Eist Linn Child & Adolescent In-patient Unit

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mental health commission

Annual Inspection Report 2021

Promoting Quality Safety and Human Rights in Mental Health

EIST LINN CHILD & ADOLESCENT IN-PATIENT UNIT

Eist Linn Child & Adolescent In-patient Unit, Bessborough, Blackrock, Cork

Date of Publication:
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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:
22 December 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr. Hugh Scully, Acting General Manager, Mental Health Services – Cork Kerry Community Healthcare

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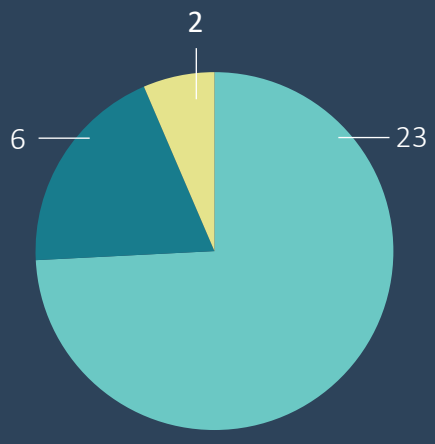
Inspection Date:
25 – 28 May 2021

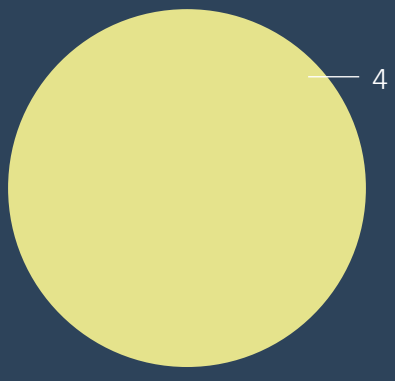
Previous Inspection date:
15 – 18 September 2020

Inspection Type:
Announced Annual Inspection

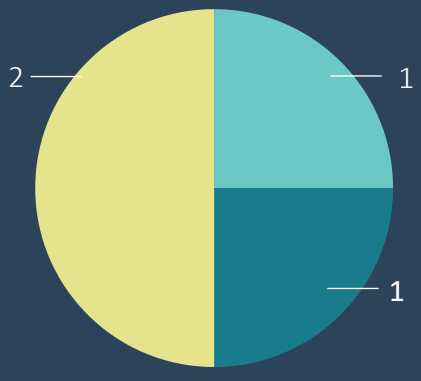
2021 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



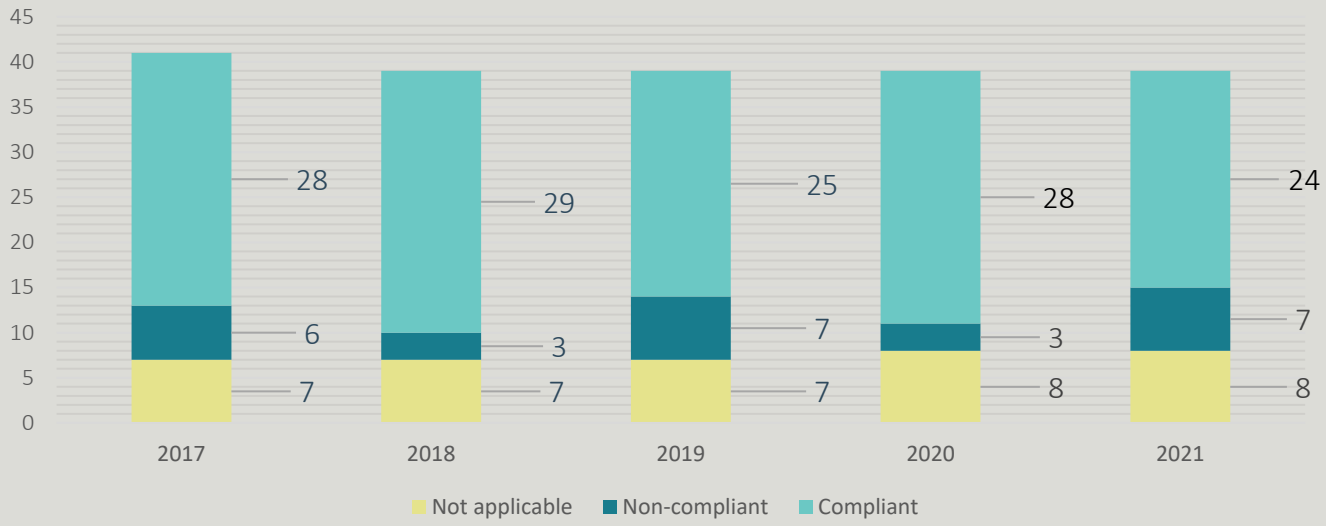
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2017 – 2021

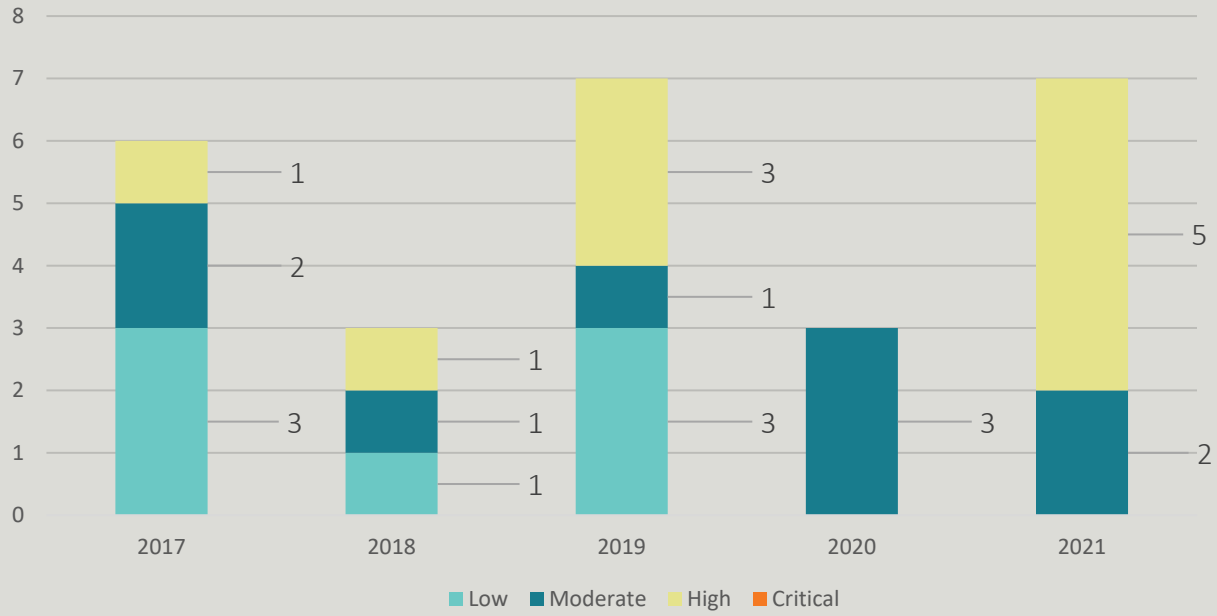
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Eist Linn Child & Adolescent In-patient Unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. Although Eist Linn was registered for 16 beds, it had only 9 in-patients at the time of inspection. It was one of four national in-patient child and adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry, and Cork. Seventeen community child and adolescent teams referred into the approved centre, including the Child and Adolescent Regional Eating Disorder Service (CAREDS) team.

The new extra care area known as Suaimhneas became operational in 2021. This provides an expansive space for a young person to be cared for in a single setting. This included a de-escalation room, single bedroom with en suite, and living and dining facilities. There was an elevated external outdoor space and a sensory room.

As well as the single en suite room in Suaimhneas, there were 15 single en suite bedrooms located on the upper floor.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	82%	91%	78%	90%	77%
Regulations Rated Excellent	2	8	9	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 ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*	Health care staff were trained in the Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes. Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022. The approved centre provided a progress update on staff training to the Mental Health Commission.
The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 26 at the time of inspection.	

Escalation and enforcement actions since last inspection

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

Safety in the approved centre

We found that the approved centre did not always operate safe practices to reduce the risk of harm to 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.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- There was a minimisation of ligature points to the lowest practicable level.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However:

- There was no senior nurse manager on call on 24 occasions between January and February 2021.
- There were not enough staff to safely manage the needs of the young people on two occasions. Shortages were mostly managed through overtime and agency, however, there was not enough nursing staff to meet the required needs of the young people on site within the approved centre.
- There was no cover for the dietitian for 9 months.

- A physical examination of a young person who had been physically restrained had not taken place within the stipulated timeframe of three hours.

Appropriate care and treatment of residents

We found that while staff provided therapeutic activities and physical health monitoring appropriate to needs of residents, this was not based on a high standard of individual care planning.

- Social work, occupational therapy, and psychology services were involved in the design and delivery of therapeutic group sessions. Groups which ran included occupational therapy, art, creativity, and relaxation.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

However, individual care plans (ICPs) inspected were not of a good standard: four ICPs did not identify appropriate goals for the resident, four ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment, and four ICP's did not identify the resources required to provide the care and treatment. This is the third year in succession that the approved centre has been non-compliant with Regulation 15: Individual Care Plan.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre did not always respect the privacy, dignity, and autonomy of young people.

- All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.
- Noticeboards did not display resident names or other identifiable information.
- Residents 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 residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However:

- Not all bathrooms, showers, and toilets, had locks on the inside of the door, and there was no evidence that this was on the basis of risk assessment to the current resident cohort. This has been an ongoing non-compliance issue in previous inspections and a corrective and preventative action plan submitted by the registered proprietor stated that this would be completed by 31 March 2021.
- The resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. There was no explanation documented in the clinical file for not informing the resident.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of residents, but the complaints procedure required improvement.

- Recreational activities included gym, walking, baking, television, music, books, arts and crafts, pool table and board games. The approved centre provided access to recreational activities on weekdays and during the weekend.
- 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 choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

However, although there was documentation of a complaint in the resident's clinical file, there was no evidence that it was followed up in accordance with the approved centres policy on dealing with complaints. This complaint was not dealt with by the nominated person and was not recorded in the complaints log.

Governance of the approved centre

We found that there were serious deficiencies in the clinical governance of the approved centre.

- The approved centre was under the governance and management of the Cork and Kerry Community Health Care Organisation. There were two executive management teams, one for each county. The approved centre was under the governance and management of the Cork Mental Health Area Management Team.
- There were local committees that met quarterly which included a therapeutic and recreational group meeting and the audit group respectively.
- The risk register had been reviewed at least quarterly and risks were added and escalated as required. The multi-disciplinary teams were involved in risk management and a risk review meeting was held at least once weekly.
- While the Area Lead for Mental Health Engagement was a member of the Cork Mental Health Management Team, this role did not involve working with the young people or their families. There was a suggestion box and community meetings were held in the approved centre. A board named

'You said we did', aimed at providing visual feedback to suggestions made in the approved centre, was placed alongside the suggestion box.

However:

- A policy group which initially met monthly was disbanded in November 2020 due to the absence of a multi-disciplinary team member and difficulties to re-allocate a chairperson. This disbandment impacted directly on the approved centres compliance with Regulation 29: Operating Policies and Procedures.
- A Youth Advocacy Programme (YAP) that was available in other child and adolescent services, was not provided in Eist Linn.
- The approved centre's complaints process was not displayed in a prominent position within the approved centre on the first two days of inspection. One complaint was not addressed in accordance with the approved centre's complaints policy.
- Not all of the components of the risk management policy were implemented throughout the approved centre. Clinical risks were not fully identified, assessed, reported, treated, monitored, and recorded in the risk register in a timely manner. There was no senior nurse manager on call for 24 days during January and February 2021 and this was identified on the risk register in May 2021. There were no appropriate control measures in place by the approved centre to mitigate this clinical risk.

COVID-19 response

- COVID-19 was a standing item on the agenda of the Cork Mental Health Area Management Team. There were separate and regular COVID-19 management meetings since the onset of the pandemic.
- There was a well-developed and proactive COVID-19 preparedness plan. Technological solutions, such as teleconferencing, had been adopted to allow virtual attendance at assessments and other meetings, such as care planning.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The new extra care area known as Suaimhneas became operational in 2021. This provided an expansive space for a young person to be cared for in a single setting. This included a de-escalation room, single bedroom with en suite and living and dining facilities. There was an elevated external outdoor space and a sensory room. The sensory room by its location could be used by all young people in the approved centre, with staff support.

2. Clinical psychology initiated service user feedback to inform Psychology Group Therapy.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Eist Linn Child & Adolescent In-patient Unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. It was one of four national in-patient child and adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry, and Cork. Seventeen community child and adolescent teams referred into the approved centre, nine from Cork and Kerry which include the Child and Adolescent Regional Eating Disorder Service (CAREDS) team and eight from the remaining counties.

Eist Linn was registered to accommodate 16 young people. On the first day of inspection there were 9 young people in the approved centre from counties Cork, Kerry, and Tipperary. One young person had been in the approved centre longer than six months. Refurbishment works recently completed included a low stimulus extra care area named Suaimhneas which was operational for three months. This included one en suite bedroom, a de-escalation room, living and dining space and an elevated enclosed outdoor space. A sensory room that could be accessed both from the Suaimhneas extra care area and the main upstairs accommodation area was also recently completed and operational for a period of three month on the week of inspection.

As well as the single en suite room in Suaimhneas, there were 15 single en suite bedrooms located on the upper floor. There was a TV room/lounge that was small for the numbers it was anticipated to accommodate. The lower floor comprised of day activities, group rooms, television/sitting rooms, dining room with a servery kitchen and staff offices. There was a pool room and a small computer room with two computers for young people's use under staff supervision.

There was a school located across two internal gardens with classrooms, an activity kitchen, and an expansive gym hall. A smaller gym had been developed with a treadmill, cross-trainer, and fixed bicycle. Along with a number of identified visiting rooms there was a parent's flat with sleeping accommodation. At the time of inspection, this was used for day visiting due to COVID-19 restrictions.

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**9**
Number of detained patients	1
Number of wards of court	0
Number of children	9
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the governance and management of the Cork and Kerry Community Health Care Organisation. There were two executive management teams, one for each county. The approved centre was under the governance and management of the Cork Mental Health Area Management Team. Meeting monthly, agenda items included Compliance, Service Planning and Finance, Quality Patient Safety (QPS), Complaints and Compliments, and Mental Health Engagement. COVID-19 was now a standing item on the agenda, although there were separate and regular COVID-19 management meetings since the onset of the pandemic. There were also quarterly standalone QPS meetings.

Business Team Meeting met once every two months. During a six-month period, two meetings were held and one meeting was deferred because of the Nursing Industrial Dispute. There were local committees that met quarterly inclusive of a therapeutic and recreational group meeting and the audit group respectively. A policy group which initially met monthly. The Policy Review Group met on 3 occasions: 18.01.2021, 22.02.2021, and 19.04.2021. The last meeting acknowledged the group was no longer operational due to lack of resource which impacted directly on the approved centres compliance with regulation 29: Operating Policies and Procedures. The risk register had been reviewed at least quarterly and risks were added and escalated as required. The person with responsibility for risk was identified and known by staff. The multi-disciplinary team were involved in risk management and a risk review meeting was held at least once weekly.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The authority and responsibility of line managers for the various disciplines were clear.

Appropriate staffing resources were not always available to meet the needs of residents. There were seven nursing vacancies at the time of inspection with three nursing staff required to work remotely due to HSE guidelines. In May 2021 day staff were directed to remain on duty due to unsafe night duty staffing numbers. A senior nurse manager was required to assist and staff from other mental health services were required to attend. Several incidents highlighted that no senior nurse management was on call during the night in January 2021 and February 2021. Of two senior nurse managers who rotated the on-call roster; only one senior nurse manager was available for on call cover from February 2021 until the first day of inspection. This risk was identified in the local risk register on the 10th of May 2021. Shortages were mostly managed through overtime and agency however there was not enough nursing staff to meet the required needs of the young people on site within the approved centre. This was on two occasions when the new Suaimhneas extra care area required opening. The Suaimhneas extra care area as set out in the policy required 2 extra nursing staff per day and night when in use. Statutory leave had not been covered for a member of the multi-disciplinary professional group for a period of nine months.

While the Area Lead for Mental Health Engagement was a member of the Cork Mental Health Management Team, this role did not involve working with the young people or their families. A Youth Advocacy Programme (YAP) that was available in other child and adolescent services, was not provided in Eist Linn. Multi-Disciplinary team members stated a period of research was to be undertaken by the multi-disciplinary team to formulate a bespoke advocacy service for the young people in Eist Linn. No timeframe was given to the inspection team of when this was due to be completed. The voice of the service user was sought by staff

of Eist Linn from “Fred the Frog” suggestion box and community meetings held in the approved centre. A review of the community meetings minutes and requests from these meetings had been completed by a staff member in Eist Linn. The new Suaimhneas extra care area and sensory room had been operational for three months at the time of inspection. A board named ‘You said we did’ aimed at providing visual feedback to suggestions made in the approved centre was placed alongside the suggestion box. This visualised how suggestions made by the young people were being actioned.

In line with wider Cork Mental Health Services, there was a well-developed and proactive COVID-19 preparedness plan. Staff representatives were members of the wider COVID-19 management team. Information was disseminated to the staff in Eist Linn. Virtual attendance through technological solutions such as teleconferencing had been adopted where required for assessments and other meetings such as care planning. This was to support the care and treatment of the young people using the services of Eist Linn Adolescent and children’s Mental Health Services where remote working was required.

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	
Regulation 15: Individual Care Plans	✓		✓		✗	Low	✗	Moderate	✗	High
Regulation 21: Privacy	✓		✓		✗	Low	✗	Moderate	✗	High
Regulation 26: Staffing	✗	Low	✗	Moderate	✗	High	✓		✗	High
Regulation 29: Operating Policies and Procedures	✓		✓		✓		✓		✗	Moderate
Regulation 31: Complaints Procedures	✓		✓		✓		✓		✗	Moderate
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	High
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✗	Low	✗	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 25: Use of Closed Circuit Television	As CCTV was used in the reception area (for security purposes only) this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As this was a Child and Adolescent Mental Health Service, tribunals were not applicable in this approved centre.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was 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.

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.

Feedback was received by the inspection team via telephone and questionnaires with the young people using the approved centre. Six questionnaires were completed: five by young people and one by a family member. Three young people and one family member indicated they understood their/ the young person's care plan. One young person and a family member stated in their questionnaires they were always involved in setting goals in the young person's individual care plan whilst four young people indicated they were only sometimes involved in their goal setting.

Four young people and one family member stated they knew the mental health care team and keyworker whilst one young person commented they did not know their team or keyworker. One young person reported they were always able to discuss worries or concerns with a member of staff as soon as they needed to whilst four young people and a family member indicated this was only sometimes. One young person commented this could be impacted by how busy staff were or if they were short staffed.

Four young people commented they were happy with how the staff spoke with them. Three young people only sometimes felt able to give feedback to staff and towards making complaints. A comment suggested this could sometimes be due to communication challenges and understanding. Four young people indicated they sometimes felt safe in the approved centre. One young person attributing their feeling of safety depending on incidents of violence and aggression within the approved centre. All questionnaires that completed this question indicated the young people using Eist Linn were able to communicate freely with family and friends.

One young person reported to the inspection team via interview they were happy they received information on their medication and diagnosis.

Questionnaires asked those completing the questionnaire to score on a scale of 1 – 10 with 1 being poor and 10 being excellent toward the overall care and treatment. Five questionnaires completed this question, and four questionnaires score the approved centre six or above.

5.2 Advocacy

The approved centre did not have an advocacy service. Eist Linn were not provided with funding for the YAP advocacy service. Eist Linn sought clarification in November 2020 from the National Office of the model of advocacy being provided by the YAP service to two of the other three national Child and Adolescent Mental Health approved centres. In the meantime, Eist Linn are seeking to engage with service users as to their preferred model of advocacy.

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 Nominee / General Manager
- Head of Service
- Area Administrator
- Business Manager
- Executive Clinical Director
- Clinical Director
- Consultant Psychiatrist
- Principal Social Worker
- Occupational Therapy Manager
- Psychology Manager
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager III
- Principal Teacher
- Speech and Language Therapist

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

Each resident was readily identifiable by staff when receiving medication, health care, and other services. The approved cere used a minimum of two appropriate resident 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 choices within 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 at all times. The needs of residents identified as having special nutritional and dietary requirements at the time of inspection 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 adequate 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 to support food safety requirements. A daily log was taken of fridge temperatures, and food temperatures were checked ay each meal.

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 did not wear nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with emergency personal clothing that was appropriate and considered their preferences, dignity, bodily integrity, and religious and cultural practices. The emergency clothing was kept in the property room and checked weekly by nursing staff.

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 policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2019. Residents could bring in personal property and possessions on admission, and these were safeguarded when the approved centre assumed responsibility for them. 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 individual care plan (ICP).

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Residents were encouraged to leave money and valuable items at home. The approved centre had secure facilities including a locked property room for the safe-keeping of 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

The approved centre provided access to a range of recreational activities appropriate to the resident group profile during the week and at the weekend. This included, gym, walking, baking, television, music, books, arts and crafts, pool table and board games.

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. Contact numbers of local religious leaders was available to residents.

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 policy and procedures in relation to visits. The policy was last reviewed in January 2020, an addendum was added to the policy in July 2020 relating to COVID-19. Visiting times were appropriate and reasonable.

There was a separate visitor rooms available where private visits could take place, 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 these visits. The visiting rooms were suitable for children visiting residents.

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 policy and procedures in relation to resident communication. The communication policy was last reviewed in July 2018. Residents had access to postal mail, the approved centre's portable telephone, and the approved centre's two electronic tablets. There were no restrictions on resident's communication at the time of the inspection. The senior staff member only examined incoming and outgoing resident communication on the basis of risk assessment - if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

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 in relation to the implementation of resident searches. The policy was last reviewed in October 2017 with an addendum added in July 2020 relating to COVID-19.

The policy addressed all of 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, and a written record was kept of all environmental searches. 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 a 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 one of the searches was of the same gender as the resident being searched.

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 relation to caring for residents who are dying. The policy was last reviewed in April 2019, with a policy addendum added July 2020 in relation to COVID-19.

As no resident had died in the approved centre premises since the last inspection compliance for this regulation was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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). Five ICPs were inspected. All ICPs were a composite set of documentation, with allocated space and sections for goals, treatment, care, resources required, and reviews. ICPs were stored within the clinical file, were identifiable and were not interrupted. ICPs were not integrated with progress notes.

All ICPs for resident admissions were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of 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.

Four ICPs did not identify appropriate goals for the resident. Four ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Four ICP's did not identify the resources required to provide the care and treatment.

A multi-disciplinary team reviewed and updated individual care plans in all five ICPs. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances and goals, this was documented.

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

a) **Four individual care plans did not identify appropriate goals for the resident.**
b) **Four individual care plans did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.**
c) **Four individual care plans did not identify the resources required to provide the care and treatment.**

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 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 physical and psychosocial functioning of a resident.

At the time of the inspection, social work, occupational therapy, and psychology services were involved in the design and delivery of therapeutic group sessions. Groups which ran included occupational therapy, art, creativity, and relaxation.

Where a resident 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

All residents were assessed regarding their individual education requirements with consideration of their individual needs and age on admission.

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 - four teachers (three whole time equivalents), were available for the provision of education to the residents within the approved centre.

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 a written operational policy and procedures in place in relation to the transfer of residents. The policy was last reviewed in July 2020.

The clinical file of one resident who had been transferred from the approved centre in a non- emergency situation was examined. Full, complete, and relevant written information about the resident was transferred to the receiving hospital when they moved there. The transfer documentation included a letter of referral including a list of current medication, and the resident transfer form.

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 general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in July 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator, (AED).

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Residents received appropriate general health care interventions in line with individual care plans.

One resident was in the approved centre for more than six months and their clinical file was inspected. This resident had received a six-monthly general health assessment which was reviewed by the inspection team. This six-monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, nutritional status, a medication review, body mass-index, weight, and dental health.

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 January 2020.

Residents were provided with a resident 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 written and verbal information on their diagnosis. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

The general behaviour of staff and the manner in which staff addressed and interacted with residents indicated respect. Staff were discreet when discussing the resident's condition or treatment needs. Staff were dressed respectfully.

All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

Not all bathrooms, showers, and toilets, had locks on the inside of the door, and there was no evidence that this was on the basis of risk assessment to the current resident cohort. Specifically, the doors of the en suite bathrooms were unlockable for years prior to this inspection because the internal bar within the lock of each en suite bathroom door was removed. The locks had not been replaced since and at the time of the inspection en suite bathrooms could not be locked by residents, which compromised all residents' privacy and dignity.

The approved centre was non-compliant with this regulation because residents' privacy and dignity was not respected at all times. All of the en suite bathrooms in the approved centre did not have locks on the inside of the doors, 21.

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, heated, and ventilated. 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. All resident 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, including indoor and outdoor spaces.

Appropriate signage and sensory aids were provided to help residents in finding their way around the approved centre. Hazards were minimised throughout the approved centre. Ligature points were minimised to the lowest practicable level based on a risk assessment. The approved centre was kept in a good state of repair externally and internally and there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained.

The approved centre had a designated utility room which was used as a sluice room and a designated cleaning room. Assisted devices and equipment were provided to address resident needs. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

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 November 2017. An addendum to the policy in relation to COVID-19 precautions had been added to the policy in July 2020.

Each resident had a Medication Prescription and Administration Record (MPAR), and five of these were inspected. All MPARs evidenced a record of appropriate 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 the date of discontinuation for each medication. 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 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 unit 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, and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in November 2019. An addendum to the policy in relation to COVID-19 precautions had been added to the policy in July 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

(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 and procedures in relation to the recruitment, selection and Garda vetting requirements. The policy was last reviewed in February 2019. An appropriately qualified staff member was on duty at all times, and this was documented. The number and skill mix of staffing were insufficient to meet resident needs.

Firstly, incidents noted there were 24 days where there was not a senior member of nurse management on call between January and February 2021. Secondly there was no cover for the dietitian during their statutory leave of 9 months. Thirdly, the nursing department were working with a 50% loss of whole-time equivalent staff due to seven vacancies, illness and COVID-19 related leave of nursing staff. Two incidents indicated there were not enough nursing staff during shifts in April and May 2021 to meet the needs of the needs of the young people in the approved centre.

The multi-disciplinary team (MDT) consisted of medical, psychology, occupational therapy, social work, nursing, dietetics, speech and language therapy and teaching in school terms.

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 in the Mental Health Act 2001:

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (19)	19	100%
Medical (4)	4	100%

Occupational Therapist (1)	1	100%
Social Worker (2)	2	100%
Psychologist (2)	2	100%
Dietitian (1)	1	100%
Speech and Language Therapist (1)	1	100%

The approved centre was non-compliant with this regulation because the numbers and skill mix of staffing were not sufficient to meet resident needs for the following reasons:

a) **There was no senior nurse manager on call on 24 occasions, 26.2.**
b) **There was no cover for the dietitian during a statutory leave of 9 months, 26.2.**
c) **There were not enough staff to safely manage the needs of the young people on two occasions, 26.2.**

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 January 2020. 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 to a logical sequence. 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 hard copy 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

NON-COMPLIANT

Risk Rating **MODERATE**

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

Three out of fifteen operational policies and procedures required by the regulations were not reviewed within the required three-year time frame. These were as follows: The Searches Policy, which was last reviewed in October 2017, the Medication Management Policy which was last reviewed in November 2017, and the Risk Management Policy which was last reviewed in February 2018.

The approved centre was non-compliant with this regulation because three out of fifteen operational policies and procedures required by the regulations were not reviewed within the required three-year time frame.

Regulation 31: Complaints Procedures

NON-COMPLIANT

Risk Rating **MODERATE**

(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 October 2019. 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 person who was available to the approved centre with responsibility for dealing with all complaints in the approved centre. The complaints procedure including how to contact the nominated person was not publicised and accessible to residents, their representatives, and families until the third day of this inspection.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made, and this information was contained in the resident's information booklet. 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.

Not all complaints were handled promptly, appropriately, and sensitively. In one case, there was documentation of a complaint in the resident's clinical file but there was no evidence that it was followed up in accordance with the approved centres policy on dealing with complaints. This complaint was not dealt with by the nominated person and was not recorded in the complaints log.

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

a) **Not all complaints were investigated promptly and handled appropriately. One complaint was evidenced in the resident's clinical file, but it was not investigated as part of the complaints process nor in accordance with the approved centre's policy on dealing with complaints, 31 (5).**
b) **The registered proprietor did not ensure that the nominated person maintained a record of all complaints. One complaint was not dealt with by the nominated person and was not recorded in the complaints log, 31 (6).**
c) **The complaint's process was not displayed in a prominent position within the approved centre on the first two days of inspection, 31 (3).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untohouse 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, which was last reviewed in November 2019. An addendum to the policy in relation to COVID -19 had been added in July 2020. The risk management policy addressed all requirements of the regulation. The policy did not include processes specifically in relation to:

- Capacity risks relating to the number of residents in the approved centre.
- Risk to the resident group during the provision of general care and services.
- Risks to individual residents during the delivery of individualised care.

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.

Not all of the components of the risk management policy were implemented throughout the approved centre. Clinical risks were not fully identified, assessed, reported, treated, monitored, and recorded in the risk register in a timely manner. No senior nurse manager on call for 24 days during January and February 2021 was identified on the risk register in May 2021. There were no appropriate control measures in place by the approved centre to mitigate this clinical risk.

Corporate and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Structural risks including ligature points were removed or effectively mitigated. Multi-disciplinary teams (MDT) were involved in the development, implementation, and review of individual risk management processes.

Individual risk assessments were completed prior to physical restraint episodes and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated and recorded in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team (MDT), and a record was maintained of clinical reviews 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 non-compliant with this regulation because the registered proprietor did not ensure that all of the risk management policy was implemented throughout the approved centre as a clinical risk was not adequately and timely identified, assessed, treated, reported and monitored, 32 (1).

Regulation 33: Insurance

COMPLIANT

The registered proprietor of an approved centre shall ensure that the house 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 relating to the certificate of registration attached to it, which was displayed prominently.

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)

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

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

NON-COMPLIANT

Risk Rating HIGH

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 September 2020. The policy covered:

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

Training and Education: There was a written record to show that all staff involved in physical restraint had read and understood the policy.

Monitoring: The approved centre submitted an annual report to the MHC (Mental Health Commission) on its use of physical restraint.

Evidence of Implementation: The clinical file of one resident who had been physically restrained 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. The restraint order lasted for a maximum of thirty minutes. Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The consultant psychiatrist was notified of the physical restraint episode as soon as was practicable.

The registered medical practitioner did not complete a physical examination of the resident within the stipulated timeframe of three hours. The resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. There was no explanation documented in the clinical file for not informing the resident.

The episode of physical restraint was reviewed by the multi-disciplinary team (MDT). A completed clinical practice form was placed in the resident's clinical file. The resident was given the opportunity to discuss the episode with members of MDT as soon as was practicable.

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

a) **The registered medical practitioner did not complete a physical examination of the resident within the required timeframe, 5.4.**
b) **The resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. There was no explanation documented in the clinical file for not informing the resident, 5.8.**

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. The admission policy was last reviewed in July 2020, the transfer policy was last reviewed in July 2020, and the discharge policy was last reviewed in September 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, transfer, and discharge policies.

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. With the resident's consent, their family member was involved in the admission process. 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, and a risk assessment. The resident received a full physical examination.

Transfer: The approved centre complied 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 (MDT) 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, social and housing needs, and a comprehensive risk assessment and risk management plan. A preliminary discharge summary was sent to the Child and Adolescent Mental Health Team (CAMHS) within three days. The discharge summary included details of a timely follow-up appointment.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10002107		**Four individual care plans did not identify appropriate goals for the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review and audit of current care plan was undertaken in the week following the inspection to ensure appropriateness of goals as they pertained to the residents.	Full review/ Audit of all resident care plans completed.	This action is complete	30/07/2021	Clinical Leads for Eist Linn.
Preventative Action	1. Service user engagement project to review process and formatting of our care plans. 2. The quality of the ICP will be monitored to ensure compliance with Regulation 15. 3. ICP audit results will be a standing item on the monthly Heads of Discipline meeting.	1. In house training sessions weekly to carry this out. 2. Weekly audit of the ICPs and reported monthly to the Audit Group. 3. Identified on the minutes of both meetings.	1. This is both achievable and realistic. An interim review will be undertaken prior to year-end 2021. 2. Achievable. 3. Achievable. Achievable Achievable	31/12/2021	1. Clinical Leads for the Unit. 2. Clinical Leads for the Unit. 3. Clinical Leads for the Unit.
Reason ID : 10002108		**Four individual care plans did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A Review and audit of current care plan was	Care plans were Reviewed	This Action is now complete.	30/07/2021	Clinical Leads for Eist Linn

	undertaken to ensure appropriate goals				
Preventative Action	1. Service user engagement project to review process and formatting of our care plans. 2. Goals, frequency of interventions, responsibilities will all be and clearly identified in the ICP format.	1. In house training sessions to be provided to all staff. 2. Performance will be measured by weekly Audits.	This is both achievable and realistic. An interim review will be undertaken prior to year end 2021.	31/12/2021	1.Clinical Leads for Eist Linn. 2. Clinical Leads for Eist Linn.
Reason ID : 10002109		**Four individual care plans did not identify the resources required to provide the care and treatment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Resident Care plans are now Audited weekly to ensure resources are identified clearly in the ICP.	Performance will be measured by weekly Audits.	Achieved.	30/08/2021	Clinical Leads for Eist Linn.
Preventative Action	Service user engagement project to review process and formatting of our care Plans.	In house training sessions to be provided to all staff.	This is both achievable and realistic	31/12/2021	Clinical Leads for Eist Linn.

Regulation 21: Privacy					
Reason ID : 10002115		**Residents' privacy and dignity was not respected at all times. All of the en suite bathrooms in the approved centre did not have locks on the inside of the doors, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Thumb turn locks with override function have been fitted to all the en-suite doors on the unit.	Locks have been installed.	Completed	30/07/2021	Maintenance Department.
Preventative Action	1. Regular reviews of locks to ensure compliance with Regulation 21. 2. Ensure locks are working and provide a proactive approach to those that are found to require repair checklist.	1. To be added to the checklist as part of the quarterly maintenance and estates walk through of Eist Linn. 2. As part of the quarterly proactive maintenance program in place in Eist Linn.	This is both achievable and realistic.	31/12/2021	1. Maintenance Department. 2. CNM2 with responsibility for Maintenance in Eist Linn/ CNM3.

Regulation 26: Staffing

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 29: Operating Policies and Procedures					
Reason ID : 10002111		**Three out of fifteen operational policies and procedures required by the regulations were not reviewed within the required three-year time frame.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Policies reviewed.	The Policy Group chair will update on performance at the Policy Group.	This is Achievable and realistic the policy group is in the process of actioning.	31/12/2021	Chair of Policy Group.
Preventative Action	1. Policy and procedures review and update all policies, procedures and codes of practice. 2. The master schedule of policies and procedures will be updated following each Policy meeting.	Minutes of the policy group will be held.	This is both achievable and realistic.	16/09/2022	Chair of the Policy group.

Regulation 31: Complaints Procedures

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 32: Risk Management Procedures

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10002105		**The registered medical practitioner did not complete a physical examination of the resident within the required timeframe, 5.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review of the residents file and record updated to reflect the status. Retrospective entry to be highlighted.	Completed.	Completed	31/07/2021	Clinical Leads for Eist Linn.
Preventative Action	Training revision on the Code of Practice and PMAV. Physical examination requirements to be highlighted in NCHD training at rotation July and January.	Training material to be updated to ensure requirement is highlighted at induction.	This is both achievable and realistic.	31/12/2021	Heads of Discipline
Reason ID : 10002106		**The resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. There was no explanation documented in the clinical file for not informing the resident, 5.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review undertaken of all restraints since last audit since May 2021 and an action plan agreed to improve compliance with the COP.	All 3 restraints since May 2021 have been audited and an action plan developed to implement the results associated with the findings.	Completed	30/08/2021	CNS/RPN.
Preventative Action	1. Education sessions for staff on COP. 2. Audit all restraints individually by	1. Education sessions to be provided. 2. Every restraint in Eist Linn to be audited.	1. This is both achievable and realistic. 2. The relatively low numbers of patients and the volume of restraints	31/12/2021	1. Clinical Leads for Eist Linn. 2. CNS/RPN.

	suitably experienced staff.	Performance will be measured by Audit and results will be reviewed by the Audit Group.	undertaken make this an achievable and realistic item for completion.		

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.

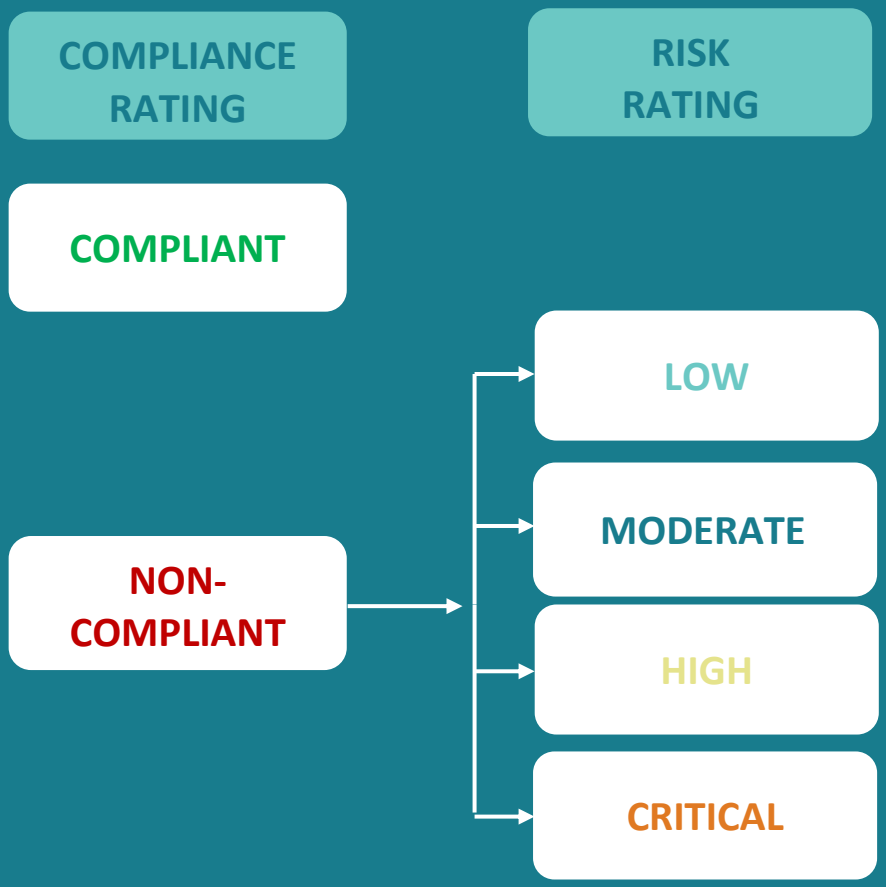
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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