programme changed themes each week and included; assertiveness, friendship, expressing emotions, non-verbal communication, and conversation skills groups. Occasionally groups were activity based to help boost motivation. Social work programmes included a new four-week parent group, which was facilitated remotely and aimed to support patents' communication skills with the young person.

Play therapy and art therapy were also available in the approved centre. Where a young person required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

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.

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 January 2021.

The clinical file of one young person who had undergone an emergency transfer was examined. Full and complete written information for the young person was transferred when they were moved from the approved centre. Communications between the approved centre and the receiving facility were documented and followed up with a written referral.

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 January 2021. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator, both of which were checked weekly. The young persons received appropriate general health care interventions in line with individual care plans. General health needs were monitored and assessed as indicated by the young person's specific needs, but not less than every six months. At the time of inspection, no young person had been in the approved centre longer than six months and therefore the fully six monthly health assessment was not applicable.

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 January 2021.

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 their rights, housekeeping arrangement, including arrangements for personal property and mealtimes, as well as the complaints procedure and visiting times and arrangements. Information regarding relevant advocacy and voluntary agencies was available in the approved centre's foyer.

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 discreet 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 en suites had locks on the inside of the door, unless there was an identified risk to a young person.

All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. 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.

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. Sufficient spaces were provided for residents 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.

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. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated. 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 January 2021 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.

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 to the young person was stored securely in a locked storage unit within the pharmacy room.

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 January 2021.

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 January 2021. The policy included the purpose and function of using CCTV for observing young persons in the approved centre.

CCTV was not used to monitor a young person if they started to act in a way that compromised their dignity. 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. CCTV did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the young person.

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 January 2021. 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.

Two multi-disciplinary teams were based in the approved centre – one in Hazel and one in Rowan Ward. These teams were fully staffed and included: medical, nursing, occupational therapy, social work, psychology, dietetics and speech and language therapy. The approved centre also had access to family therapy, play therapy and an art therapist. The approved centre did not have a dedicated pharmacy service.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (29)	29	100%
Medical (9)	9	100%
Occupational Therapist (2)	2	100%
Social Worker (2)	2	100%

Psychologist (2)	2	100%

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 January 2021. The policy included:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

The young peoples' records were secure, up-to-date, and in good order, and were physically stored together in a secure office. All young person records were reflective of their 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 January 2021 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 approved centre 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. All complaints minor and other were reviewed by the complaints officer at least once monthly. Minor complaints were addressed locally when possible. 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 individual care plan.

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 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 January 2021, 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. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

Individual risk assessments were completed prior to and during seclusion, physical restraint and mechanical restraint. Risk assessments were also completed in conjunction with medication requirements 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. 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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion, which was last reviewed in January 2021. 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 maintained and cleaned to ensure respect for the young person's dignity and privacy. 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 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 also 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 compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

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 2021. 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 who 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 was 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. The young person had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

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, 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 January 2021, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in January 2021, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in January 2021, 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 contained 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: 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.

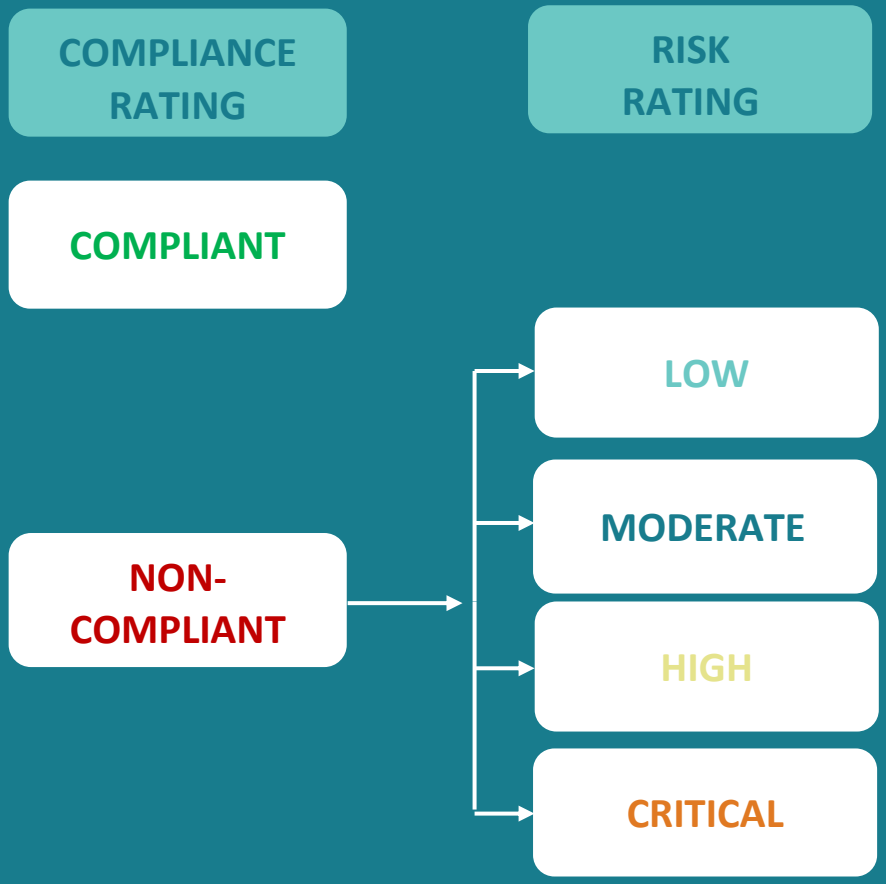
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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