CHILD & ADOLESCENT MENTAL HEALTH IN-PATIENT UNIT, MERLIN PARK UNIVERSITY HOSPITAL

Annual Inspection Report 2021

Promoting Quality Safety and Human Rights in Mental Health

CHILD & ADOLESCENT MENTAL HEALTH IN-PATIENT UNIT, MERLIN PARK UNIVERSITY HOSPITAL

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

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2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
9 December 2019

Registered Proprietor:
HSE

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

Inspection Team:
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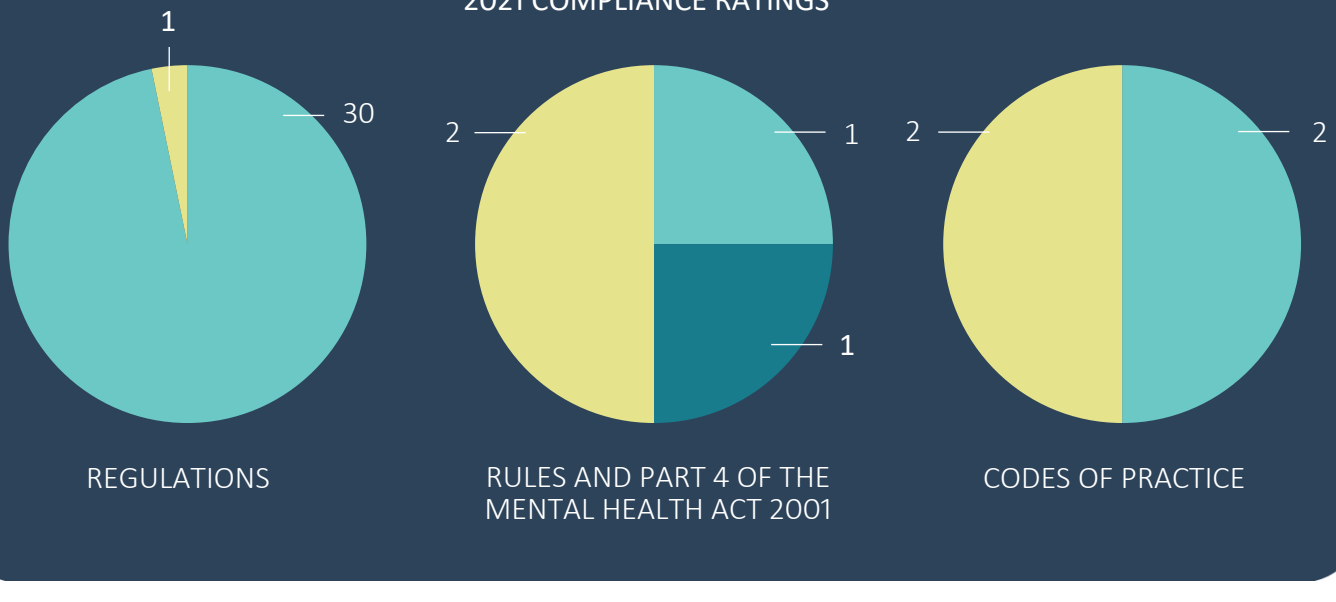
Dr Susan Finnerty MCRN009711

Inspection Date:
23 – 26 March 2021

Previous Inspection date:
1 – 4 September 2020

Inspection Type:
Announced Annual Inspection

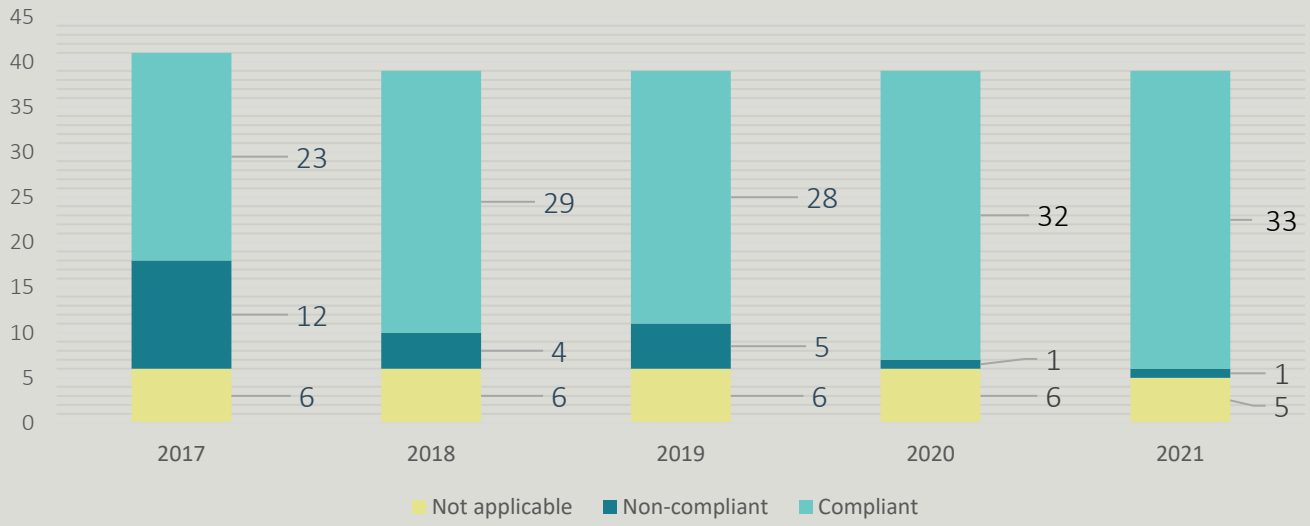
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

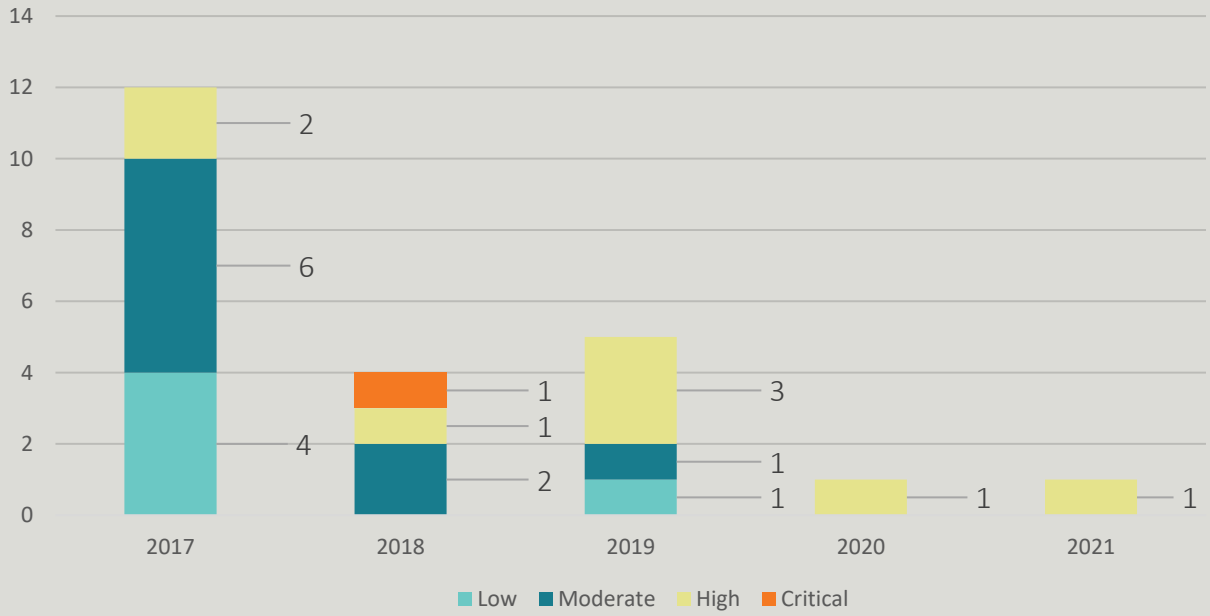
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

The approved centre was a 20-bed inpatient facility located within the campus of Merlin Park University Hospital in Galway. It was a purpose-built inpatient unit for the Child and Adolescent Mental Health Service (CAMHS). The approved centre comprised of two individual units: Woodsend (6 beds) and the Willows (14 beds). The Willows had a high dependency suite, with three bedrooms. A seclusion facility was also located in the Willows. There was a separate administration block that included the main dining facilities, therapy and activity rooms and staff offices. There was also a school campus and a parent accommodation flat.

The approved centre had two multi-disciplinary teams. It served the catchment area of Clare, Limerick, North Tipperary, Galway, Roscommon, Mayo, Sligo, Leitrim and Donegal and was also a national referral centre.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	66%	88%	85%	97%	97%
Regulations Rated Excellent	5	9	14	N/A	N/A

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

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *To continue the use of seclusion, the Health Service Executive, as registered proprietor, shall develop and approve a costed, funded and time bound plan to replace the current seclusion facilities. This plan must be submitted by a date specified by the Mental Health Commission.*	The approved centre developed and approved a costed, funded and time bound plan to replace the current seclusion facilities. This plan was submitted by a date specified by the Mental Health Commission and accepted by the Mental Health Commission.
The approved centre was not breach of Condition 1 and the approved centre was non-compliant with the Rules Governing the Use of Seclusion at the time of inspection.	

Escalation and enforcement actions since last inspection

There were no escalation and enforcement actions since the last inspection.

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm to the young people and that effective safeguarding systems were in place, with the exception of the condition of the seclusion room.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- 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.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, stored, prescribed and administered in a secure and safe manner.

However, the floor in the seclusion room was of a hard-fitting material which was not conducive to resident safety.

Appropriate care and treatment of residents

We found that that staff provided therapeutic activities appropriate to needs of young people.

- Each resident 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 therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of psychosocial functioning of a resident. Examples of therapeutic groups facilitated included: Social Club Group, Radically Open Dialectical Behaviour Therapy (DBT) Group, Psycho-Education Eating Disorder Group and Virtual Meal Supports. Three new therapeutic programmes for young people with eating disorders had been developed.

Respect for residents' privacy, dignity and autonomy

We found that most of the facilities and processes respected young people's privacy and dignity and that interactions respected young people's wishes.

- Woodsend was a six bedded facility with one double bedroom and four single bedrooms. The Willows accommodated up to fourteen young people within two double bedrooms and ten single bedrooms. Due to the risk of COVID-19, the double bedrooms were used as single rooms.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- 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.

However, residents in seclusion did not have suitable access to toilet and washing facilities as there was no shower unit in the room with a toilet.

Responsiveness to residents' needs

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

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. The activities available at the time of the inspection in the approved centre included arts and crafts, crochet, boardgames, baking, sporting activities and a gym. Residents also had access to Netflix, Disney + channel and games consoles.
- The information booklet was clearly and simply written. Young people and their families 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.
- There was an apartment for parents who wished to spend time with their child in the approved centre.
- The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre.

Governance of the approved centre

We found there were good governance structures and processes in place.

- The approved centre was part of Community Healthcare West, Galway Roscommon Mental Health Service. The Galway Roscommon Mental Health Service governance structure encompassed two core monthly meetings; an Area Management Team meeting and a Quality and Safety meeting. An Area Quality and Patient Safety committee, which met monthly, reported into the Area Management Team.
- Within the approved centre, there was a local business meeting, which was scheduled approximately every six weeks.
- The approved centre had a standardised process for the management of risks and incidents. Identified risk were documented in the risk register.
- The approved centre's policies were developed by the Policies, Procedures, Protocols and Guidelines (PPPG) committee and all required operating policies and procedures were reviewed within the specified timeframe of three years.
- The approved centre had an established programme of audit. Performance was measured through the regular review of key performance indicators; comments, compliments and complaints; incident reports and audit findings.
- Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement. The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre.
- The approved centre's complaints process was publicised and accessible to residents and their representatives.

COVID-19 response

- Due to the risk of COVID-19, the double bedrooms were used as single rooms.
- The risk of COVID-19 was managed through the approved centre's risk management process. In response to the COVID-19 crisis, the approved centre developed the Pandemic Business Continuity Planning document. The approved centre established a CAMHS Merlin Park COVID-19 Unit Planning Committee. This committee convened on a bi-weekly or monthly basis, dependent on need.
- The YAP advocate obtained resident feedback remotely as the advocate was unable to visit the approved centre due to COVID-19. Some of the residents reported to the advocate that they were finding the COVID-19 restrictions difficult. Positive feedback included that some of the residents felt

listened to by staff and that the approved centre facilitated visiting where possible, in line with public health guidance on COVID-19.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of new therapeutic groups:

    a. Social Club Group: This group was for service users with eating disorders to give them an opportunity to experience some typical everyday life experiences with food prior to discharge.

    b. Radically Open Dialectical Behaviour Therapy (DBT) Group: This group provided evidence-based therapy for residents with eating disorders.

    c. Psycho-Education Eating Disorder Group: The aim of this group was to help enhance resident autonomy regarding food choices and to provide support in exploring and creating life after an eating disorder.

2. Facilitation of Virtual Meal Supports. Virtual meal support was the provision of emotional support during mealtimes, focused specifically on helping the resident to consume the food on their meal plan and redirecting behaviours that may compromise recovery.

3. Refurbishment of the courtyard in the Willows unit. This included new slabbing and garden furniture and the installation of a water feature.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located within the campus of Merlin Park University Hospital in Galway. It was a purpose-built inpatient facility for the Child and Adolescent Mental Health Service (CAMHS). The approved centre comprised of two individual units: Woodsend and the Willows. There was a separate administration block that included the main dining facilities, therapy and activity rooms and staff offices. These three buildings were located amid a well-kept internal garden. There was access to the school campus and a parent accommodation flat from this garden area.

The approved centre consisted of 20 beds. Woodsend was a six bedded facility with one double bedroom and four single bedrooms. The Willows accommodated up to fourteen young people within two double bedrooms and ten single bedrooms. Due to the risk of COVID-19, the double bedrooms were used as single rooms. Residents within Woodsend and the Willows had access to internal courtyards and the garden.

The Willows incorporated a high dependency suite, with three bedrooms. A seclusion facility was also located in the Willows. However, it was separate from the high dependency suite.

The approved centre had two multi-disciplinary teams. It served the catchment area of Clare, Limerick, North Tipperary, Galway, Roscommon, Mayo, Sligo, Leitrim and Donegal and was also a national referral centre.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**17**
Number of detained patients	3
Number of wards of court	0
Number of children	17
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Community Healthcare West, Galway Roscommon Mental Health Service. The Galway Roscommon Mental Health Service governance structure encompassed two core monthly meetings; an Area Management Team meeting and a Quality and Safety meeting. Both meetings were scheduled monthly and membership included relevant heads of service and discipline. An Area Quality and Patient Safety committee, which met monthly, reported into the Area Management Team. Within the

approved centre, governance was further enhanced by a local business meeting, which was scheduled approximately every six weeks. This was augmented by various sub-committees, which included Health & Safety and Infection Prevention & Control. An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.

The Child and Adolescent Mental Health Service (CAMHS) inpatient service comprised of two multi-disciplinary teams. Each team had an assigned psychologist and social worker. There was one designated occupational therapist within the approved centre. However, there was no cover available when the occupational therapist was on leave. All healthcare staff were trained in the Mental Health Act 2001.

The approved centre had a standardised process for the management of risks and incidents. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. Risks were identified, assessed, treated, reported, and monitored. Identified risk were documented in the risk register. The risk of COVID-19 was managed through the approved centre's risk management process. In response to the COVID-19 crisis, the approved centre developed the Pandemic Business Continuity Planning document. The approved centre established a CAMHS Merlin Park COVID-19 Unit Planning Committee. This committee convened on a bi-weekly or monthly basis, dependent on need.

The approved centre's policies were developed by the Policies, Procedures, Protocols and Guidelines (PPPG) committee. In accordance with Regulation 29 Operating Policies and Procedures, all required operating policies and procedures were reviewed within the specified timeframe of three years. The approved centre had an established programme of audit.

Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement. The approved centre's complaints process was publicised and accessible to residents and their representatives. No formal complaints had been submitted to the complaints officer since the last inspection. The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre. The YAP advocate obtained resident feedback remotely. Due to COVID-19, the YAP advocate and the Area Lead for Mental Health Engagement were unable to visit the approved centre. The Area Lead for Mental Health Engagement was a member of the Area Management Team.

Governance questionnaires were completed by each head of discipline and submitted to the inspection team, except for psychology. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. Performance was measured through the regular review of key performance indicators; comments, compliments and complaints; incident reports and audit findings.

The approved centre had one condition attached to its registration with the Mental Health Commission, which pertained to the use of the seclusion facility. The Rule on the Use of Seclusion was a reoccurring non-compliance, which had been assigned a high-risk rating since 2018. The non-compliance applied to the structure of the seclusion facility. The Mental Health Commission recently received the approved centre's costed, funded and time-bound plan to replace the current seclusion facility.

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 2017 and 2021 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Rule Governing the Use of Seclusion	✗	Low	✗	High	✗	High	✗	High	✗	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, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent 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.
- The Youth Advocacy Programme (YAP) advocate was contacted to obtain residents' feedback about 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.

Twelve service user questionnaires were completed by residents and returned to the inspection team. Overall, questionnaire responses were positive. Most of the residents reported that they understood their individual care plan (ICP), that they knew their multi-disciplinary team and that there were enough activities for them during the day.

The inspection team was available to speak with the residents via telephone during the inspection. However, no resident requested to engage with the inspection team.

5.2 Advocacy

The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre. The YAP advocate obtained resident feedback remotely as the advocate was unable to visit the approved centre due to COVID-19. The YAP advocate provided the inspection team with verbal feedback. Some of the residents reported to the advocate that there was a lack a communication regarding their individual care plans and that they were finding the COVID-19 restrictions difficult. Positive feedback included that some of the residents felt listened to by staff and that the approved centre facilitated visiting where possible, in line with public health guidance on COVID-19.

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:

- Registered Proprietor (General Manager)
- Executive Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Principle Social Worker
- Senior Dietitian
- Business Manager
- Consultant Psychiatrist x2
- Administration Manager
- Assistant Director of Nursing
- Clinical Nurse Manager III

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. Any relevant information provided to the inspection team at the feedback meeting was included within the report.

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

Each resident was readily identifiable by staff when receiving medication, health care and other services. A minimum of two resident identifiers appropriate to the resident group profile were used. The approved centre used resident date of birth and photograph as identifiers. The identifiers, detailed in each resident's clinical file, were checked when staff administered medications, undertook medical investigations, and provided 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 in the approved centre. Food was properly prepared and comprised of servings from different food groups as per the Food Pyramid. Residents received at least two choices for meals. Residents had sufficient supplies of safe and fresh drinking water from water dispensers throughout the approved centre. The needs of residents identified as having special nutritional and dietary requirements were assessed, addressed, and documented in residents' 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 appropriate and sufficient catering equipment, crockery, and cutlery to suit the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained in relation to the storage, preparation, and disposal of food and related refuse.

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 changed out of nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with emergency personal clothing that was appropriate to them and considered their preferences, dignity, bodily integrity, and religious and cultural practices. There was a supply of male and female clothing kept in the Willows Ward.

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 which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in June 2020.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan (ICP). The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's ICP.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Residents had lockers and wardrobes within their bedrooms. The approved centre had secure facilities for the safe keeping of residents' valuables, including a safe for residents' valuables.

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

Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. The activities available at the time of the inspection in the approved centre included arts and crafts, crochet, boardgames, baking, sporting activities and a gym. Residents also had access to Netflix, Disney + channel and games consoles.

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

Residents' 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

There was a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2020.

At the time of the inspection, visiting was restricted within the approved centre due to COVID-19. Pre-booked private visits, between residents and their parents, were permitted to take place. This was unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting area was 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 in relation to resident communication. The policy was last reviewed in July 2020. Residents were free to communicate and had access to postal mail, the internet including e-mail, and telephone.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there is reasonable cause to believe the communication may result in harm to the resident 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 in relation to the implementation of resident searches. The policy was last reviewed June 2020**.** The policy addressed all the requirements of the regulation*,* including the following:

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

The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches. A written record was kept of all searches, which included the reason for the search.

The clinical file of one resident who was searched was inspected. The resident's consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during the search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

The search was implemented with due regard to the resident's dignity and privacy. One of the staff members who conducted the search was of the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

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 in place which set out the processes in place for caring for residents who were at the end stage of their life. The policy was last reviewed in June 2020.

The clinical file of one resident who had died since the last inspection was inspected. The sudden death of the resident was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends.

All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

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

Each resident had an individual care plan (ICP). All ICPs were a composite set of documentation. Five ICPs were inspected. The ICPs included allocated sections for goals, treatment, care, resources required, and for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not combined with progress notes.

All ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of resident admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals, appropriate care and treatment, and interventions. All ICPs specified the resources required to provide the care and treatment identified, including the frequency and responsibilities for implementing the care and treatment. The MDTs reviewed care plans once a week. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances and goals, and this was documented.

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 range of therapeutic services and programmes provided by the approved centre were appropriate and met the needs of the residents, as documented in the residents' individual care plans (ICPs). The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of psychosocial functioning of a resident.

Examples of therapeutic groups facilitated included; Social Club Group, Radically Open Dialectical Behaviour Therapy (DBT) Group, Psycho-Education Eating Disorder Group and Virtual Meal Supports. Where a resident required a therapeutic service or programme that was not provided internally, such as speech and language therapy, 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

As this was a children's approved centre, all residents were assessed regarding their individual education requirements with consideration of their individual needs and age on admission. Individual education plans were maintained by the school, which was located on the grounds of the approved centre.

Where appropriate to the needs and age of the young person, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities were available for the provision of education.

Sufficient personnel resources were available for the provision of education to child residents within the approved centre. There were two teachers and two special needs assistants designated to the primary school, and two teachers and two special needs assistants designated to the secondary school.

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 residents, which was last reviewed in July 2020. No resident had been transferred from the approved centre since the last inspection. Therefore, compliance against this regulation was assessed on the basis of the policy alone.

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 written operational policy and procedures for responding to medical emergencies. The policy was last reviewed in June 2019. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED).

At the time of the inspection no resident was in the approved centre for a period greater of six months and greater. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, but at least every six months.

Residents received appropriate general health care interventions in line with individual care plans. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

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 policy and procedures in relation to the provision of information to residents. The policy was last reviewed in July 2020.

Residents were provided with an information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be damaging to the resident'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 residents' and family's needs. Residents 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

The general manner of staff and the way staff interacted with residents indicated respect. Staff were discreet when discussing the resident's condition or treatment needs. Staff were dressed respectfully. Staff sought the resident's permission before entering their room.

All bathrooms, showers, and toilets had locks on the inside of the door, unless there was an identified risk to a resident. Each resident had their own single bedroom at the time of the inspection and their privacy was not compromised. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make and take private phone calls.

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

The approved centre was adequately lit and ventilated. It was adequately heated with underfloor heating which was centrally controlled. It was clean, hygienic, and free from offensive odours. Furnishings supported resident independence and comfort. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. While there were single and double bedrooms in the approved centre, each resident had their own single rooms at the time of the inspection. Single bedrooms were appropriately sized to address the resident needs. There was a sufficient number of toilets and showers for residents in the approved centre. There was adequate space for residents to move about.

Appropriate signage and sensory aids were provided to help residents orientation needs. Hazards were minimised throughout the approved centre. Ligature points were minimised to the lowest practicable level and this was based on a risk assessment. The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained.

Current national infection control guidelines were followed. The approved centre had a designated sluice room and a designated cleaning room. Assisted devices and equipment were provided to address resident needs.

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 operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in February 2021. Each resident had a Medication Prescription and Administration Record (MPAR), and five of these were inspected. All MPARs evidenced a record of medication management practices, including a record of the following: allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, frequency of medication, and stop date of all medicines. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases.

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 resident's care or condition, and this was documented in the clinical file. Medication was stored in the appropriate environment within the clinical room, as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage house was taken daily.

Medication dispensed or supplied to the resident was stored securely in a locked storage press unless it required refrigeration. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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, procedures, and a safety statement relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in July 2020.

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 policy and processes in relation to the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in July 2020.

There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe residents were incapable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre's use of CCTV.

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 staffing policy in place, which was last reviewed July 2020. The policy covered information and procedures in relation to the recruitment, selection and Garda vetting requirements. An appropriately qualified staff member was on duty at all times, and this was documented on the duty roster. The number and skill mix of staffing were sufficient to meet resident needs. The approved centre had two multi-disciplinary teams. This included psychiatry, nursing, occupational therapy, social work and psychology staff. All healthcare staff were trained in the Mental Health Act 2001.

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.

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 (38)	38	100%
Medical (5)	5	100%
Occupational Therapist (1)	1	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 creation of, access to, retention of, and destruction of records. The policy was last reviewed in July 2020. All residents' records were secure, up to date, in good order, with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements.

Resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were physically stored together. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation relating to 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 and up-to-date register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 to the Mental Health Act 2001.

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

Operating policies and procedures required by the regulations were all reviewed within the required three-year time frame.

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 in relation to the management of complaints. The policy was last reviewed in July 2020. The policy covered the process for the management of 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 individual with responsibility for dealing with all complaints was available to the approved centre. The complaints procedure, including how to contact the nominated individual, was publicly displayed. Residents, 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, are investigated promptly and handled appropriately and sensitively. Minor complaints were documented. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. There were no formal complaints since the last 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

There was a comprehensive written policy in relation to risk management which was last reviewed in June 2020. The policy included all of the policy related regulation requirements, including:

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

The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of resident seclusion, physical restraint, and at resident admission and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying

individual risk factors. Structural risks, including ligature points, were effectively mitigated and minimised in the approved centre.

The requirements for the protection of children within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. 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 was adequately insured against accidents and injury to residents. The approved centre's insurance certificate and indemnity scheme statement was available 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 one condition attached to it, which was prominently displayed in the main reception.

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 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

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. The policy addressed who may implement seclusion, the provision of information to the resident, and 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.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Residents in seclusion did not have access to adequate toilet and washing facilities. The washroom located closest to the seclusion room was not directly accessible and it did not have a shower unit. For this reason, residents in seclusion had to access the toilet by going to the main ward area which meant their privacy and dignity was not appropriately respected.

The floor in the seclusion room was not padded and was made of a hard floor fitting, which was a risk to resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file.

One seclusion episode was inspected. In this episode, seclusion was used in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The approved centre had considered all other interventions to manage the resident's unsafe behaviour before deciding to use seclusion. The resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The clinical file recorded that the next of kin were notified on the use of seclusion, and this was what the resident consented to.

The use of seclusion was based on a risk assessment of the resident. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident received a medical review by the registered medical practitioner every four hours.

This episode of seclusion was recorded in the resident's clinical file and this use of seclusion was recorded in the seclusion register. The seclusion register was signed by a responsible consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the resident's clinical file and available to inspectors. This episode of seclusion was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion.

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

a) **Residents in seclusion did not have suitable access to toilet and washing facilities, 8.1. There was no shower unit in the room with a toilet.**
b) **The floor in the seclusion room was of a hard fitting material, which meant it was not furnished so as not to endangered resident safety, 8.3.**

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 a child, who had been in the approved centre for more than three months and who had been in continuous receipt of medication, was examined. The child was admitted to the approved centre under Section 25 of the Mental Act 2001. A Form 18 *Treatment of a Child in Respect of Whom an Order under Section 25 is in force* was completed. After a three month period, the administration of medication was continued as it was approved and authourised by two consultant psychiatrists as set out in Form 18.

The approved centre was compliant with this regulation.

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: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in July 2020. The policy covered:

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

Evidence of Implementation: One episode of physical restraint was inspected. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident's unsafe behaviour.

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident's next of kin was informed about the physical restraint. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered nurse, and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the resident within three hours after the start of the episode of physical restraint.

The order for physical restraint lasted for two minutes and this was recorded in the clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after episode.

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 a series of separate written policies in relation to admission, transfer, and discharge, which were each last reviewed in July 2020. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident admission was inspected in relation to the admission process. Their admission was because of a mental illness. The resident was assigned a keyworker. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a keyworker. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident's family. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A comprehensive discharge summary was issued to relevant personnel within 14 days. The discharge summary included details of diagnosis, prognosis, medication, 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 such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Due to the HSE cyber security attack, the approved centre could not provide Corrective and Preventative Action Plans (CAPAs) in time for publication of the report. The CAPAs will be published at a later date.

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.

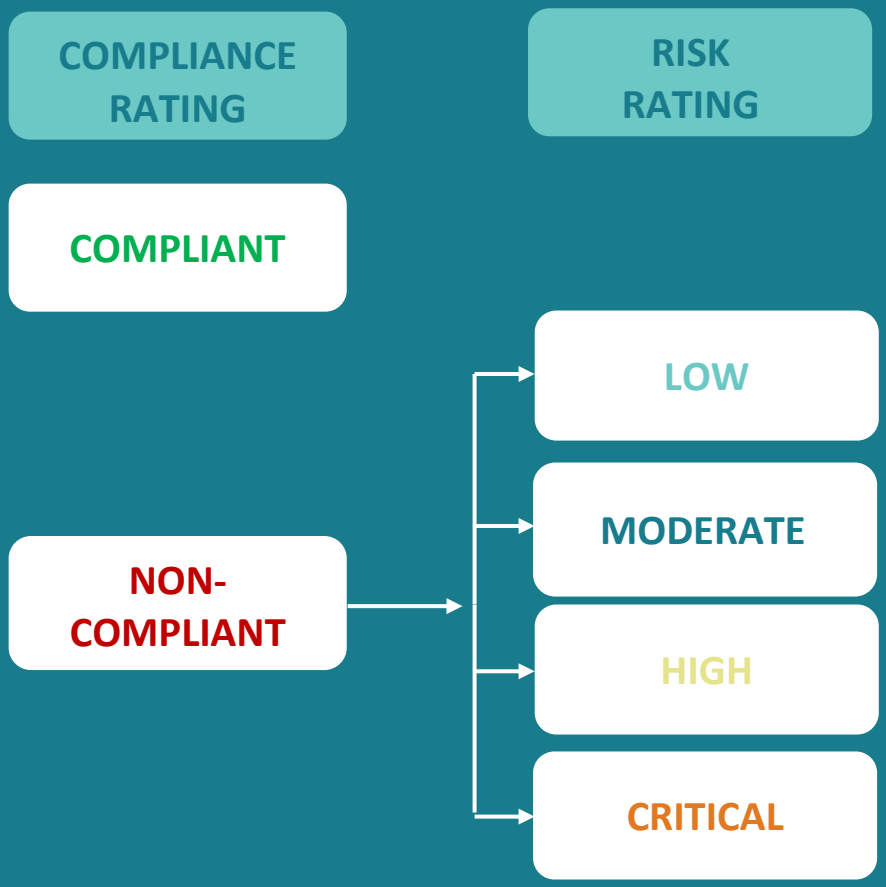
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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