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

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

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

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

Date of Publication: 03 Jan 2023

ID Number: AC0180

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
9 December 2019

Registered Proprietor:
HSE

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

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Sarah Jones
Aoife Gallaher

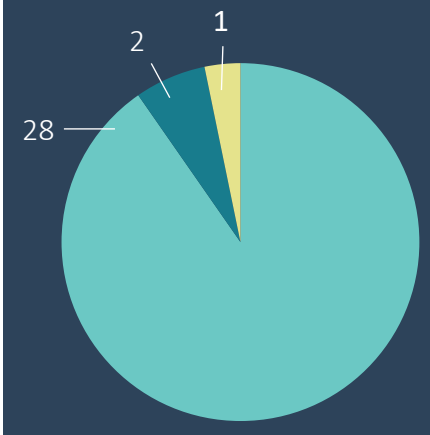
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
26 April – 03 May 2022

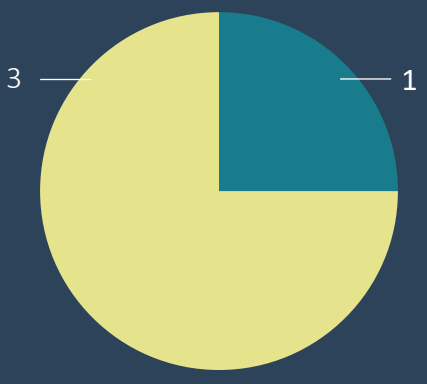
Previous Inspection date:
23 – 26 March 2021

Inspection Type:
Announced Annual Inspection

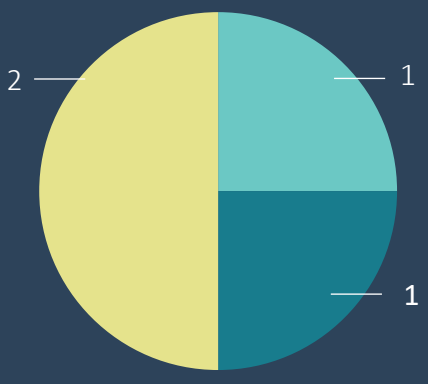
2022 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



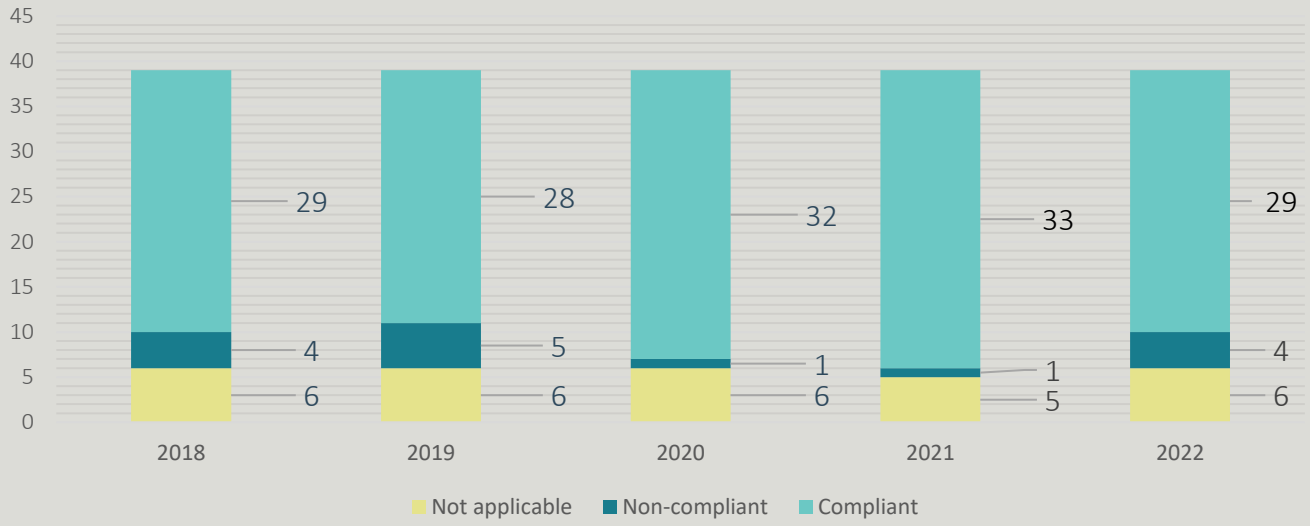
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2018 – 2022

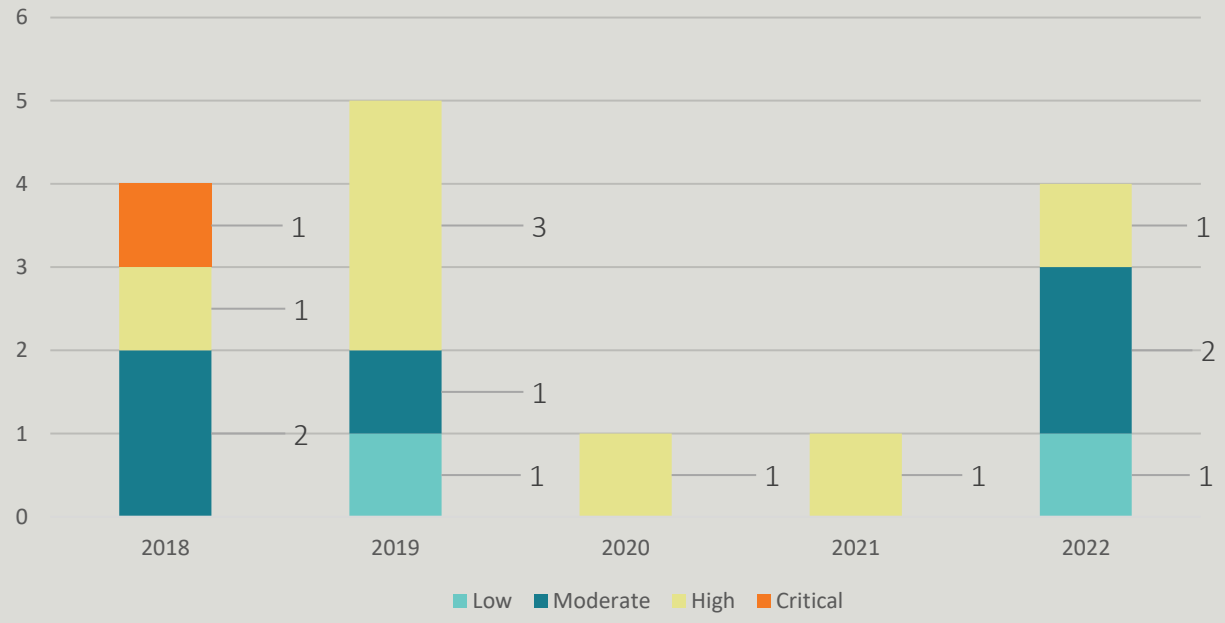
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

The approved centre was located on the campus of Merlin Park University Hospital in Galway. It was a purpose-built inpatient facility for the Child and Adolescent Mental Health Service (CAMHS). The approved centre comprised of two individual units: Woodsend and The Willows. There was a separate administration block that included the main dining facilities, therapy and activity rooms and staff offices. The approved centre also had a school and a parent accommodation flat.

The Willows incorporated a high dependency suite, with three bedrooms. A seclusion facility was also located in the Willows. At the time of inspection, the approved centre had secured funding for a new seclusion room. However, the proposal was not yet time-bound.

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

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	88%	85%	97%	97%	88%

Conditions to registration

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

Conditions	Findings
Condition 1: *To continue the use of seclusion, the Health Service Executive, as registered proprietor, shall develop and approve a costed, funded and time*	The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 22: Premises at the time

bound plan to replace the current seclusion facilities. This plan must be submitted by a date specified by the Mental Health Commission.	of inspection. The inspection team were informed that work on the new build was to commence by year's end.

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 did not always operate safe practices to ensure the safety of residents:

- Each young person had ongoing individual risk assessments.
- Processes for the protection of young people within the approved centre were in place.
- 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.

However:

- Not all staff disciplines had completed mandatory training in Fire Safety and the Management of violence and aggression.
- Ligature points were not minimised to the lowest practicable level, based on risk assessment. Ligatures anchor points were found throughout the parents flat where visits had been taking place. Visits in the parents flat ceased during the inspection due to the identified risk. Visits were moved to the gym and garden areas.
- The flooring of the seclusion room had a hard surface.

Appropriate care and treatment of residents

We found that the approved centre provided appropriate care and treatment for young people.

- 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. The approved centre had a Therapeutic Group Programme, which included life skills, Wellness Recovery Action Plan (WRAP), decider skills, self-esteem groups, health promotion, anxiety management, interpersonal skills groups, therapeutic art groups and anxiety management.
- Adequate arrangements were in place for residents to access general health services and for their referral to other health services if required.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre respected young people's privacy, dignity and autonomy but that there were maintenance and structural problems in the centre.

- The general demeanour of staff and the way in which they interacted with residents was observed to be respectful during the inspection.
- Woodsend was a six bedded facility with one double bedroom and four single bedrooms. The Willows accommodated up to fourteen young people within two double bedrooms and ten single bedrooms.
- Medical files and other personal documentation were stored in a secure way.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.

However:

- The approved centre was not found to be kept in a good state of repair externally and internally on inspection. Plaster cracks were observed in the gym, stained paintwork under the eaves at the Woodend's unit entrance, and three curtains were found to have paint stains, one in a bedroom and two in the corridor.
- Residents in seclusion did not have access to adequate toilet and washing facilities, as there was no shower facility in the seclusion area.

Responsiveness to residents' needs

- There was a formal therapeutic and recreational program which ran Monday to Friday. There was one to two hours of physical exercise per day. Other recreational activities included walking, relaxation, arts and crafts, bracelet-making, daily outings such as coffee shops, and a weekly formalized outing. Weekend activities included arts and crafts, painting, crocket and knitting, mindfulness colouring, DVD night, quizzes, soap-making, board games, decider skills, badminton,

pool tournament, and gardening. Six individual DVD players were available to residents who were on bed rest in line with the approved centre's eating disorder procedures.

- 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.
- The approved centre had a designated visitors' room where residents could meet visitors in private.
- 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

- The approved centre was part of Community Healthcare West, Galway Roscommon Mental Health Service. The Galway Roscommon Mental Health Service governance structure encompassed an Area Management Team meeting and a Quality and Patient Safety (QPS) committee.
- Within the approved centre, there were local business meetings. An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.
- Identified risk were documented in the risk register.
- The approved centre's policies were developed by the Policies, Procedures, Protocols and Guidelines (PPPG) committee.
- The approved centre had an established program of audit.
- Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement.
- The approved centre's complaints process was publicised and accessible to residents and their representatives.
- The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre. The YAP advocate visited the young people in the approved centre weekly and provided feedback to the inspection team.
- Performance was measured through the regular review of key performance indicators; comments, compliments and complaints; incident reports and audit findings.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The introduction of a 12-part Decider Skills Programme: This group used Cognitive Behaviour Therapy to teach young people to recognise their own thoughts, feelings, and behaviours, allowing them to monitor and manage their own mental health.

2. A Therapeutic Groups Booklet had been developed to explain to the young people the differences between each therapeutic group.

3. The internal courtyard in The Willows had been developed into a quiet outdoor space for young people to enjoy.

4. The approved centre had commenced rolling out Trauma Informed Care to staff. Trauma Informed Care is a quality implementation programme for organisations committed to working with people from a trauma perspective.

5. The approved centre had introduced a Safewards Programme designed to improve the safety of everyone by reducing conflict and containment events.

6. A new Clinical Nurse Manager role had been created to assist in managing education, development, and intake for the approved centre.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

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

The approved centre consisted of 20 beds. Woodsend was a six bedded facility with one double bedroom and four single bedrooms. The Willows accommodated up to fourteen young people within two double bedrooms and ten single bedrooms. Due to the risk of COVID-19, the double bedrooms were used as single rooms, which reduced the bed capacity to 17 at the time of inspection. Residents within Woodsend and The Willows had access to internal courtyards and a large well-kept garden. The Willows incorporated a high dependency suite, with three bedrooms. A seclusion facility was also located in the Willows. This was separate from the high dependency suite.

The approved centre had two multi-disciplinary teams. It served the catchment area of Clare, Limerick, North Tipperary, Galway, Roscommon, Mayo, Sligo, Leitrim, and Donegal and was also a national referral centre. Staff had reported an increase in young people presenting with eating disorders.

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

Resident Profile	
Number of registered beds	***20***
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	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Community Healthcare West, Galway Roscommon Mental Health Service. The Galway Roscommon Mental Health Service governance structure encompassed two core monthly meetings: an Area Management Team meeting and a Quality and Patient Safety (QPS) meeting. Membership for both meetings included relevant heads of service and discipline. An Area Quality and Patient

Safety committee, which met monthly, reported into the Area Management Team. Standing agenda items for the Area Management Team Meeting included: finance, human resources, QPS, health and safety, service user engagement and COVID-19. Within the approved centre, governance was further enhanced by local business meetings. An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.

The Child and Adolescent Mental Health Service (CAMHS) inpatient service comprised of two multi-disciplinary teams. Young people in the approved centre had access to a senior social worker. There were two dedicated psychology posts for the approved centre. At the time of inspection one post was vacant, recruitment was underway to fill this position. There was one designated occupational therapist within the approved centre; however, there was no cover available when the occupational therapist was on leave. Young people in the approved centre had access to two dietitians (1.1 whole-time equivalent). Not all staff disciplines had completed mandatory training in Fire Safety and the Management of Violence and aggression.

The approved centre had a standardised process for the management of risks and incidents. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. Risks were identified, assessed, treated, reported, and monitored. Identified risk were documented in the risk register. The ongoing risk of COVID-19 was managed through the approved centre's risk management process.

The approved centre's policies were developed by the Policies, Procedures, Protocols and Guidelines (PPPG) committee. The approved centre had an established program of audit.

Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement. The approved centre's complaints process was publicised and accessible to residents and their representatives. No formal complaints had been submitted since the last inspection. The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre. The YAP advocate visited the young people in the approved centre weekly and provided feedback to the inspection team.

Governance questionnaires were returned to the inspection team by the executive clinical director, principal social worker, the occupational therapy manager, the area director of nursing and the manager of dietetics. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. Performance was measured through the regular review of key performance indicators; comments, compliments and complaints; incident reports and audit findings.

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

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 2018 and 2022 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2018		2019		2020		2021		2022	
Regulation 22: Premises	✗	Moderate	✗	High	✓		✓		✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	High	✓		✓		✗	Moderate
Rules on the Use of Seclusion	✗	High	✗	High	✗	High	✗	High	✗	High
Code of Practise: Physical Restraint	✓		✓		✓		✓		✗	Low

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
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 practise 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:

- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- The representative from the Youth Advocate Programme (YAP) was contacted to obtain residents' feedback about the approved centre.

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

The inspection team spoke with nine young people during the inspection. Seven service user experience questionnaires were completed and returned to the inspection team. Feedback suggested that the residents were happy with the food and food choices. Five of the young people said they understood their individual care plans (ICPs), seven residents said they were only 'sometimes' involved in setting goals for their ICPs. Five of the respondents said they were happy with how staff spoke to them. Three of the respondents said they were able to discuss worries or concerns with members of staff and two said they could 'sometimes'.

Two of the young people mentioned that staff didn't always sit down and talk to them when they were upset and were told instead to use their decider skills. They asked that staff interact with them more even if they looked okay at the time. The young people also mentioned not having enough activities on the weekends. Feedback suggested that the young people found it daunting attending their multi-disciplinary team meetings (MDT). Most said they felt safe in the approved centre and most said they knew who their key worker was. One resident stated that the staff were nice, and that the approved centre was a safe space.

On a scale of 1-10, with 1 being poor and 10 being excellent, residents were asked to rate their overall experience of the care and treatment in the approved centre. One young person rated their experience a six, two residents responded with a rating of seven, two responded with ratings of eight and one rated their overall experience as a ten.

5.2 Advocacy

The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre. The YAP advocate visited the young people in the approved centre weekly and provided feedback to the inspection team. Feedback from the advocate suggested that the young people would like to be provided with support when attending their weekly multi-disciplinary meeting and with discharge planning. Feedback also suggested that the residents weren't always supported by staff when they were feeling upset. Food in the approved centre was of a high standard.

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:

- Executive Clinical Director
- Consultant Psychiatrists x 2
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Senior Register
- Non- Consultant Hospital Doctor
- Business Manager
- Occupational Therapy Manager
- Senior Dietitian
- Speech and Language Therapist
- Quality & Patient Safety Advisor

Apologies:

- Registered Proprietor
- Principal Psychologist
- Principal Social Worker

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

The approved centre used a minimum of two resident identifiers, appropriate to the resident group profile, and individual resident's needs. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other healthcare 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 and a source of safe, fresh drinking water was available at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Residents were assessed by nursing staff on admission using the St. Andrew's Nutrition Screening Instrument (SANSI), and assessed by the dietician where indicated. The approved centre provided access to two dietitians, and a Speech and Language Therapist (SALT) by referral.

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Emergency clothing was kept and logged as required when used. There was a mixture of clothing, underwear, and shoes for different age groups and genders. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in April 2021. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. There were safes located in the nursing office to hold valuables and small monies, and a new property room with a cupboard for each resident had been made available to hold any excess property.

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 appropriate to the resident group profile. There was a formal therapeutic and recreational program which ran Monday to Friday. The approved centre also provided one to two hours of physical exercise per day, risk-assessed and dependent on need. Other recreational activities included walking, relaxation, arts and crafts, bracelet-making, daily outings such as coffee shops, and formalized outing on a Wednesday which were risk-assessed as per the resident's presentation. Activities were documented in the clinical file and in the ward diary on the weekends.

Weekend activities included arts and crafts, painting, crocket and knitting, mindfulness colouring, DVD night, quizzes, soap-making, board games, decider skills, badminton, pool tournament, and gardening. Six individual DVD players were available to residents who were on bed rest in line with the approved centre's eating disorder procedures.

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 practicable. There was a chapel on the grounds of the campus, and a multi-faith room for use by residents as required. The Chaplain was available attend the approved centre, and a contact list of different religious orders was maintained.

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 policies and procedures in relation to visits. The policy was last reviewed in July 2020.

Visiting times were appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The approved centre had two visiting areas in the gym and the garden, 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. The visiting area was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

INSPECTION FINDINGS

The approved centre had a written policies and procedures in relation to communication. The policy was last reviewed in March 2020.

Residents in the approved centre had access to mail, fax, e-mail, Internet, telephone or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Residents did not have access to personal mobile phones, but there was an office phone and mobile phone in each unit. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where 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 policies and procedures on the conducting of searches. The policy was last reviewed in June 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.

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident’s dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record of every resident and 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. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in June 2020.

As there had been no resident deaths in the approved centre since the last inspection, this regulation was assessed on the policy alone.

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). Five ICPs were inspected. All IPCs were a composite set of documentation. Specific space and sections were allocated for needs, treatment and care, and resources required.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The IPCs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident, weekly in an acute setting, and at least every six months for residents in a continuing care faculty. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a Therapeutic Group Programme, which included life skills, Wellness Recovery Action Plan (WRAP), decider skills, self-esteem groups, health promotion, anxiety management, interpersonal skills groups, therapeutic art groups, and anxiety management. The Activity Nurse Co-ordinator worked in association with the social worker for the WRAP groups, with the senior occupational therapist for groups including art therapy, and with the psychologist and intern psychologist for life skills and self-care.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. 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 the young people admitted to the approved centre were assessed in relation to their educational requirements with consideration of their individual needs and age on admission. All residents had an education plan. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities were available for provision of education to child residents in the approved centre. The approved centre had sufficient personnel resources to provide education to child residents in the approved centre, with four teachers and four special needs assistants (two primary and two post-primary).

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 policy and procedures in relation to transfers. The policy was reviewed in June 2020. No resident had been transferred from the approved centre since the last inspection. Therefore, compliance against this regulation was assessed on the basis of the policy alone.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in June 2020.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans.

At the time of the inspection, no young person had been in the approved centre for a period longer than six months. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care.

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 written provision of information policies and procedures in place. The policy was last reviewed in July 2020.

On admission, the young people were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs.

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team. Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to the young persons' needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation 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 the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(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

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. Each young person had a single room. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. The heating in bedroom and day areas was suitable and sufficient for residents' comfort and safety. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. The approved centre had a wild garden in its rear courtyard which had been previously developed by the residents. Outside space was provided throughout the units, and there was an AstroTurf pitch and basketball court being built alongside the school. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points, however, were not minimised to the lowest practicable level, based on risk assessment. Ligatures anchor points were found throughout the parents flat where visits had been taking place. Visits in the parents flat ceased during the inspection due to the identified risk. Visits were moved to the gym and garden areas.

The approved centre was not found to be kept in a good state of repair externally and internally on inspection. Plaster cracks were observed in the gym, stained paintwork under the eaves at the Woodend's unit entrance, and three curtains were found to have paint stains, one in a bedroom and two in the corridor. However, the approved centre had a programme of general and decorative maintenance,

cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address the young people's needs.

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

a) **Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(4).**
b) **The approved centre was not kept in a good state of repair externally and internally, due to plaster cracks in gym, stained paintwork, and paint-stained curtains, 22(1)(a).**

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 in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in July 2020, and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including a record of any (or no) allergies or sensitivities to medications and a record of medications administered to the resident and the administration route for all medications. The date of discontinuation for each medication was clearly recorded.

All entries in the MPARs were legible. No young person had been in the approved centre for longer than six months, but MPARs and clinical files inspected evidenced that medication review took place as required. None of the MPARs inspected evidenced withholding of a resident's medications. None of the MPARs inspected evidenced the crushing of medications.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified, and Scheduled 2 and 3 controlled drugs were secured separately from other medications 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 policies and procedures relating to the health and safety of residents, staff, and visitors. The policy was last reviewed in July 2020.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in June 2020.

The inspection found that there were clear signs in prominent positions where CCTV cameras or other monitoring devices were utilized throughout the approved centre. Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed solely by the health professional with responsibility for the resident. CCTV was only used in the context of seclusion, with only external CCTV monitoring of the seclusion unit. CCTV was not used to monitor a resident in the event of their dignity being compromised, and all monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc, hard drive, or any other form. 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

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy in place, which was last reviewed in July 2020. The policy covered information and procedures in relation to the recruitment, selection, and Garda vetting requirements.

An appropriately qualified staff member was on duty and in charge at all times. This was documented. The numbers and skill mix of nursing staffing were sufficient to meet resident needs. The approved centre had two multi-disciplinary teams. Both teams included psychiatry, social work, psychology, occupational therapy and dietetic disciplines. Residents had access to a speech and language therapist by referral.

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.

Not all healthcare staff had received up-to-date mandatory training in basic life support, Fire Safety, and the Management of Violence and Aggression. The following table shows the number and percentages of staff trained in the different areas of mandatory training:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (36)	35	97%	34	94.4%	26	72%	36	100%	36	100%
Medical (6)	6	100%	5	83%	3	50%	6	100%	6	100%

Occupational Therapist (1)	1	100%	1	100%	0	0%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	0	0%	1	100%	1	100%	1	100%
Dietitian (2)	2	100%	2	100%	2	100%	2	100%	2	100%

The approved centre was non-compliant with this regulation because not all staff in the approved centre had completed mandatory training in fire safety and the management of violence and aggression, 26(4).

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 policy and procedures in relation to the creation of, access to, retention of and destruction of records. The Clinical Records policy was last reviewed in March 2020.

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence, and kept in good order with no loose pages.

Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorized access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented register of 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 were reviewed within the required three-year time frame, having due regard to any recommendation made by the Inspector or the Commission.

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 policy and procedures in relation to the complaints process. The policy was last reviewed in July 2020, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. The complaints process was well-documented in the Information Booklet. Information about the complaints procedure, including how to contact the nominated person, were displayed on noticeboards in both units.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint can be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and there were no formal complaints at the time of inspection. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). As part the approved centre's complaints processes, the complainants are informed promptly of the outcome of the complaint investigation and details of the appeal process made available to them.

The registered proprietor ensured that the quality of service, care, and treatment is not adversely affected by reason the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

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

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

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

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

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

A six-monthly summary of incidents was produced to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the main reception.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It was last reviewed in May 2021, and addressed the following:

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

Training and Education: There was an incomplete written record to indicate that staff involved in seclusion had read and understood the policy. Not all staff members who had taken part in the two seclusion episodes examined during this inspection had signed the policy.

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

Evidence of Implementation: Residents in seclusion did not have access to adequate toilet and washing facilities, as there was no shower facility in the seclusion area. Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, as far as was practicable. Furniture and fittings were not adequately designed to ensure patient safety, as the flooring had a hard surface. At the time of inspection, the approved centre had secured funding for a new seclusion room. However, the proposal was not yet time-bound. The seclusion area was not used as a bedroom.

Two episodes of seclusion had occurred since the previous inspection and were inspected. Seclusion was only implemented in the resident's best interests and in rare and exceptional circumstances where the resident posed immediate threat of serious harm to self or others. Cultural awareness and gender sensitivity were demonstrated. The resident was informed of the reasons, duration, and circumstances

leading to discontinuation of seclusion. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter.

Seclusion episodes were recorded in the resident's clinical file and the episodes recorded in the seclusion register by the responsible consultant psychiatrist.

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

a) **Residents in seclusion did not have access to adequate toilet/washing facilities, 8(1).**
b) **All furniture and fittings were not of a design and quality so as not to endanger patient safety due to hard flooring, 8(3).**
c) **Written records indicated that not all staff involved in seclusion had read and understood the policy, 10(2)(b).**

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 LOW

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in May 2021. It addressed the following:

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

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

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

Evidence of Implementation: Three episodes of physical restraint were inspected. Physical restraint was only used in rare and exceptional circumstances where 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 in question. Staff had first considered all other interventions to manage the resident's unsafe behaviour.

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

The orders for physical restraint lasted a maximum of 30 minutes. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episodes, and each CPF was placed in each individual clinical file. However, in one of the episodes inspected, the CPF form was not signed by the consultant psychiatrist.

The residents were afforded the opportunity to discuss the episodes with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint

was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was non-compliant with this Code of Practice because in one episode of physical restraint inspected, the consultant psychiatrist did not sign the clinical practice form (CPF), 5.7(c).

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 2020, included all the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in June 2020, included all the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2020, included all the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, and all other relevant information. A key worker system was in place, full physical examination carried out, and a family member or carer was involved in the admission process with the resident's consent.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of any risk or relapse, and documented communications with the relevant general practitioner, primary care team, or community mental health team (CMHT).

A discharge meeting with the appropriate multi-disciplinary team (MDT) with an input into discharge planning took place. The discharge assessment was coordinated by a key worker, and addressed the resident's psychiatric, psychological, social, and housing needs. It contained a comprehensive risk assessment and risk management plan. The preliminary discharge summary was sent within 3 days, and a comprehensive summary issued within 14.

The approved centre was compliant with this Code of Practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 22: Premises					
Reason ID : 10002959		**Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	We carried out a ligature audit of the parents flat following the recommendations of the inspectors. the findings were brought to the nurse managers consultant meeting and business meeting and a decision was made to only use the parents flat for families and no patients are now allowed in this area.	the annual ligature audit.	This is currently in place and is achieved.	11/04/2022	All inpatient CAMHS staff are responsible to ensure that the parents flat is not used for visits.
Preventative Action	the Parents flat is now included in our annual ligature audit and we will be following recommendation	the annual ligature audit.	We discussed the possibility of making the Parents flat anti ligature but this would involve a major reconstruction of the parents flat and would make	01/03/2023	All inpatient CAMHS staff are responsible to ensure that the parents flat is not used for visits.

	from this. The recommendation currently is it is not safe for use by patients.		the area less homely for parents staying there. The new building that is planned for the future will have specific visiting rooms for parents.		
Reason ID : 10002960		**The approved centre was not kept in a good state of repair externally and internally, due to plaster cracks in gym, stained paintwork, and paint-stained curtains, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Plaster cracks were assessed by maintenance they were found to be structural concern with them and they have now been fixed. We are currently awaiting the replacement of all curtains with wipeable blinds which comply with IPC guidelines and are ligature resistant. A maintenance biannual program for cleaning the eves has not been put in place.	A Quarterly walk around of the building is been undertaken by the DON/CNM3 , consultant psychiatrist, maintenance liaison and section officer to ensure the upkeep of the premises.	All actions are in the process of being achieved or have been completed.	31/12/2022	Brian O'Malley, director of nursing, and maintenance are working closely to achieve these actions.

Preventative Action	A Quarterly walk around of the building is been undertaken by the DON AND section officer to ensure the upkeep of the premises.	Following the walkaround the DON/CNM3 and section officer will call a quarterly meeting to ensure any areas highlighted will be addressed.	no barriers to this action.	30/12/2022	Brian O'Malley, director of nursing, and maintenance.

Regulation 26: Staffing					
Reason ID : 10002961		**Not all staff in the approved centre had completed mandatory training in fire safety and the management of violence and aggression, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	During Covid 19 outbreaks we struggled to provide in person training, this has changed with the introduction of mandatory training happening on a monthly basis. We have now set out a plan with a rolling three-month program for in person training. Fire Training has now been provided online by a private operator and staff are now completing same.	A new excel spreadsheet has been developed specifically for mandatory training to ensure we are alerted when their training goes out of date.	Sometimes it can be difficult to ensure all staff training is completely up to date as training won't always be available due to staffing levels and prior commitments.	30/12/2022	All heads of disciplines are responsible for ensure all staff have completed their mandatory training.
Preventative Action	A new excel spreadsheet has been developed specifically for mandatory training to ensure we are	The training register template is checked on a weekly basis and a notification is sent by email to staff	Sometimes it can be difficult to ensure all staff training is completely up to date as training won't always be available due to staffing	01/11/2022	All heads of disciplines are responsible for ensure all staff have

	alerted when their training goes out of date.	when their training is out of date.	levels and prior commitments.		completed their mandatory training.

Rules Governing the Use of Seclusion					
Reason ID : 10002954		**Residents in seclusion did not have access to adequate toilet/washing facilities, 8(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	We are unable immediately to rectify this problem but it will be addressed with the redevelopment of the seclusion area. This is currently awaiting going to tender which is due to happen this month. with a plan for a builder to be appointed in early 2023 and work to commence shortly after.	We have regular update meetings with Estates and the architects to finalise plans and progress to tender.	We hope to commence construction in February 2022.	28/02/2023	HSE Estates.
Preventative Action	Seclusion is only used a last resort and staff are trained to deescalate situations to prevent seclusion. If a person requires to use the bathroom while in seclusion, we facilitate the use of the bathroom outside	We are regularly monitoring our interactions on the unit through safewards and trauma informed care. This will increase our level mutual understanding with	At audit and review will be conducted at the end of the year to measure the effectiveness of safewards and trauma informed care and have they reduced the incidents of seclusion.	31/12/2022	clinical nurse managers, staff nurses, medical staff including consultants and members of the MDT.

	of the seclusion room when it is deemed safe to do so. This is based on risk assessment and will have a minimum of 4 staff present when undertaking this. This is to ensure the safety of the young person and staff.	the young people and help to promote a culture where seclusion is significantly reduced.			
Reason ID : 10002955		**All furniture and fittings were not of a design and quality so as not to endanger patient safety due to hard flooring, 8(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	We are unable immediately to rectify this problem but it will be addressed with the redevelopment of the seclusion area. This is currently awaiting going to tender which is due to happen this month. with a plan for a builder to be appointed in early 2023 and work to	We have regular update meetings with Estates and the architects to finalise plans and progress to tender.	We hope to commence construction in February 2022.	28/02/2023	HSE Estates.

	commence shortly after.				
Preventative Action	Seclusion is only used a last resort and staff are trained to deescalate situations to prevent seclusion. If a person requires to use the bathroom while in seclusion, we facilitate the use of the bathroom outside of the seclusion room when it is deemed safe to do so. This is based on risk assessment and will have a minimum of 4 staff present when undertaking this. This is to ensure the safety of the young person and staff.	We are regularly monitoring our interactions on the unit through safewards and trauma informed care. This will increase our level mutual understanding with the young people and help to promote a culture where seclusion is significantly reduced.	At audit and review will be conducted at the end of the year to measure the effectiveness of safewards and trauma informed care and have they reduced the incidents of seclusion.	31/12/2022	clinical nurse managers, staff nurses, medical staff including consultants and members of the MDT.
Reason ID : 10002956		**Written records indicated that not all staff involved in seclusion had read and understood the policy, 10(2)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following the mental health commission visit an email was	We continue to audit the policies on a quarterly basis to	This is in place as of today.	14/10/2022	All CAMHS inpatient staff

	sent to all inpatient staff to ensure they were up to date with policy signatures. From today there is a reminder email sent out each month to all inpatient staff to remind them to read and sign on the policy. they are also notified when policies are updated.	ensure they are read and signed off.			
Preventative Action	A quarterly audit of the policies to ensure they read and signed off.	Through audit and review.	This will be in place as of today.	14/10/2022	Clinical Nurse Manager 3.

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10002953		**The approved centre was non-compliant with this Code of Practice because in one episode of physical restraint inspected, the consultant psychiatrist did not sign the clinical practice form (CPF), 5.7(c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	With the reintroduction of in person handover each morning all clinical practice forms from the previous 24 hours are brought to handover to be discussed and with the consultant and signed.	Following each episode of restraint, a checklist is completed and as part of this we ensure that consultants have signed off on same.	We are undertaking reeducation of our nursing staff around the rules of restraint and seclusion and the introduction of the new codes of practice as provided by the MHC on HSELand.	13/10/2022	Clinical nurse managers and consultants.
Preventative Action	With the reintroduction of in person handover each morning all clinical practice forms from the previous 24 hours are brought to handover to be discussed and with the consultant and signed. we are setting up a local working group to oversee the	Following each episode of restraint, a checklist is completed and as part of this we ensure that consultants have signed off on same.	We intend to have this achieved by the end of the year.	30/12/2022	Clinical nurse managers and consultants.

	implementation of the new regulations around seclusion and restraint.				

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.

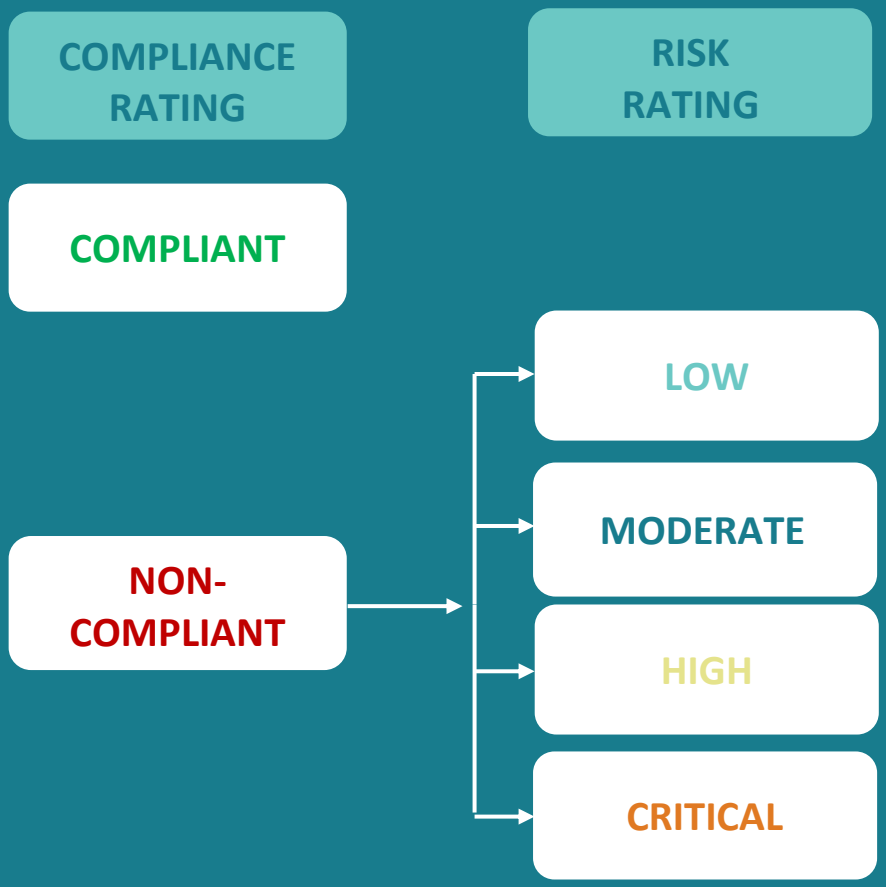
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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