Linn Dara Child & Adolescent Mental Health In-patient Unit

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

Linn Dara Child & Adolescent Mental Health In-patient Unit

Cherry Orchard Hospital Campus, Ballyfermot Road, Ballyfermot, Dublin 10

Date of Publication: 26th May 2023

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2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child & Adolescent Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
10 December 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Brady, Head of Mental Health, CHO7.

Inspection Team:
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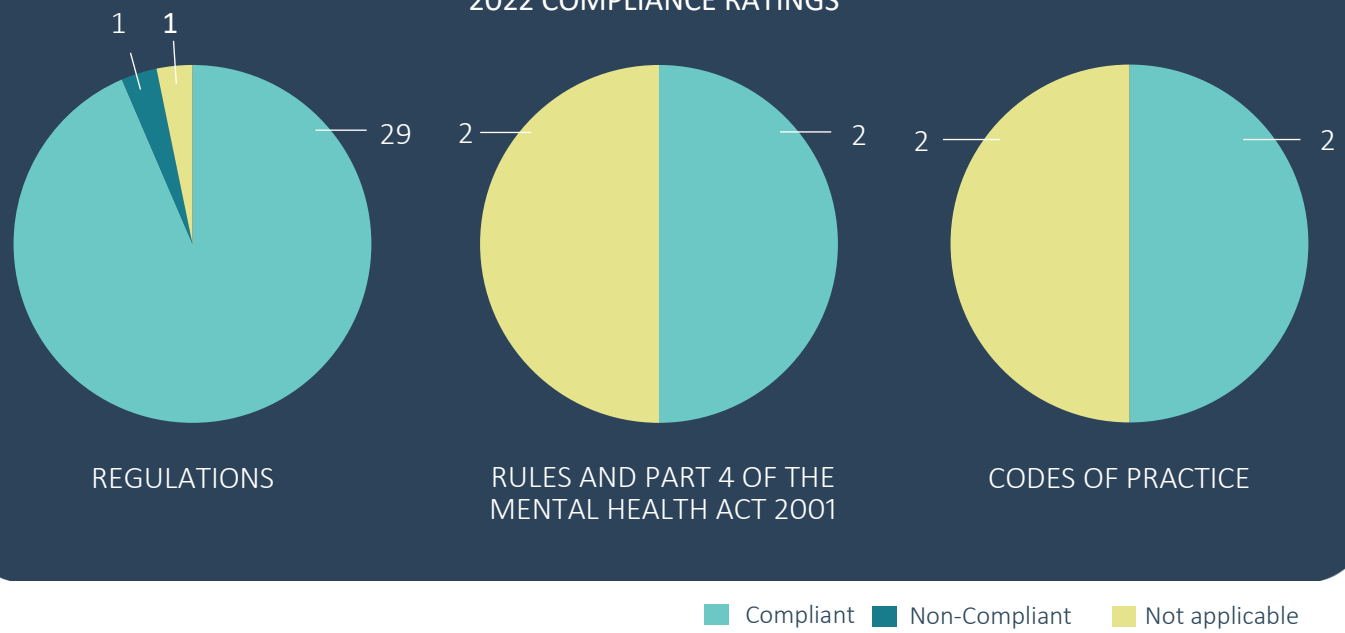
Inspection Date:
31 March – 1 April 2022

Previous Inspection date:
27 – 30 April 2021

Inspection Type:
Announced Annual Inspection

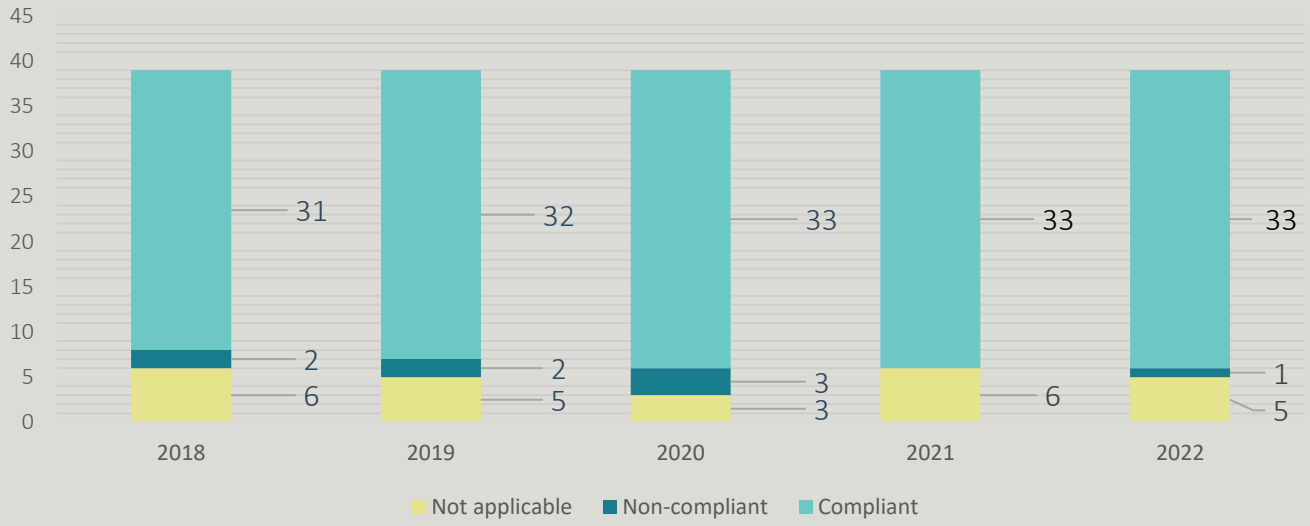
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

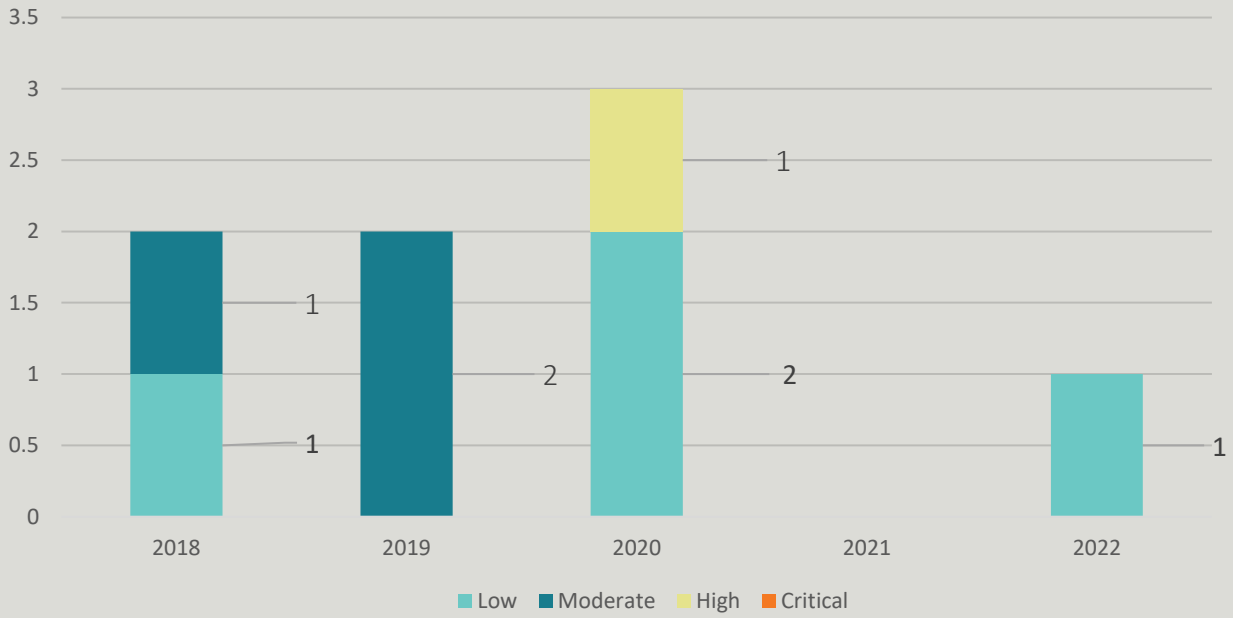
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

Linn Dara Child and Adolescent Mental Health Services (CAMHS) opened in 2015, and was located on the Cherry Orchard Hospital Campus in Ballyfermot, Dublin 10. Of the 24 registered beds, 14 were acute/emergency beds, eight were specialist eating disorder beds, and two were High Dependency beds. The approved centre catered for residents aged from 10 to 18, with younger children residing on Hazel Ward, and older adolescents cared for on Rowan Ward.

The approved centre had two multi-disciplinary teams (MDT) based onsite in Linn Dara – one each on Hazel and Rowan ward. The approved centre was part of the national CAMHS network and took referrals predominantly from the east and north of the country. At times, young people from other areas were also referred into the approved centre for treatment.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	94%	94%	92%	100%	97%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	19/04/2022	To provide further information on how the approved centre would ensure that young people's privacy and dignity were respected.	Approved centre submitted a report that did not provide sufficient information and further information was requested
Regulatory compliance meeting	25/05/2022	To provide assurances that the young people's right to privacy and dignity was respected	Plans were received at the regulatory compliance meeting. Further information has been requested.

Safety in the approved centre

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

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, stored and administered in a secure and safe manner.

Appropriate care and treatment of residents

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

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the young person and their family. There were clearly defined goals with associated interventions and resourcing in each care plan.
- There was a Therapeutic and Services Committee in which therapeutic programmes were discussed. The occupational therapy programme changed themes each week and included assertiveness, friendship, expressing emotions, non-verbal communication, and conversation skills groups. Other groups included a play therapy group, an art therapy group, a relaxation group, and a CBT skills group.

Individual sessions from psychology, social work, occupational therapy, dietetics, and speech and language therapy were also available to residents as required.

Respect for residents' privacy, dignity and autonomy

The inspection found that the following respected young people's privacy and dignity as follows:

- Each bedroom was single with en suite bathroom and toilet.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.

However:

- Reports from some residents stated that the way in which staff dealt with residents was not always respectful. In reply, the approved centre stated that this was not the case.

Responsiveness to residents' needs

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

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. There were numerous recreational facilities providing indoor and outdoor exercise and physical activities (arts & crafts room, games room, sports hall, outdoor basketball court and a gym). There was a range of age-appropriate resources such as games, Audio/DVD, comics, books, and arts and craft equipment. Supervised access to electronic tablets, and PCs was also provided.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance

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

- The approved centre was part of Community Healthcare Organisation 7 (CHO7) encompassing: Dublin South West, Kildare and West Wicklow. The approved centre also provided a catchment area service to Laois, Offaly, Westmeath, and Longford.
- The Executive Management Team (EMT) met on a monthly basis with agenda items relating to human resource issues, including staff vaccination roll out, education and training, recruitment for vacant

positions, regulation/compliance, the COVID-19 returning to business plan, the risk register and financial planning.

- The Linn Dara Governance group reported to the EMT. Several committees reported to the Governance group, including the Quality Patient Safety, Health and Safety (QPSHS) committee, the Quality network for inpatient CAMHS (QNIC) committee, the Restrictive Practice Reduction committee and quality improvement working groups (CRÓGA, Care Metrics, Policies Procedures Protocols and Guidance and clinical audit).
- The Quality and Patient Safety and Health and Safety (QPSHS) meeting also took place on a two-monthly basis. And local management held an operations meeting on a weekly basis.
- The approved centre had a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register. Training in risk management had been provided to staff.
- All Heads of Discipline reported having formal structures and processes in place for measuring and encouraging staff performance and personal development.
- There were weekly resident community meetings, suggestion boxes, service user surveys. A designated advocate from the Youth Advocacy Programme (YAP) contacted the approved centre on a weekly basis and spoke with residents. Advocacy contact details were displayed within the approved centre.
- A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a local policy group which provided a multi-disciplinary approach to policy development, review, approval and dissemination, and all policies were up to date at the time of inspection.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The service developed a virtual tour of the approved centre which was hosted on the HSE server and was an online resource for residents and families (and other stakeholders) so that they could view the approved centre prior to admission.

2. Qualification and registration of an Advanced Nurse Practitioner.

3. In response to an outbreak of COVID-19 within the approved centre an Assertive Outreach Approach was developed and led by nursing staff to provide enhanced support to residents and families in their home as part of discharge preparations.

4. Full redesign of the approved centre's school brand identity which included a new school name, logo, and a new school website.

5. The school developed an information booklet for all new residents and their families to receive on admission.

6. Redesigning of the school's wild garden area, in collaboration with Rotary Ireland for design, project management, and funding in developing a sensory path.

7. The school held a Céilidh before the St. Patrick's Day break for residents, with live music, dancing, a photobooth, and prizes. Pupils were involved in planning, promoting, setting up and hosting the event.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Linn Dara Child and Adolescent Mental Health Services (CAMHS) opened in 2015, and was located on the Cherry Orchard Hospital Campus in Ballyfermot, Dublin 10. The approved centre was registered for 24 beds. There were 11 beds in the Hazel and Rowan Wards, and two beds in Oak Ward, which was the High Dependency Unit (HDU). Of the 24 registered beds, 14 were acute/emergency beds, eight were specialist eating disorder beds, and two were HDU beds. The approved centre catered for residents aged from 10 to 18, with younger children residing on Hazel Ward, and older adolescents cared for on Rowan Ward.

The innovative design of the Linn Dara approved centre had won prizes for its use of light and space. All rooms looked out onto a green space. Each resident had their own en suite bedroom, and additionally, residents had access to numerous seating areas, visiting rooms, therapy rooms, a prayer room, a games room, a multisensory room, a large and small TV room, and a resident kitchen and dining room. The approved centre had a six-classroom school with a garden onsite, a sports hall and gym, an outdoor basketball court, an occupational therapy suite, and a family accommodation suite.

Linn Dara had recently enhanced all garden spaces with synthetic grass and new outdoor seating and furnishings. An art mural was completed in Oak unit's garden, the approved centre and school had been newly repainted, and multipurpose rooms had been upgraded. Infection Prevention and Control (IPC) related improvements had also been implemented, which included replacement beds, replacement seating and upholstery, lino replacement, and new curtains throughout the approved centre.

The approved centre had two multi-disciplinary teams (MDT) based onsite in Linn Dara – one each on Hazel and Rowan ward. The approved centre was part of the national CAMHS network and took referrals predominantly from the east and north of the country. At times, young people from other areas were also referred into the approved centre for treatment.

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

Resident Profile	
Number of registered beds	***24***
Total number of residents	**22**
Number of detained patients	4
Number of wards of court	0
Number of children	22
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	N/A

3.2 Governance

The approved centre was part of Community Healthcare Organisation 7 (CHO7) encompassing: Dublin South West, Kildare and West Wicklow. The approved centre also provided a catchment area service to Laois, Offaly, Westmeath, and Longford. Linn Dara was one of four approved centres within CHO7 and was the only one registered to provide Child and Adolescent Mental Health services. Linn Dara had established governance structures in place and a number of senior management meetings took place within the approved centre on a regular basis in order to deliver the governance processes.

The Executive Management Team (EMT) met on a monthly basis. Minutes from the EMT meetings evidenced strategic agenda items relating to human resource issues, including staff vaccination roll out, education and training, recruitment for vacant positions, regulation/compliance, the COVID-19 returning to business plan, and financial planning. The management team also discussed the approved centre risk register at their meetings. This meeting was attended by the head of service, accounts manager, business manager, and heads of discipline.

The Linn Dara Governance group was an overarching group which reported to the EMT. This meeting was held every two months. Minutes from governance meetings included agenda items such as compliance with the Mental Health Act, including Corrective and Preventative Actions plans that had been developed for the approved centre, quality improvement initiatives, monitoring of approved centre activity, staff training and development, and building related issues. Several committees reported to the Governance group, including the Quality Patient Safety, Health and Safety (QPSHS) committee, the Quality network for inpatient CAMHS (QNIC) committee, the Restrictive Practice Reduction committee and quality improvement working groups (CRÓGA, Care Metrics, Policies Procedures Protocols and Guidance and clinical audit).

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

Local management held an operations meeting on a weekly basis. Minutes from operations meetings included agenda items such as service activities/KPIs, complaints and compliments, facilities, estates, legal, staffing, and COVID-19.

The approved centre had a standardised process for the management of risks and incidents. The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. The risk of COVID-19 was actively managed through the approved centre's risk management processes. Training in risk management had been provided to staff.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. Health and Social care professionals, including occupational therapy, psychology, social work, physiotherapy, dietetics, and speech and language therapy were accessible to all residents. At the time of inspection, however, a psychologist, a dietician, and a social worker post were vacant. These services were being provided to residents through cross care cover, or from an outside agency.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, psychology, speech, and language therapy (SLT), and dietetics. The lead inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development.

Annual staff training plans were completed to identify and address training needs. Operational risks highlighted within these questionnaires included: recruitment and retention of staff, high usage of agency staff to maintain existing levels of service, significant demand for bed availability, COVID-19 impacts including the lack of opportunity to offer face to face consultations with parents and carers, the reduction in collaborative working, and the impact on mandatory training. The identified risks were effectively mitigated, escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, weekly resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Youth Advocacy Programme (YAP) contacted the approved centre on a weekly basis and spoke with residents. Advocacy contact details were displayed within the approved centre.

The approved centre had an established culture of quality improvement. This was evident by the ongoing refurbishment of the approved centre. The progression and development of various quality initiatives in the approved centre was also a standing agenda item at the governance meeting. A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a local policy group which provided a multi-disciplinary approach to policy development, review, approval and dissemination, and all policies were up to date at the time of inspection. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre. Staff held a 'Safety Pause' each day; this was a morning meeting of all clinical staff working with young residents, used to discuss any current and updated risk issues pertaining to residents.

The approved centre followed all public health advice in regard to the COVID-19 outbreak. Contingency planning included the potential risks posed by the COVID-19 virus. COVID-19 was a standing agenda item for the EMT and local operations meetings, and issues arising were actively managed. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.

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 21: Privacy	✓		✓		✓		✓		✗	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 no resident had been mechanically restrained since the last inspection, this rule 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.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001.	As the approved centre was a child and adolescent mental health facility, this Code of Practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team. This was used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- The Youth Advocacy Programme (YAP) representative 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.

Out of twenty two (22) residents, eleven (11) service user questionnaires were completed by the residents and returned to the inspection team.

- 4 out of 11 residents indicated that they did not have space for privacy and that their privacy and dignity were not respected.
- 1 resident ticked that they "never" felt safe in the approved centre, 8 indicated that they "sometimes" felt safe in the approved centre, and the 2 remaining residents indicated "always" for this question.
- 1 resident ticked that they "never" felt they were able to discuss worries or concerns with staff as soon as they needed to, 8 indicated that they "sometimes" could, and the 2 remaining indicated "always" for this question.
- 2 residents felt they were never able to give feedback to staff or to make complaints when they are not satisfied with any part of their stay in the approved centre, 4 indicated that they "sometimes" could, 3 indicated they "always" could and the 2 remaining indicated that they did "not know how to make a complaint".
- Seven residents ticked to indicate that on admission to the approved centre a member of staff had explained what was happening in a way that they could understand, 4 indicated that they could not remember if this occurred.
- Nine residents indicated that they understood their individual care plan and 2 residents indicated that they did not. Six residents indicated that they were "always" involved in setting goals for their individual care plans, and 5 indicated that they were 'sometimes' involved.

- 9 questionnaires indicated that residents knew who their multi-disciplinary team members were and 2 indicated they did not.
- 10 residents indicated that they knew who their keyworker was, and 1 resident indicated that they did not.
- 8 residents felt that there were enough activities during the day with 3 residents stating they did not.

On a scale of 1-10, with 1 being poor and 10 being excellent, the 11 residents on average scored 4 out of 10 for overall care and treatment.

The inspection team spoke with 2 residents over the phone. This feedback indicated certain positive and certain negatives as follows:

- Residents knew who their keyworkers were and were informed about their individual care plans. They commented that there was a lot of input from their MDT.
- Residents commented that the approved centre building was very nice, and that it was a very well-kept unit.
- Residents felt that communication with their families was facilitated adequately in terms of phone calls and access to an electronic tablet.
- Residents felt that there were no activities during the weekend and school holidays. They suggested that art, baking, and garden groups would be welcomed.
- Residents felt that some staff were rude and could be harsh in manner when communicating with them. The approved centre denied this and pointed to interactions documented in the clinical file which did not show evidence of disrespectful communication. Other young people found the staff "O.K." and "nice". The approved centre stated that it was central to their professional values that they communicate respectfully and treat people with dignity.
- Residents felt at times their privacy was not respected by staff. An example given was that when changing or showering, staff have walked in on them without seeking the resident's permission before entering their rooms. The approved centre stated that, following risk assessment, it may have been necessary for staff to enter a young person's room without their consent when the young person has not responded to a knock or name call,
- Residents commented that the complaint/suggestion box was located through two locked doors and that they could not readily access it.
- Residents told inspectors that when one person broke the rules, everyone was punished, for example, by the removal of Netflix and no access to the school garden. The approved centre stated that it is their duty to ensure that they provide a safe therapeutic environment and on occasion measures may need to be taken which are necessary and proportionate to the identified risk and which in turn may be perceived by young people as being punitive.

5.2 Advocacy

The approved centre had an advocacy service, the Youth Advocacy Programme (YAP). The advocate visited the approved centre on a weekly basis (alternating Rowan and Hazel wards each week). Face-to-face individual and group consultations had been reintroduced.

The inspection team spoke with a representative from the advocacy service who furnished the inspectors with a report detailing advocacy activity within Linn Dara. The most frequently raised issues by residents in group consultations with the advocacy service were communication difficulties with staff, issues surrounding outings and activities, issues with the living environment/equipment, and difficulties surrounding unit policies. Residents also expressed to the advocate that staff could sometimes use insensitive language and that physical restraints were used too quickly rather than talking to them.

6.0 Feedback Meeting

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

- Clinical Director
- Director of Nursing
- Head of Service / Registered Proprietor Nominee
- Assistant Director of Nursing
- Clinical Nurse Manager 3 x 2
- OT Manager
- SLT Manager
- Dietitian Manager
- Executive Clinical Director
- Area Director of Nursing
- Principal Social Worker
- Service Manager
- Clinical Nurse Manager 2 x 2
- Consultant Psychiatrist x 2
- School Principal
- Senior Registrar

Apologies were received on behalf of the Principal Psychologist.

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing, if required, that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. At the time of inspection, no residents were wearing nightclothes during the day as indicated by their individual care plan. Laundry facilities were provided in the approved centre.

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 January 2020.

Residents' 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. A property room was provided to residents in Hazel and Rowan wards. Each property room had a safe in it for any valuable items.

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 by their ICP and 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. The approved centre provided access to a range of recreational activities appropriate to the resident group profile during the week and at the weekend. As part of the unit design, there were numerous recreational facilities providing indoor and outdoor exercise and physical activities (arts & crafts room, games room, sports hall, outdoor basketball court and a gym). In the approved centre, there was a range of age-appropriate resources such as games, Audio/DVD, comics, books, and arts and craft equipment. Supervised access to electronic tablets, and PCs was also provided.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. A prayer room was provided in the Hazel and Rowan wards for residents to practice religious beliefs. A list of local religious services was also available in each ward.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits, which was last reviewed in January 2021.

At the time of the inspection, visits to the approved centre were in line with infection control measures and public health guidance. There were designated visitor rooms available where private visits could take place, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during these visits. The visiting rooms were suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in January 2021.

Residents had access to a phone and internet unless otherwise risk assessed with due regard to residents' wellbeing, safety, and health. On admission, each young person was provided with a ward mobile phone and each ward had three electronic tablets and a phone booth available to residents. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing young person communication if there was reasonable cause to believe the communication would result in harm to the young person or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in January 2021. The policy 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.
- Carrying out searches with the consent of a resident.
- Carrying out searches in the absence of consent.
- The finding of illicit substances during a search.

The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches, and a written record was kept of all environmental searches. The clinical file of three residents who were searched was inspected. The resident's consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted, one of whom was the same gender as the resident. The search was implemented with due regard to the resident's dignity and privacy.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and protocols for care of residents who were dying, which were last reviewed in January 2021.

No resident had died in the approved centre since the previous inspection. Therefore, this regulation was inspected on the policy requirement only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

All ICPs identified appropriate goals for the resident. All ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICP's identified the resources required to provide the care and treatment. All ICP's included educational requirements.

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

At the time of the inspection there was a Therapeutic and Services Committee in which therapeutic programmes were discussed. The occupational therapy programme changed themes each week and included; assertiveness, friendship, expressing emotions, non-verbal communication, and conversation skills groups. Other groups included a play therapy group, an art therapy group, a relaxation group, and a CBT skills group. Individual sessions from psychology, social work, occupational therapy, dietetics, and speech and language therapy were also available to residents as required.

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

Child residents were assessed in relation to their educational requirements, with consideration of their individual needs and age on admission. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities were available for the provision of education, as were sufficient personnel resources.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the transfer of residents. The policy was last reviewed in January 2021.

The clinical file of a resident who had been transferred was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer, to a named individual, including a letter of referral that contained a list of current medications and a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy. The policies were last reviewed in January 2021.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Clinical files were examined in relation to provision of general health services during the inspection process. 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. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The clinical file of one resident who had been in the approved centre over six months was reviewed. The six-monthly health assessments documented a physical examination, family history, blood pressure, smoking status, dental health, nutritional status, a medication review, BMI, weight, and waist circumference. 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 operational policy and procedures on the provision of information to residents. The policy was last reviewed in January 2021.

The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and residents' rights.

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.

Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

Residents were called by their preferred name, and during the inspection the inspectors observed the general demeanour of staff as respectful. Staff were discreet when discussing the resident's condition or treatment needs. However, reports from residents stated that the way in which staff addressed and communicated with residents was not always respectful. The approved centre denied this and pointed to interactions documented in the clinical file which did not show evidence of disrespectful communication.

Some residents complained that staff entered their bedrooms when they were undressing or in the shower. The approved centre stated that, following risk assessment, it may have been necessary for staff to enter a young person's room without their consent.

One feedback questionnaire that a resident completed anonymously for inspectors was viewed by nursing staff without the resident's permission. The approved centre subsequently stated that as Mandated Persons under the Child Care Act (2015), staff acted to ascertain if the young person had experienced harm and if there were reasonable grounds for concern in terms of Children First. The approved centre stated that the feedback questionnaire was viewed by a staff member as a consequence of the manner in which it was presented to that staff member. Staff said they were concerned when they saw what was written on part of one young person's questionnaire indicating potential for verbal and physical abuse of a child. The staff member was required to ascertain the facts in line with service policy and child protection legislation.

Residents told the inspectors that that when one person broke the rules, everyone was "punished". The approved centre stated that it is their duty to ensure that they provide a safe therapeutic environment and on occasion measures may need to be taken which are necessary and proportionate to the identified risk and which in turn may be perceived by young people as being punitive. The approved centre stated that access to outdoor areas are subject to risk assessment; access to all other amenities such as electronic devices etc are also subject to risk assessment in terms of an acute need for creating an environment that is conducive to the provision of a safe therapeutic environment ensuring appropriate engagement between staff and young people.

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to a resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass, and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.

Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was adequately lit, heated, and ventilated. Furnishings supported resident independence and comfort. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. There was a large and small living room in each of the two wards. All resident bedrooms were en suite rooms and were appropriately sized to address the resident needs. There was adequate space for residents to move about. There was an outdoor garden area and separate outdoor space available to residents in each of the two wards.

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

There was a sufficient number of toilets and showers for residents in the approved centre. Current national infection control guidelines were followed. The approved centre had a designated sluice room and a designated cleaning room on each floor.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in January 2021.

Each resident had a Medication Prescription and Administration Record (MPAR), and ten of these were inspected. All MPARs evidenced a record of medication management practices, including a record of the following: medications administered, allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, date of discontinuation for each medication, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently, where there was a significant change in the resident's care or condition, and this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a health and safety of residents, staff, and visitors policy. The policy was last reviewed in January 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in January 2021.

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Two multi-disciplinary teams (MDTs) were based in the approved centre – one in Hazel and one in Rowan Ward, which included the disciplines of: medical, nursing, occupational therapy, social work, psychology, dietetics and speech and language therapy. At the time of inspection, however, a psychologist, a dietician, and a social worker post were vacant. These services were being provided to residents through cross care cover, or from an outside agency. The approved centre also had access to family therapy, play therapy and an art therapist. The approved centre did not have a dedicated pharmacy service.

All staff training was documented, and staff training logs were maintained. All health care staff were trained in the fire safety, basic life support and the management of violence and aggression and children first. All health care staff were trained in the Mental Health Act 2001.

The following is a table of mandatory staff training completion in the approved centre:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (26)	26	100%	26	100%	26	100%	26	100%	26	100%
Medical (10)	10	100%	10	100%	10	100%	10	100%	10	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%

Social Worker (1)	1	0%	1	100%	1	0%	1	100%	1	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Dietician (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Speech & Language Therapy (2)	2	100%	2	100%	2	100%	2	100%	2	100%

Though the requirement of the basic life support training and management of violence and aggression training was not met, this was due to a healthcare professional starting the post recently within the approved centre and was therefore not deemed a reason for non-compliance.

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in January 2021 and included:

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

All residents' records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. All resident records were physically stored together, where possible. Resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Records were maintained in good order, without loose pages. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a hardcopy register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 of 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 fifteen operating policies and procedures required by the regulations were all reviewed within the required three-year time frame, having due regard to any recommendations 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 operational policy and procedures in relation to the management of complaints. The policy was last reviewed in January 2021. It included the process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

There was a nominated individual responsible for dealing with all complaints available and based in the approved centre. The complaints procedure and the nominated person's contact details were publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints were handled promptly, appropriately, and sensitively. The nominated person maintained a record of all complaints relating to the approved centre. Any resident who had made a complaint was not adversely affected by reason of the complaint having been made. All complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded, these records were in addition to and distinct from a resident's individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There was a comprehensive written policy in relation to risk management and incident management processes. The policy was last reviewed in January 2021. The policy included all of the policy related regulation requirements, including:

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

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

Clinical, corporate, structural, health and safety, and organisational risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to and during episodes of resident seclusion, physical restraint, and at resident admission,

transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration.

Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk reviewed incidents for any trends or patterns occurring in the service.

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre was adequately insured against accidents and injury to residents. The approved centre's insurance certificate and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered 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 which was displayed prominently in the entrance foyer.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion, which was last reviewed in January 2022. The policy addressed the following:

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

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

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

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. Seclusion rooms were not used as bedrooms. Three seclusion episodes which took place since the last inspection were reviewed on inspection.

Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, as far as practicable taking into account Rule 5.1 (direct observation). Seclusion was only used in rare and exceptional circumstances and in the resident's best interests, when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including a risk assessment, and after all other interventions to manage each of the resident's unsafe behaviour were considered. Each of the resident's next of kin was not informed about the seclusion episode and the explanation for not informing them was documented in each clinical file.

Seclusion was initiated by a registered medical practitioner (RMP) or registered nurse (RN). The Consultant psychiatrist (CP) was notified as soon as practicable of the use of seclusion. Seclusion initiation was recorded in each of the clinical files and seclusion register by the person initiating seclusion. The seclusion order was recorded in the clinical files and seclusion register by the RMP. The RMP indicated the duration of the seclusion order, to be no longer than eight hours. The seclusion register was signed by the responsible CP or duty CP within 24 hours. A medical review of each of the patients took place no later than four hours after the commencement of the episode of seclusion.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.

(2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

a) the patient gives his or her consent in writing to the continued administration of that medicine, or

b) where the patient is unable to give such consent –

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

INSPECTION FINDINGS

The clinical file of two young people's files that were admitted under Section 25 of the Mental Health Act, 2001 who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In both cases, the administration of medication was approved and authorised by two consultant psychiatrists as set out in *Form 18: Treatment of a Child in Respect of Whom an Order Under Section 25 is in Force.*

The approved centre was compliant with Part 4 of the Mental Health Act 2001

10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services".

The Mental Health Act, 2001 ("the Act") does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated January 2022. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- 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: The clinical file of three residents that had been physically restrained were examined on inspection. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical files. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Completed clinical practice forms had been placed in the resident's clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. Each of the three policies were last reviewed in January 2021.

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 during the inspection process. Admission had been on the basis of mental illness or disorder and an admission assessment had been completed. The assessment included presenting problem, past psychiatric history, family and medical history, social and housing circumstances, current and historic medication, and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the resident's parents were involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged showed a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and the relevant members of the multi-disciplinary team. A preliminary discharge summary had been sent to relevant personnel within 3 days, and a comprehensive discharge summary was issued within 14 days. The comprehensive summary detailed diagnosis, prognosis, medication, mental state at discharge, risk issues including signs of relapse. A follow-up appointment had been arranged for the resident.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 21: Privacy					
Reason ID : 10002962		**The registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review of existing service policy relating to this regulation and cross referenced against exiting policy on risk management was conducted. A re audit against the specific monitoring requirements and evidence of implementation as outlined in this regulation was conducted.	Two observational audits were conducted. A review of clinical documentation, review of Approved Centre layout and furnishings , review of minutes of community meetings occurred. Monthly walk through of the Approved Centre occurred. Reviewed our existing systems for capturing and acting on service user experiences to ensure they are transparent and documented. Review of service user feedback logs and other forums of capturing service user feedback was conducted.	Achieved. There were no areas of non compliance found against the requirements of this regulation or service policy.	01/09/2022	CNM3, ADON, Consultant Psychiatrist, Director of Nursing, Clinical Director
Preventative Action	Continue with CPD session, policy awareness sessions, Induction sessions for all staff. Ensure Young people are informed of the variety of forums/ means they have of raising any issues / concerns they have	Attendance records at CPD sessions, Induction records, supervision records	Achievable	03/10/2022	Responsibility for all staff is outlined in the service policy on Privacy, Policy No 21 . CNM3 to maintain log of attendance at CPD sessions. Each Head of Discipline

	in regards to privacy and dignity at local level and with the Youth Advocacy Rep. Young people/ family , careers informed of how exceptions to privacy are managed in the context of risk management as outlined in the service policy on Risk Management Policy No 21 Section 6.8 & 6.9 Ensure all opportunities are availed of to incorporate service user feedback into existing forum's in the Approved Centre . Service user feedback continues to be incorporated into minutes of QPS, Approved Centre Governance meetings and Team business meetings,				to maintain log of induction and supervision sessions.

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.

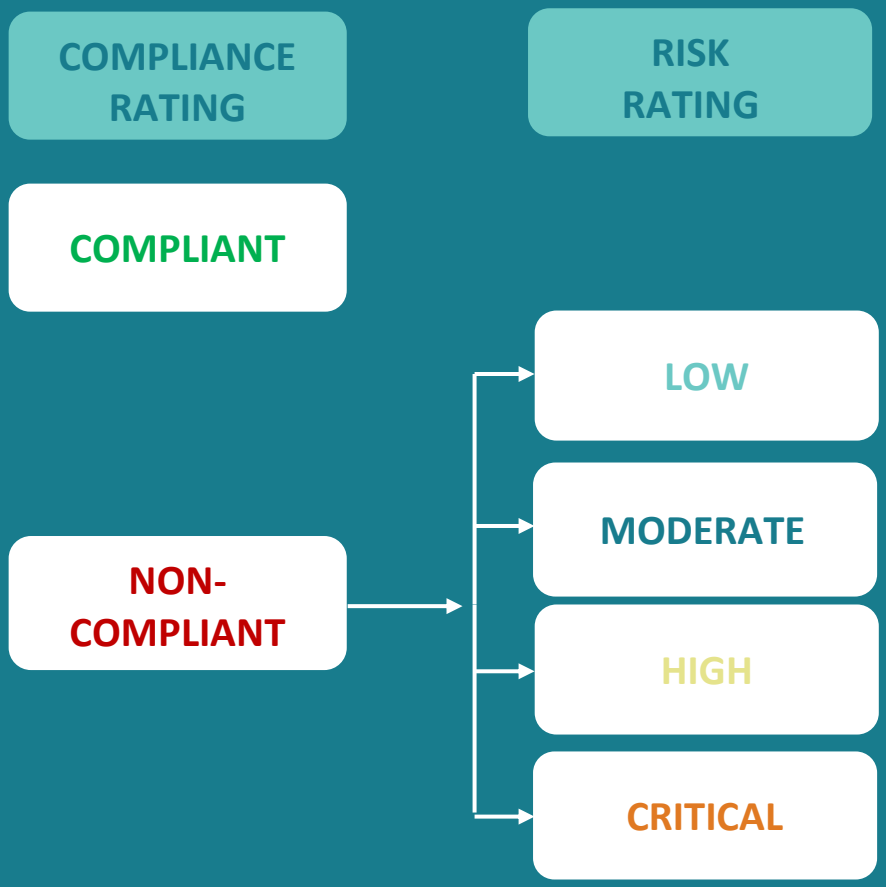
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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