Willow Grove Adolescent Unit

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mental health commission

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

WILLOW GROVE ADOLESCENT UNIT

St. Patrick's University Hospital, James's St., Dublin 8

Date of Publication:
11 August 2022

ID Number: AC0183

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
30 April 2019

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
N/A

Inspection Team:
Noeleen Byrne, Lead Inspector
Siobhan Dinan
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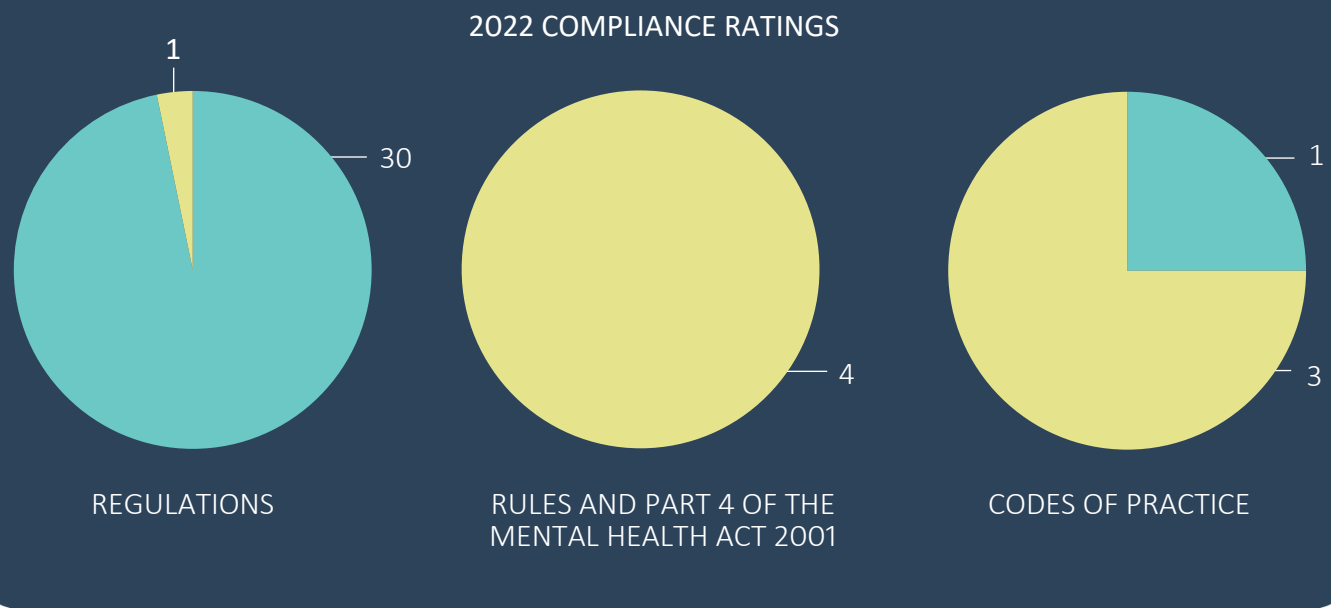
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
14 – 17 February 2022

Previous Inspection date:
24 – 27 August 2021

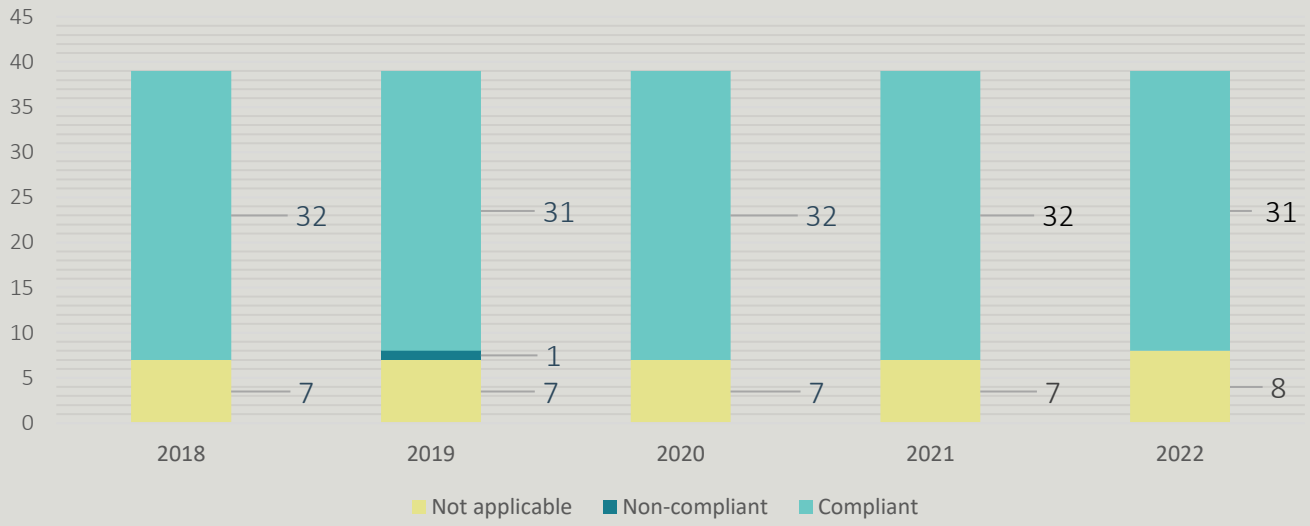
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2018 – 2022

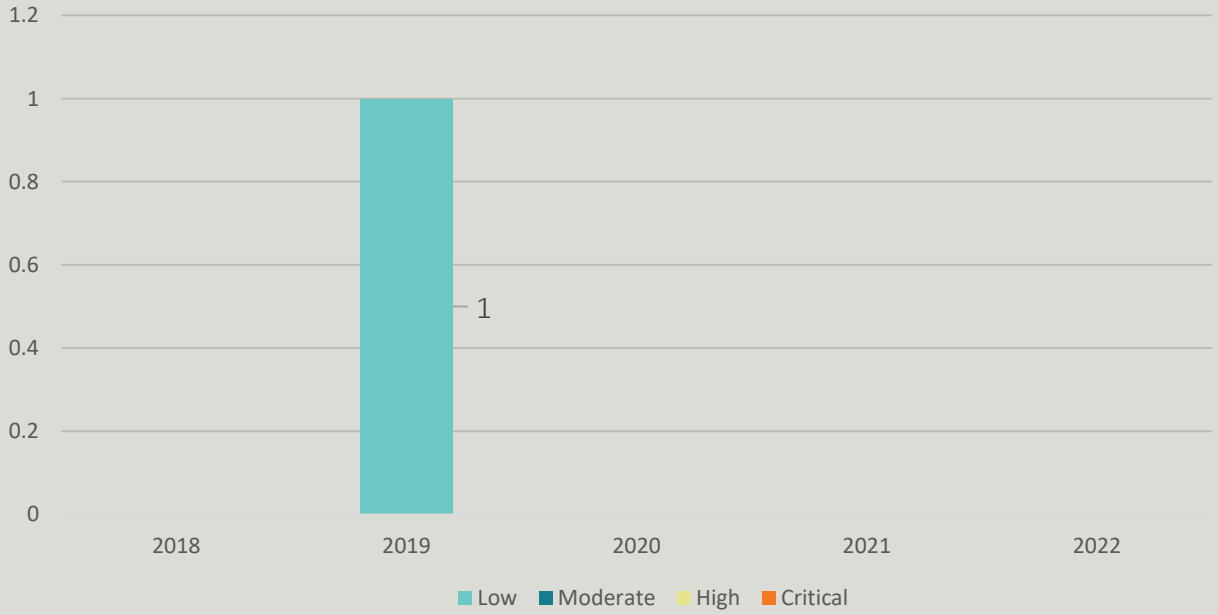
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022



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 2018 – 2022



Contents

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. 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

Willow Grove Adolescent Unit (WGAU) was an independent 14-bed dedicated, standalone unit located within the grounds of St. Patrick's Hospital and was part of St. Patrick's Mental Health Service (SPMHS) but operated independently from the adult service. It provided treatment to young people aged from 12 to 17 from all over Ireland. There was a school attached to the unit.

The approved centre has been fully compliant with all regulations and codes of practice over the past three years

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	100%	97%	100%	100%	100%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None

Safety of residents in the approved centre

We found that the approved centre operated safe practices to ensure the safety of residents:

- Each resident had ongoing individual risk assessments.

- Processes for the protection of children within the approved centre were in place.
- Structural risks, including ligature points, were removed, or managed to reduce risk to residents.
- The approved centre followed food safety requirements.
- Infection prevention and control processes, and COVID-19 protocols, were in place.
- Medication management was compliant with regulations and good practice.
- Six young people who provided feedback to the inspectors all said that they felt safe in the approved centre.
- There was an emergency plan in place that incorporated evacuation procedures.
- All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.
- Policy requirements were implemented when illicit substances were found in the approved centre.

Appropriate care and treatment of residents

We found the care and treatment of residents to be appropriate and met the treatment needs of the young people.

- Admissions to the approved centre were because of a mental illness or disorder and admission assessments had been completed and this included a risk assessment and full physical examination.
- All residents had a multi-disciplinary individual care plan (ICPs) which included goals, treatment and care, resources required and reviews. The ICP was discussed and drawn up with the resident and their family, as appropriate.
- The therapeutic services and programmes provided by the approved centre met the assessed needs of the residents.
- Adequate arrangements were in place for residents to access general health services and for their referral to other health services if required.
- The number and skill mix of staffing were sufficient to meet resident needs.
- A comprehensive pre-discharge assessment was completed, which addressed the residents' psychiatric, social and psychological needs, and included a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process. A comprehensive discharge summary was issued to relevant health care professionals within 14 days.

Respect for residents' privacy, dignity and autonomy

- The general demeanour of staff and the way in which they interacted with residents was observed to be respectful during the inspection.
- Residents had their own single, en suite bedrooms.
- Medical files and other personal documentation were stored in a secure way.
- Searches were implemented with consideration of residents' dignity, privacy and gender, and consent was sought prior to all searches. A minimum of two clinical staff were in attendance when searches were being conducted.

- There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. The approved centre's use of CCTV was also detailed in the resident information booklet. CCTV cameras were not capable of recording and CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident.
- The approved centre provided information about residents' diagnosis and medication to assist them in making informed choices.

Responsiveness to residents' needs

- The approved centre provided access to recreational activities on weekdays and weekends appropriate to the resident group profile.
- The approved centre was kept in a good state of repair externally and internally.
- Sufficient indoor and outdoor spaces were provided for residents to move about.
- Residents had access to personal space and to appropriately sized communal rooms.
- Residents were provided with a variety of wholesome and nutritious food, with choices for meals.
- Secure facilities including secure lockers were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions.
- The approved centre had a designated visitors' room where residents could meet visitors in private. Visiting rooms were suitable for child visitors.
- Residents had access to the internet through a computer station in the approved centre which was risk-assessed with due regard to the resident's wellbeing, safety, and health.
- Residents were provided with an information booklet on admission that included details about the approved centre. The information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Governance, Leadership and Accountability

Willow Grove was part of St. Patrick's Mental Health Services. The approved centre was governed by the board of St. Patrick's Mental Health Services. The senior management team were responsible to the board for the direct operation of the approved centre.

There was a strong clinical and corporate governance structure in place:

- Governance processes made provision for the involvement of service users and their representatives and there were daily meetings with the residents and suggestion boxes were in place.
- Key performance indicators assisted the senior management to measure how well they were doing in relation to achieving set goals.
- Defined lines of responsibility were evident in each department and staffing numbers were in accordance with agreed numbers.
- Clinical, corporate and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate.

- Requirements for the protection of children within the approved centre were implemented as required.
- Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting.
- Clear systems were in place to support quality improvement.
- Residents had access to advocacy services through Youth Advocate Programmes (YAP) Ireland.
- There was a complaints process in place. No complaints had been escalated to the complaints officer since the last inspection.
- Service development, health and safety, facilities, and risk management, including review of the overall risk register were discussed at Senior Management Team meetings, with outcomes and actions documented.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. St Patrick's Mental Health Services (SPMHS) launched a new webinar series called Mental Health Recovery: A Family Perspective. All staff were invited to attend. A 14-part, monthly webinar series, aimed to provide information for families and carers supporting a loved one with a mental health difficulty.
2. A Nursing Quality Initiative working group has been established to focus on activities designed to monitor, analyse, and improve the quality of nursing processes in order to improve the healthcare outcomes.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Willow Grove Adolescent Unit (WGAU) was a dedicated, standalone unit located within the grounds of St. Patrick's Hospital and forming part of St. Patrick's Mental Health Service (SPMHS). The unit operated independently to the adult service. It provided treatment to young people aged from 12 to 17 from all over Ireland.

All bedrooms were single and included en suite and shower facilities. The unit provided therapeutic services which included counselling and clinical psychology, occupational therapy, family therapy and social work. There were adequate communal areas and young people had access to outdoor recreational facilities. There was a school attached to the unit. The unit had accommodation for up to 14 young people. At the time of the inspection there were nine residents.

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

Resident Profile	
Number of registered beds	***14***
Total number of residents	**9**
Number of detained patients	0
Number of wards of court	0
Number of residents in the approved centre for more than 6 months	0

3.2 Governance

Willow Grove was part of St. Patrick's Mental Health Services. The approved centre was governed by the board of St. Patricks Mental Health Services. The senior management team were responsible to the board for the direct operation of the approved centre. Governance processes made provision for the involvement of service users and their representatives where appropriate. A detailed clinical and corporate governance structure was in place.

There was one multi-disciplinary team (MDT) and members of the team included Consultant Psychiatrists, registrars, nurses, social workers, occupational therapy, psychologists, a family therapist, a teacher and a dietitian. Speech and language therapy was available however the speech and language therapist was not part of the MDT.

The inspection team were provided with governance questionnaires by the head of clinical disciplines during the inspection process. These provided a clear overview of the governance issues and current risks within

their respective departments. Each head of discipline was based in the approved centre. Defined lines of responsibility were evident in each department. Each head of discipline met with staff on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the senior management team. The medical, nursing and psychology departments had formal staff performance appraisals in place. The occupational therapy and social work department did not have staff performance appraisals; however, this was addressed through supervision. All disciplines reported that their staffing numbers were in accordance with agreed numbers.

All heads of discipline had received training on clinical risk management and a risk register was maintained. All heads of discipline identified strategic aims for their teams and discussed potential operational risks with their departments. Key performance indicators assisted the senior management to measure how well they were doing in relation to achieving set goals. Clear systems were in place to support quality improvement.

The senior management team (SMT) met fortnightly. The minutes from these meetings were provided to the inspection team and outlined an active governance process involving senior management and, as appropriate, members of various disciplines within the approved centre. Issues such as service development, health and safety, facilities, and risk management, including review of the overall risk register were discussed at these meetings. The minutes emphasised issues relating to the management of COVID-19 risks. The SMT process evidenced a robust governance structure with outcomes and actions documented.

The residents had access to advocacy services if required through Youth Advocate Programmes (YAP) Ireland. Fortnightly sessions were facilitated remotely due to the pandemic. At a local level, daily meetings with the residents, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement. No complaints had been escalated to the complaints officer since the last inspection.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

No areas were assessed as non-compliant during the inspection.

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of 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 on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was not an adult centre, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

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.

Six young people met with the inspection team and commented positively on their interactions with staff. Staff provided support and were available if the young people needed to talk. All were invited to attend their care plan meeting. Young people said there were plenty of activities during the week but two said they would like more at the weekends as it sometimes got boring. They would like to have a remote control for the television as they had to ask staff to change the channel. Young people said the food was generally good although some would prefer different options including more vegetarian food. Community meetings were held daily and young people could make requests for change at these meetings.

Parents were permitted to visit by appointment and the young people asked if they could nominate other family members to visit. This request was brought to the management and it was agreed.

During the inspection seven questionnaires were received. All stated that the young people knew their key worker and six said they were involved in setting goals in their care plan. All knew their key worker and all said they were able to discuss concerns with staff.

5.2 Advocacy

The approved centre had an advocacy service, the Youth Advocate Programme (YAP).

6.0 Feedback Meeting

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

- Clinical Director
- Director of Services
- Chief Executive Officer
- Director of Nursing
- Consultant Psychiatrist
- Unit Clinical Nurse Manager
- Principal Social Worker
- Occupational Therapy Manager
- Director of Psychology
- Clinical Governance Manager
- Clinical Practice Development Co-ordinator
- Dietitian
- Clinical Governance Administrator

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. A source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed by the dietician, where necessary, and addressed 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 suitable and sufficient catering equipment in the approved centre and proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and it took account of their preferences, dignity, bodily integrity, and religious and cultural practices. No residents wore nightclothes during the day.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to residents' personal property and possessions, which was last reviewed in September 2021. Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities including secure lockers were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities on weekdays and weekends appropriate to the resident group profile. Residents had access to jigsaws, films, magazines, pool table, books, table football, quizzes, art sessions – jewellery making, pottery, tie dye and painting, table tennis, badminton, pool, yoga, gym exercise equipment, baking, music, and computer 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.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in March 2021. Visiting times were appropriate and reasonable and visits by parents had resumed following COVID-19 restrictions. At the time of the inspection residents could have two visits per week from parents.

The approved centre had a designated visitors' room where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Visitors could also be accommodated in the garden areas. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Visiting rooms were suitable for child visitors.

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 three operational policies and procedures relating to communication. *Service user access to communication facilities* was reviewed in March 2020. *Handling of post* was reviewed in November 2019 and *Willow Grove access to electronic communication* was reviewed in June 2020. Residents were provided with mobile phones for phone calls and text messaging only, on admission for the duration of their stay. Residents had access to the internet through a computer station in the approved centre which was risk assessed with due regard to the resident's wellbeing, safety, and health.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in May 2020 and included all requirements related to:

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

Documentation relating to three searches were examined on inspection. Risk was assessed prior to each search of the resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches and the request for consent and the received consent were documented for every search. The resident search policy and procedure was communicated to all young people. Relevant staff were documented to have read and understood the policy on searches.

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

was in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in August 2021. No residents had died in the approved centre since the previous inspection and the approved centre was assessed on policy requirement only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

The ICP was reviewed by the MDT in consultation with the resident every week. All ICPs included each child's educational requirements, identified appropriate goals for the resident, and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICP's identified the resources required to provide the care and treatment. A multi-disciplinary team reviewed and updated individual care plans in all five ICPs.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed 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 the residents had access to two psychology led groups which comprised a psychotherapy group and a Dialectical Behaviour Therapy (DBT) skills-based group. Residents had access to two Occupational Therapy led groups, which included a sensory group and a task focused group and activities within these groups included jewellery making, pottery and baking. Nursing led groups included esteem building groups, psychoeducation groups and a goal setting group.

Where a resident required a therapeutic service or programme that was not provided internally, such as Physiotherapy, and Speech and Language Therapy (SALT), the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

Child residents were assessed in relation to their educational requirements, with consideration of their individual needs and age on admission. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities and personnel resources were available for the provision of education to child residents in 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 relation to the transfer of residents. The policy was last reviewed in January 2021. The clinical file of one resident who had been transferred from the approved centre. Full, complete and relevant written information about the resident accompanied the resident upon transfer, to a named individual in 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. In the case of an emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a medical emergencies policy, which was last reviewed in January 2020. The approved centre had an emergency trolley and staff had access to an automated external defibrillator (AED). Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. No resident had been in the approved centre for more than six months at the time of the inspection. Residents could access national screening programmes according to their age or gender, including retina check for diabetics.

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 detailing the process around the provision of information to residents. The policy was last reviewed in March 2020.

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

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be damaging to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to residents' and family's needs. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of staff and the way in which they interacted with residents was respectful. Staff were discrete when discussing the resident's condition or treatment needs. Residents had their own single, en suite bedrooms. 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. All bathrooms, showers, toilets, and bedrooms had locks on the inside of the door with an override function. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make phone calls in private.

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was clean, hygienic, and free from offensive odours. Residents had access to personal space and to appropriately sized communal rooms. Residents had their own single bedroom with en suite facilities. There were sufficient toilets and showers for residents in the approved centre. There was suitable and sufficient heating within the approved centre, and it was well ventilated.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. This was ongoing and was both pro-active and reactive.

The lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised in the approved centre. Ligature points were minimised to the lowest practicable level based on risk assessment. Sufficient indoor and outdoor spaces were provided for residents to move about. The approved centre provided suitable furnishings to support resident independence and comfort. Current national infection guidelines were followed.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in November 2021 and the policy included:

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

An electronic Medication Prescription and Administration Record (MPAR) was maintained for each resident. Five MPARs were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies, the administration route for the medication, a record of all medications administered to the resident and the minimum dose intervals. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible. Medication was reviewed 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 unit unless it required refrigeration.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in November 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the use of CCTV. The policy was last reviewed in November 2019. The policy included the purpose and function of using CCTV for observing residents in the approved centre.

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in place in relation to the recruitment, selection and Garda vetting requirements. The staffing policy was last reviewed in June 2021

The approved centre had one multi-disciplinary team. This included psychiatry, nursing, psychology, occupational therapy, social worker, family therapist and dietitian. The approved centre also had a clinical pharmacy service, a general practitioner and a general nurse.

The number and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times, and this was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

All staff were trained in basic life support, fire safety, management of violence and aggression, children first and the Mental Health Act 2001.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (25)	25	100%	25	100%	25	100%	25	100%	25	100%
Consultant Psychiatrist (4)	4	100%	4	100%	4	100%	4	100%	4	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%	2	100%

Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker(2)	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%	2	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in March 2021. Resident records were maintained on an electronic system called eSwift and were secure, up-to-date, and in good order. All resident records were reflective of the residents' status and the care and treatment being provided.

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in January 2022 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission. This information was available within the resident information booklet and a separate information booklet for parents of residents of the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. 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. Minor and non-minor complaints were documented in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept separate from the resident's individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in May 2021 and addressed all requirements. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical, corporate and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed, or effectively mitigated.

Individual risk assessments were completed during admission and at discharge and in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Requirements for the protection of children within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission. The information provided was anonymous at the resident level. There was an emergency plan in place that incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in June 2021, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in April 2021, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical files of three residents who had been admitted to the approved centre were examined. In all three cases, admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. In all three cases, this assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication, current mental health state. A risk assessment and full physical examination had been completed in all three cases. A key working system was in place for the three residents. With consent, each of the three individual residents' family member was involved in the admission process.

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

Discharge: The clinical files of three residents who were discharged was inspected. The discharge was co-ordinated by a keyworker. A discharge meeting was held and attended by each of the residents and their specific key worker, relevant members of the multi-disciplinary team and each of the individual residents' families. A comprehensive pre-discharge assessment was completed, which addressed each of the three

resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was issued to the Child and Adolescent Mental Health Services (CAMHS) within three days of discharge. In all three cases a comprehensive discharge summary was issued to relevant health care professionals within 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, and names and contact details of key people for follow-up. The discharge summary included risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1 Background to the inspection process

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

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

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

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

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

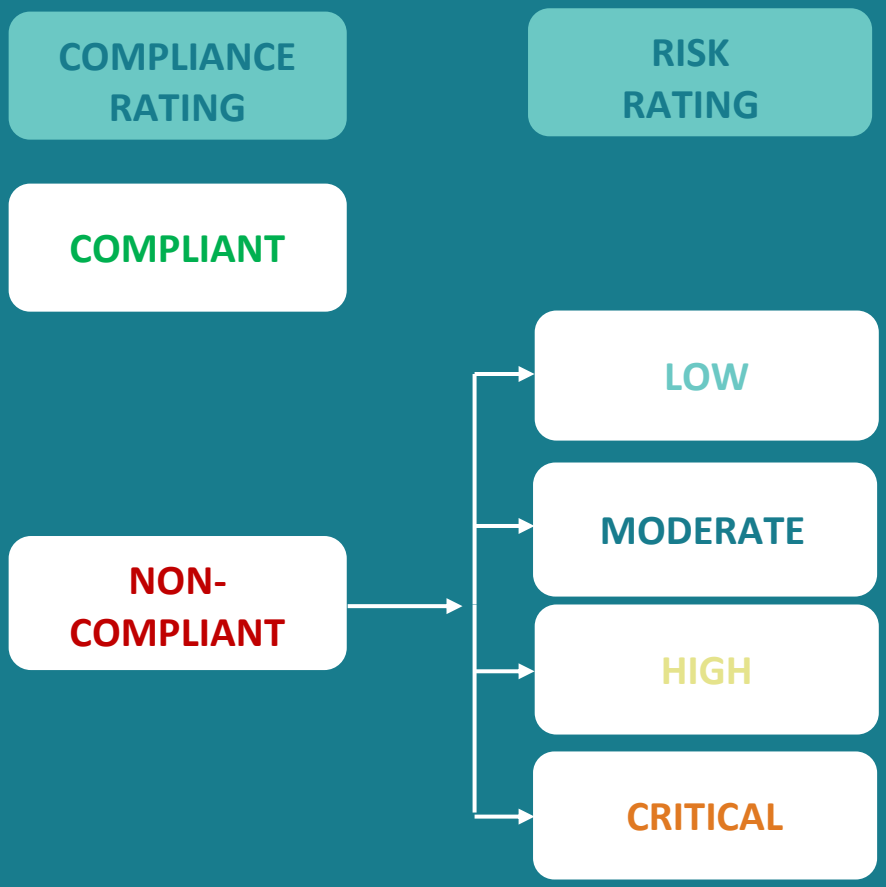
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

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



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

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

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

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