Eist Linn Child & Adolescent In-patient Unit

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mental health commission

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

EIST LINN CHILD & ADOLESCENT IN-PATIENT UNIT

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

Date of Publication: 7th June 2023

ID Number: AC0181

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
22 December 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Hugh Scully, Acting General Manager, Mental Health Services

Inspection Team:
Megan Barry Sheehy, Lead Inspector
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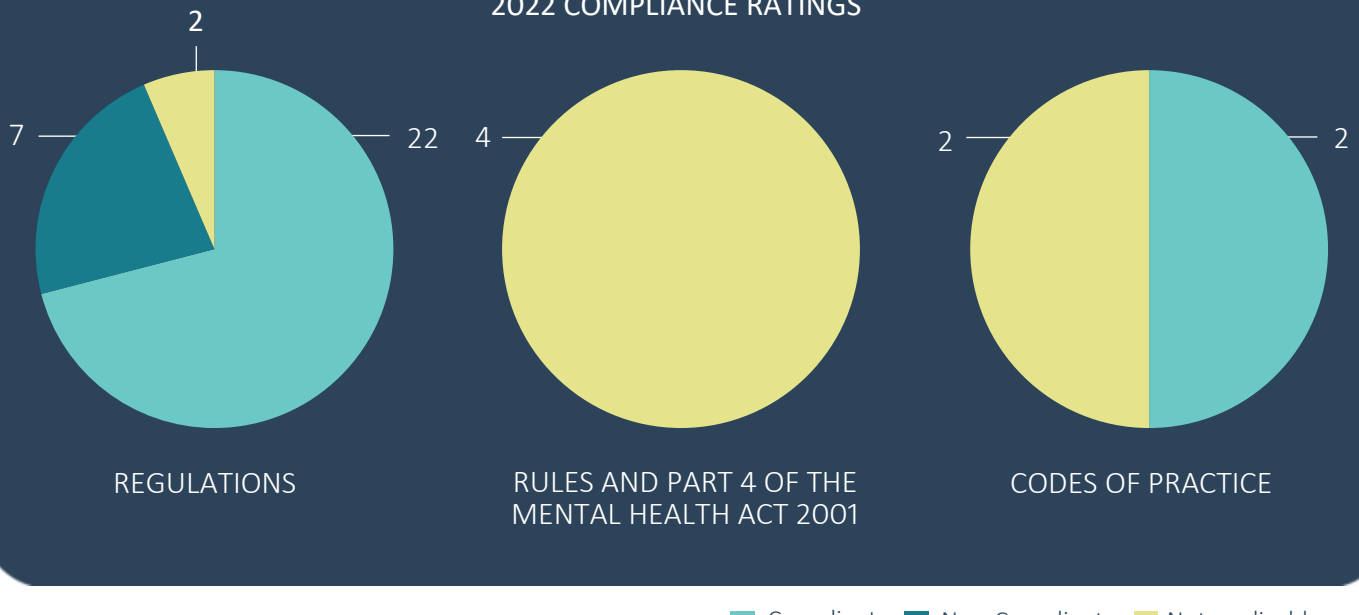
Inspection Date:
28 June – 1 July 2022

Previous Inspection date:
25 – 28 May 2021

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

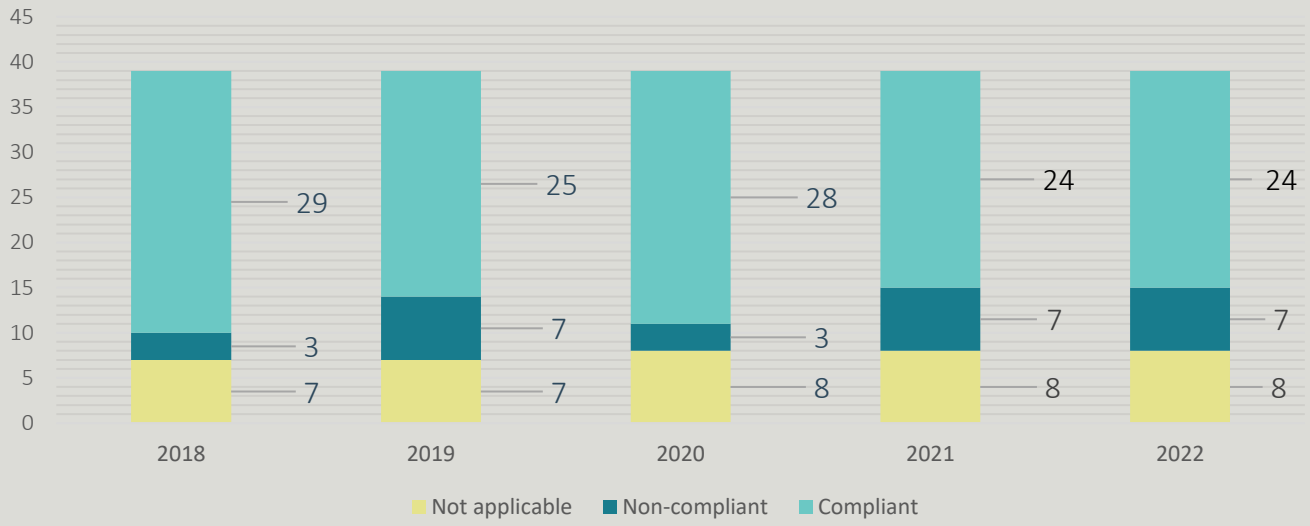
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

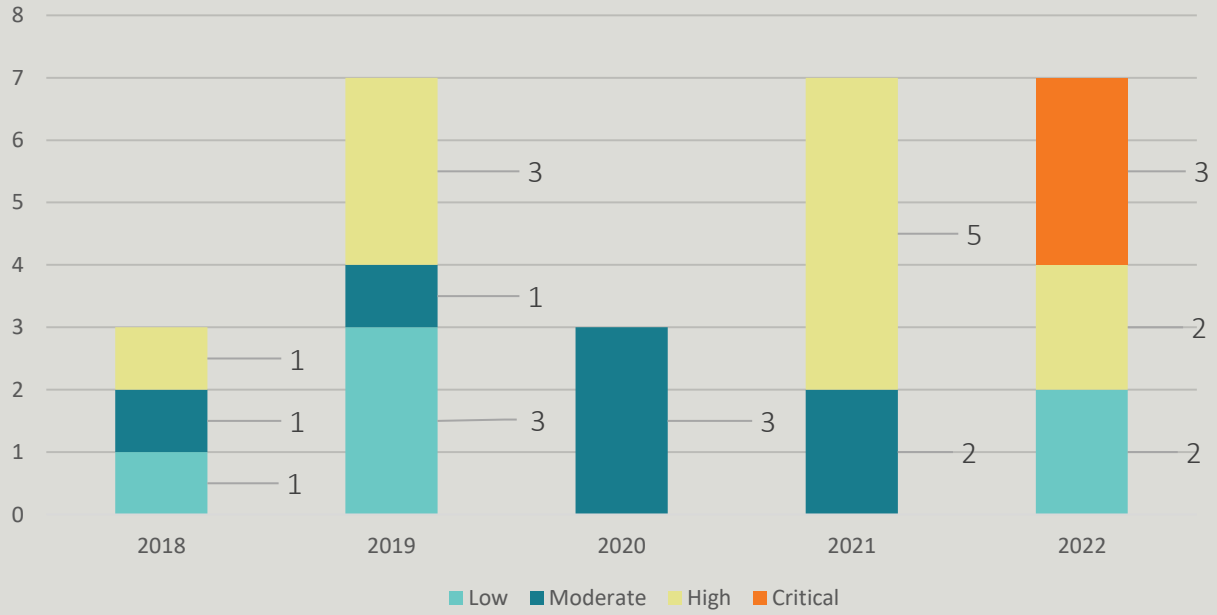
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Eist Linn Child and Adolescent In-patient Unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. It was one of four national in-patient child and adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry, and Cork. Seventeen community child and adolescent teams referred into the approved centre, nine from Cork and Kerry, which included the Child and Adolescent Regional Eating Disorder Service (CAREDS) team, and eight from the remaining counties. Eist Linn was registered to accommodate 16 young people.

The Suaimhneas suite, a low stimulus one-bed extra care was located on the first floor of the approved centre.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	91%	78%	90%	77%	81%

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental*	The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Health Commission in a form and frequency prescribed by the Commission.	

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	*11/07/2022*	*Required the approved centre to take immediate steps to address non-compliance with Regulation 22: Premises, Regulation 31: Complaints Procedures, and Regulation 32: Risk Management Procedures.*	*The Mental Health Commission continues to engage with the HSE on this matter.*

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm to the residents 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 residents.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

We found that facilities and processes respected residents' privacy and dignity in the following areas:

- There were single bedrooms 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.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However:

- The premises of the approved centre fell below an acceptable standard and this was rated as a critical risk.
    - The floor covering throughout the building was marked and scratched.
    - The building required painting, both externally and internally.
    - The garden area required weeding.
    - The windows and skylight were dirty.
    - Mould was observed in the art room and annex room off the art room in the school. Mould was also observed in the cleaning room on the first floor and there was mould and dirt in light fixtures on the first floor.
    - One bedroom door required replacing.
    - There was evidence of damp on ceilings, particularly adjacent to the heating fixtures.
    - There was staining on the ceiling in a cleaning room on the first floor.
    - The heating was not working in the art room or home economics room in the school.
    - Bedrooms were sparsely furnished with a bed, a table and one or two hard chairs, and the furniture in the rooms was marked and stained
- In two of the clinical files examined, there was no clear record of risk assessment taking place prior to searches of the resident. Two of the clinical files inspected did not record a reason as to why the search was being conducted. There was lack of documentation in the residents' clinical files regarding the searches.

- The assessment room was only accessible by passing through the main hub of the approved centre and the assessment room was directly visible from the corridor of the approved centre.
- Residents did not have access to personal space during the day.

Responsiveness to residents' needs

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

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. Activities included therapy dogs, walks, games groups, art projects, music groups, gardening, nature outings, and visits to the beach, the animal shelter, and Fota Wildlife Park.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a choice of food at mealtimes.

However:

- The art room in the school area did not have suitable and sufficient heating, as a temperature of 20.5°C was recorded there.
- The complaints procedures of the HSE and Regulation 31: Complaint procedures were not followed in the approved centre. This was rated critical risk.

Governance, Leadership and Accountability

Governance structures were in place as follows:

- The approved centre was under the governance and management of the Cork Mental Health Area Management Team, in Cork and Kerry Community Health Care Organisation.
- The Cork Mental Health Area Management Team met monthly. A Quality and Patient Safety (QPS) meeting took place each quarter and representatives from Eist Linn attended this meeting.
- The approved centre's local management team meet monthly. Agenda items at these meetings included risk registers, staffing, COVID-19, and incident reviews.
- There was a compliance group, audit group and policy group who met monthly in the approved centre.
- The person with responsibility for risk was identified and known by staff. The risk register had been reviewed at least quarterly. A monthly risk management meeting was held in the approved centre. The risk management meeting was attended by the risk advisor, acting clinical director, director of nursing, area director of nursing, consultant psychiatrists and members of the multi-disciplinary team. Minutes from these meetings evidenced that the risk register was reviewed, and significant incidents discussed.

- Incidents were recorded and reviewed on the National Incident Management System (NIMS). There was evidence that incidents were reviewed by the multi-disciplinary team on a weekly basis. The risk advisor analysed incident reports quarterly for patterns and trends.
- Each clinical discipline had its own internal governance structure, with clear line management processes in place.
- A "Fred the Frog" suggestion box was on the wall in the main hallway of the approved centre. Residents were able to voice concerns or requests anonymously using this forum. Every Thursday there was a community meeting held in the approved centre. The minutes of these meetings were reviewed and actioned by a member of the nursing team.

However:

- Three complaints since the last inspection had not gone through the complaints process as outlined in the approved centre's complaints policy.
- Details of how to make a complaint were displayed in the main hall of the centre but there was no contact information for the complaints officer provided.
- A Youth Advocacy Programme (YAP) that was available in other child and adolescent services, was not provided in Eist Linn at the time of inspection.
- Risk management procedures were poor and this was rated as a critical risk:
    - Health and Safety risks – heating not working, leaks in the heating system, damaged fire doors, mould in the art room - were not identified, assessed, treated, reported and monitored by the approved centre.
    - Clinical risks were not recorded on the risk register.
    - Health and Safety risks were not recorded on the risk register.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. An Information booklet on attention deficit hyperactivity disorder (ADHD) had been developed by the approved centre.

2. The clinical psychology department had conducted research into the needs of individuals with autism being referred to and admitted to the approved centre.

3. A Service User Satisfaction Survey was completed by the approved centre and distributed to the residents.

4. The Health Service Executive Rainbow Badge Initiative was launched in the centre. The aim of this initiative was for HSE staff to demonstrate that they are aware of the issues Lesbian Gay Bisexual Transgender Queer Plus (LGBTQ+) people can face when accessing healthcare services.

5. A clinical nurse specialist with special responsibility for compliance had been appointed in the approved centre. This clinical nurse specialist was taking the lead on audits to maintain compliance, quality improvement, and policy review within the approved centre.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Eist Linn Child and Adolescent In-patient Unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. It was one of four national in-patient child and adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry, and Cork. Seventeen community child and adolescent teams referred into the approved centre, nine from Cork and Kerry, which include the Child and Adolescent Regional Eating Disorder Service (CAREDS) team, and eight from the remaining counties. Eist Linn was registered to accommodate 16 young people. On the first day of inspection there were nine young people in the approved centre. Two young people had been in the approved centre longer than six months.

The ground floor of the approved centre provided communal spaces and therapy rooms for the residents. It consisted of staff offices, two visiting rooms, a library or assessment room, a television/sitting room, and a dining room with a servery kitchen. The residents also had access to a pool room and a small computer room on the ground floor. A parent's apartment with kitchenette, bed and bathroom facilities was also located on the ground floor.

The Suaimhneas suite was located on the first floor of the approved centre. The Suaimhneas suite was a low stimulus extra care area. This area included one en suite bedroom, a de-escalation room, living and dining space and an enclosed outdoor space also on the first floor. On the first floor there was a sensory room that could be accessed both from the Suaimhneas extra care area and the main upstairs accommodation area. A sitting room/television room and a further 15 bedrooms with en suite were also located on the first floor.

There was a school located across two internal gardens with a classroom, an art room, an activity kitchen, and an expansive gym hall. A smaller gym area was also available in the school building with a treadmill, cross-trainer, and fixed bicycle.

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

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

3.2 Governance

The approved centre was under the governance and management of the Cork and Kerry Community Health Care Organisation. There were two executive management teams, one for each county. The approved centre was under the governance and management of the Cork Mental Health Area Management Team.

The Cork Mental Health Area Management Team met monthly. Agenda items included finance, service planning, risk registers, staffing and compliance. A Quality and Patient Safety (QPS) meeting took place each quarter and representatives from Eist Linn attended this meeting.

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

The approved centre's local management team meet monthly. Those present at this forum included the assistant director of nursing, clinical nurse specialist, consultant psychiatrists, speech and language therapist, occupational therapist, social worker and clinical psychologist. Agenda items at these meetings included risk registers, staffing, COVID-19, and incident reviews.

Local working groups were active in the approved centre. There was a compliance group, audit group and policy group who met monthly. These working groups were chaired by a clinical nurse specialist and attended by the assistant director of nursing, members of the multi-disciplinary team and the consultant psychiatrists.

The person with responsibility for risk was identified and known by staff. The risk register had been reviewed at least quarterly. However, the risk register did not identify all health and safety risks or all clinical risks.

Incidents were recorded and reviewed on the National Incident Management System (NIMS). There was evidence that incidents were reviewed by the multi-disciplinary team on a weekly basis. The risk advisor analysed incident reports quarterly for patterns and trends.

A monthly risk management meeting was held in the approved centre. The risk management meeting was attended by the risk advisor, acting clinical director, director of nursing, area director of nursing, consultant psychiatrists and members of the multi-disciplinary team. Minutes from these meetings evidenced that the risk register was reviewed, and significant incidents discussed.

Each clinical discipline had its own internal governance structure, with clear line management processes in place. The inspection team interviewed heads of clinical disciplines as part of the inspection process. Heads of discipline from psychology and occupational therapy completed a governance questionnaire. This provided a clear overview of the governance issues and current risks within their respective departments. Heads of discipline were not based within the approved centre. Defined lines of responsibility were evident in each department. Each head of discipline met with team members on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the senior management team. All disciplines had formal and informal clinical supervision arrangements in place where appropriate.

The numbers and skill mix of staff was sufficient to meet resident needs. Allied health and social care disciplines, including occupational therapy, psychology, speech and language therapy, dietician, and social work, were all accessible to residents admitted. Nursing staff levels were effectively maintained. Nursing management used overtime and or agency when nursing shortages occurred.

The approved centre had a complaints policy and an appointed complaints officer. Details of how to make a complaint were displayed in the main hall of the centre but there was no contact information for the complaints officer provided. Three complaints since the last inspection had not gone through the complaints process as outlined in the approved centre's complaints policy.

Every morning in the approved centre there was a morning "meet and greet" between the staff team and the residents. This forum was a space for the residents to voice what they would like to do for the day or any grievances.

A "Fred the Frog" suggestion box was on the wall in the main hallway of the approved centre. Residents were able to voice concerns or requests anonymously using this forum.

Every Thursday there was a community meeting held in the approved centre. The minutes of these meetings were reviewed and actioned by a member of the nursing team.

While the Area Lead for Mental Health Engagement was a member of the Cork Mental Health Management Team, this role did not involve working with the young people or their families. A Youth Advocacy Programme (YAP) that was available in other child and adolescent services, was not provided in Eist Linn at the time of inspection.

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

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 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 13: Searches	✓		✓		✓		✓		✗	High
Regulation 21: Privacy	✓		✗	Low	✗	Moderate	✗	High	✗	High
Regulation 22: Premises	✓		✓		✗	Moderate	✓		✗	Critical
Regulation 26: Staffing	✗	Moderate	✗	High	✓		✗	High	✗	Low
Regulation 29: Operating Policies and Procedures	✓		✓		✓		✗	Moderate	✗	Low
Regulation 31: Complaints Procedures	✓		✓		✓		✗	Moderate	✗	Critical
Regulation 32: Risk Management Procedures	✓		✓		✓		✗	High	✗	Critical

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent facility this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team on any matter relating to their care whilst in the approved centre.

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

One resident completed an interview with members of the inspection team and four residents completed service user experience questionnaires. All five residents indicated that they understood their care plan and were involved in setting goals for their individual care plan. All five residents indicated that they knew their mental health team and their keyworker. Four residents stated that they were able to discuss their worries or concerns with a staff member. One resident indicated that they could only sometimes discuss their worries or concerns with a staff member. All five residents stated that they were happy with how the staff spoke to them. One resident stated that they only sometimes felt able to give feedback to staff or to make a complaint. All five residents stated that they felt safe in the approved centre. All residents stated that they could communicate freely with family and friends. One resident stated that they would have liked the option of going to their bedroom more. In general, young people were not encouraged to go to their bedrooms during the day. This was addressed with the approved centre during the inspection.

The service user experience questionnaire asked those completing to score on a scale of 1 – 10 the overall care and treatment in the approved centre, 1 being poor and 10 being excellent. Two residents scored the approved centre 6 and two residents scored the approved centre 9. The two residents who scored the approved centre 6 stated that they would like more activities during the day. The two residents who scored the approved centre 9 both stated how caring and kind the staff team are.

5.2 Advocacy

The approved centre did not have an advocacy service. The Cork and Kerry Community Health Care Organisation were in negotiations with a national Youth Advocates Programme (YAP) with the aim of this national body providing an advocacy service to the approved centre in 2023.

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:

- Consultant Psychiatrist
- Occupational Therapy Manager
- Principal Clinical Psychologist
- Administrator
- Executive Clinical Director (Also Acting Clinical Director)
- Head of Speech and Language Therapy
- Maintenance Manager
- Area Director of Nursing
- CNM3
- Area Manager
- 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

The approved centre used a minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs. 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 and a source of safe, fresh drinking water was available at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. There was a stock of both male and female, day clothes, night clothes, and underwear available in an assortment of sizes in the approved centre. No resident was observed wearing night clothes during the day during the inspection.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2019. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. There was a space for residents to store property in their bedroom and presses in a filing cabinet in a locked property room which they could use for valuables. Residents were discouraged from keeping money or items of value whilst in the approved centre.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile. The approved centre had a full-time activities nurse attached to the centre. Residents could request activities at the morning meeting or weekly community meeting. Activities included therapy dogs, walks, games groups, art projects, music groups, gardening, nature outings, and visits to the beach, the animal shelter, and Fota Wildlife Park. Activities were facilitated by nurses during the weekends. These were usually off-site activities, including shopping, going for ice-cream, coffee, the beach, and Fota Wildlife Park.

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. Residents had access to the faith ministry specific to their affiliation and were provided with private space to observe any rituals upon request. Arrangements could be made to observe customs specific to diet upon request and approval by the multi-disciplinary team (MDT).

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in June 2022.

Visiting times were appropriate and reasonable, and facilitated flexibly with parents. There were no visiting restrictions on any resident at the time of inspection. Three separate areas were assigned for visiting in the approved centre, all of which facilitated residents to meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits. All the visiting areas were suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in July 2018 and due to be renewed in July 2022.

Residents in the approved centre had access to postal mail, fax, Internet including e-mail, and telephone unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Residents had access to four hand-held phones and three electronic tablets .The approved centre provided separate electronic tablets for use by residents in isolation due to COVID-19. All residents had a guardian-approved telephone contact list and could make calls at any time.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others. Residents' parents were informed when mail arrived, after which the post was given to the resident. Residents opened mail in front of a nurse in order to check for dangerous items, but no post was read or checked for content.

The approved centre was compliant with this regulation.

Regulation 13: Searches

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policies and procedures on the conducting of searches. The policy was last reviewed in February 2022, and included all requirements related to:

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

The clinical files of three residents were examined on inspection in relation to the search process. In two of the clinical files examined, there was no clear record of risk assessment taking place prior to the searches. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. All three residents consented to the searches in the episodes examined, and this was documented. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Two of the clinical files inspected did not record a reason as to why the search was being conducted. A minimum of two clinical staff were in attendance at all times during the searches. Gender sensitivity was demonstrated in the searches inspected, but due regard was not shown to the resident's dignity and privacy, as no further information was documented in two of the clinical files as to where the search was preformed, or why it was conducted. A written record of every resident and property search was not

available, as no clear record of search was documented in the files or clinical notes relating to two search episodes.

A written record was kept of all environmental searches. No illicit substances were found in the three search episodes inspected.

The approved centre was non-compliant with this regulation because two of the clinical files examined did not record a clear risk assessment or reason as to why the search was undertaken, 13(8).

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in March 2022.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an Individual Care Plan (ICP). Five ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Each weekly ICP inspected had a clear section for input from the resident and their family or carer which was amalgamated into the ICP goals. The young person's contribution was clearly evident in their care and goals. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

ICPs identified goals for the resident. Goals were clearly identified in wider areas of resident well-being such as education, health, weight, and mental well-being. The person responsible and resources required for goals were evident in all ICPs. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. All ICPs were reviewed weekly with input from the resident, their family or carer, and the comprehensive multi-disciplinary team (MDT) of the resident. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals. It was evident that the goals and treatment identified in the IPCs were changing dependent on the resident's condition and progress. The educational requirements of the residents were clearly documented in all five ICPs inspected.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. A comprehensive weekly group time schedule, which was responsive to residents' wishes, was displayed in the hallway. Programs included, Pet Therapy, Creative Writing, OT Group and Teen Life Skills. All residents' multi-disciplinary teams had a wide professional scope depending on resident needs. These included occupational therapy/senior occupational therapist (OT), dietician/senior dietician, speech and language therapist/senior speech and language therapist (SLT), psychologist/senior psychologist, clinical nurse specialist (CNS), and other professionals 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

Residents were assessed in relation to their educational requirements with consideration of their individual needs and age on admission. All residents accessed the school and education programs provided based on age and assessed needs. The school in the approved centre had four teachers and a principal. The school was closed for the summer holidays at the time of inspection.

Where appropriate to the needs and age of the resident, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities and sufficient personnel resources were available for provision of education to residents in the approved centre. The approved centre had a school on-site, with a classroom, a home economics room with cooking facilities, an art room, and a large gym.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in July 2019. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in October 2019. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans.

Two clinical files were examined in relation to the 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. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, and weight.

Residents on anti-psychotic medication received an annual assessment of their glucose regulation, blood lipids, electrocardiogram (ECG) heart function, and prolactin. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

Available national screening programmes were not applicable to the age-cohort in the approved centre.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in March 2020.

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

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were not fitted with blinds, curtains, or opaque glass. The room used to conduct assessments was in the approved centre. To enter it, the person being assessed had to walk through a high-traffic area of the unit which included the resident's day room or sitting room. The glass door and glass panel between the door and the wall were not fitted with blinds, curtains, or opaque glass in the assessment room. The sitting room was located directly beside the assessment room and this was also not fitted with blinds, curtains or opaque glass. As a result, this did not ensure that the resident's privacy and dignity was respected at all times.

Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure the resident's privacy and dignity was appropriately respected at all times, as the assessment room was only accessible by passing through the main hub of the approved centre and the assessment room was directly visible from the corridor of the approved centre.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating CRITICAL

(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

Appropriately sized communal rooms were provided by the approved centre. There was a lounge room on the ground floor and a TV room on the first floor. However, residents in the approved centre did not have access to their bedrooms or other private spaces during daytime hours. All rooms in day areas did not have suitable and sufficient heating, as a temperature of 20.5 °C was recorded in the art room in the school area. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces, subject to restricted access. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in a good state of repair externally and internally. The floor covering throughout the building was marked and scratched. The building required painting, both externally and internally. The garden area required weeding. The windows and skylight required cleaning. Mould was observed in the art room and annex room off the art room in the school. Mould was also observed in the cleaning room on the first floor. One bedroom door required replacing. There was evidence of damp on ceilings, particularly adjacent to the heating fixtures. There was staining on the ceiling in a cleaning room on the first floor. Mould and dirt were also observed in light fixtures on the first floor.

The approved centre had a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. . Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C, but the heating was not working in the art room or home economics room in the school. Current national infection control guidelines were followed. Appropriate signage, facilities, and equipment to adhere to national guidelines were observed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms are appropriately sized to address the resident needs. The approved centre did not provide suitable furnishings to support resident independence and comfort, as bedrooms were sparsely furnished with a bed, a table and one or two hard chairs, and the furniture in the rooms was marked and stained.

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

a) **The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the floor covering was marked and scratched, 22(1)(a).**
b) **The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the internal walls and ceilings required painting, 22(1)(a).**
c) **The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the glass facade, skylights and windows required cleaning, 22(1)(a).**
d) **The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the external walls required cleaning and painting, 22(1)(a).**
e) **The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the garden required weeding and cleaning, 22(1)(a).**
f) **The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because there was staining on the ceilings around the ceiling mounted radiators, 22(1)(a).**
g) **The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because there was dirt inside light fixtures in the home economics and art rooms in the school building, 22(1)(a).**

h) The registered proprietor did not ensure that the approved centre was adequately heated, as the heating system in the school was not working and the temperature was below 21 degrees in that area, 22(1)(b).
i) The registered proprietor did not ensure that the overall approved centre was adequately heated and ventilated, because there was mould on the wall and ceiling of the art room in the school and in the kids room annex off the art room, 22(1)(b).
j) The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings because resident bedrooms were sparsely furnished, the tables in the bedrooms were marked and scratched and some bed linen was stained, 22(2).
k) The registered proprietor did not ensure that the overall approved centre environment was maintained with due regard to the specific needs of the residents, because residents did not have access to personal space during the day, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in November 2021, and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPRs contained a detailed record of appropriate medication management processes, including a record of the following: a record of any (or no) allergies or sensitivities to medications, a record of medications administered to the resident and the administration route for all medications, clear records of the date of discontinuation for each medication, and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. There were no medications withheld and no crushed medications in use at the time of inspection. Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified and Scheduled 2 and 3 controlled drugs were secured separately from mediations to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in January 2022.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating LOW

(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 written policy and procedures in place relating to staffing. The policy was last reviewed in February 2019, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty at all times. A Clinical Nurse Manager 2 (CNM2) was rostered to be in charge on every shift. In the event of a CNM2 being on annual or sick leave, a senior nurse was appointed acting CNM2 for the shift. The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. During the day, one CNM2, four staff nurses and one healthcare assistant (HCA) were on duty. During the night shift, one CNM2 and three staff nurses were on duty. Allied health and social care disciplines, including one occupational therapy, three psychologists, one speech and language therapist, one dietician, and two social workers, were all accessible to residents.

All healthcare staff were trained in Fire Safety, but not all staff were trained in the Management of Violence and Aggression and Basic Life Support. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. See the table below for a breakdown of the numbers and percentages of staff trained in each of the areas:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (26)	25	97%	26	100%	18	69%	26	100%

Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%
Medical (3)	3	100%	3	100%	3	100%	3	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as just 69% of nursing staff had received training in the Management of Violence and Aggression and 97% of nursing staff had received training in Basic Life Support, 26(4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in January 2020, and included the following:

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

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

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

All operating policies and procedures were not reviewed within the required three-year time frame, as the approved centre's Communication policy was last reviewed in July 2018, making it more than three years since the last review at the time of inspection.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all written operational policies and procedures were reviewed at least every three years, as the Communication policy was last reviewed in July 2018, making it more than three years since the last review at the time of inspection.

Regulation 31: Complaints Procedures

NON-COMPLIANT

Risk Rating CRITICAL

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in October 2019, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints procedure, including how to contact the nominated person, was not publicly displayed in the approved centre, as posters gave the name of the nominated person, but no email address, phone number, or physical address was displayed.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint can be made. All complaints, whether oral or written, were not investigated promptly and handled appropriately and sensitively, as one letter of complaint was stored in a residents clinical file and was not handled in accordance with the approved centre’s complaints policy. One report containing complaints was not handled in accordance with the complaints policy or other applicable Health Service Executive policy. One complainant was unsatisfied with a proposed intervention and requested their complaint be escalated to the complaints officer, but it was not escalated.

Minor complaints were documented. All non-minor complaints were not dealt with by the nominated person and recorded in the complaints log, as one complaint that was not minor was dealt with by

someone other than the nominated person and not recorded in the complaints log. One other complaint was stored in a clinical file and not recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were not fully recorded. Some complaints were stored in the resident's clinical file and not in the complaints logs. There was no reference to complaints in the ICPs, and one letter of complaint and one report of complaint were not investigated and no outcomes were recorded.

Complainants were not informed promptly of the outcome of the complaint investigation and details of the appeals process were not made available to them. One report of complaint was responded to but not investigated, and no details of the appeals or escalation process were provided to the complainant. The registered proprietor did not ensure that the quality of service, care, and treatment was not adversely affected by reason the complaint being made, as one letter of complaint was stored in a residents clinical file.

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

a) The registered proprietor did not ensure that a nominated person was available in the approved centre to deal with complaints, because incomplete contact details for the nominated person were displayed, 31(4).

b) The registered proprietor did not ensure that all complaints were investigated promptly, as one letter of complaint was not investigated and one report of a complaint was not investigated, 31(5).

c) The registered proprietor did not ensure that all complaints were investigated promptly and handled appropriately, because one letter of complaint was stored in the residents clinical file, 31(5).

d) The registered proprietor did not ensure that all complaints were investigated promptly and handled appropriately, because one complaint was not escalated to the complaints officer despite a recorded request from the complainant for escalation of their complaint, 31(5).

e) The registered proprietor did not ensure that the nominated person maintained a record of all complaints relating to the approved centre, because one letter of complaint was not recorded and one report of a complaint was not recorded, 31(6).

f) The registered proprietor did not ensure that any resident who had made a complaint was not adversely affected by reason of the complaint being made, because one letter of complaint was stored in the resident's clinical file, 31(8).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in February 2021. The risk management policy addressed all of the requirements of the regulation, 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.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. A risk advisor was in place in the approved centre with responsibility for risk management. The risk advisor and registered proprietor had responsibility for risk and were identified and known by all staff. The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. The following health and safety risks were not recorded on the risk register: heating not working, leaks from the heating system, damaged fire doors, mould in the art room, and storing of combustible items on dryers. These health and safety risks were not identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate.

Clinical risks were identified, assessed, treated, reported, and monitored, but they were not documented in the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported and monitored by the approved centre, and they were documented in the risk register.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessment was also completed prior to and during physical restraint, resident transfer, resident discharge, and in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

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

a) **Health and Safety risks – heating not working, leaks in the heating system, damaged fire doors, mould in the art room - were not identified, assessed, treated, reported and monitored by the approved centre, 32.2.**
b) **Clinical risks were not recorded on the risk register, 32.1.**
c) **Health and Safety risks were not recorded on the risk register, 32.1.**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

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 was reviewed annually, and was last reviewed in 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.

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

Evidence of Implementation: The clinical files of three residents that had been physically restrained were examined on inspection. Physical restraint had been used in rare, exceptional circumstances and the best interest of the residents. 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 medical practitioner (RNP), registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the residents. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical flies. Orders for physical restraint lasted for a maximum of 30 minutes. A physical examination of the residents had been completed no later than three hours after the start of the episodes of restraint. The clinical practice forms (CPFs) had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the consultant psychiatrist within 24 hours. There was evidence that the residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

As soon as was practicable, and with the resident's consent, the resident's next of kin or representative was informed of the use of physical restraint in each episode. A record of this communication was placed in the clinical files. 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. Where practicable, same sex staff members were present during the physical restraint episodes.

Completed clinical practise forms had been placed in the residents' clinical files. Special consideration was given when restraining a resident who was known to the staff involved in physical restraint to have experienced sexual or physical abuse.

The residents were afforded an opportunity to discuss the episode with members of the multi-disciplinary team involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in July 2019, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in July 2019, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in July 2019 included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

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

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the general practitioner, primary care team, and community mental health team within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 13: Searches					
Reason ID : 10003338		**The approved centre was non-compliant with this regulation because two of the clinical files examined did not record a clear risk assessment or reason as to why the search was undertaken, 13(8).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• Audit held on the 14/07/2022 with a result of 84%. • All standards below 100% noted on audit spot checker. • Email sent to all CNM2s to advise them of the process. • Reg 13 Searches discussed at local policy committee meeting on 20/07/2022 and Regulatory Compliance Meeting on 22/07/2022	Next six monthly audit took place on 16/02/2023 and achieved a result of 87%	Completed	16/02/2023	CNM2's
Preventative Action	• Identify search leads from the nursing team to assist with searches/documentation and one lead has been identified to-date. • Peer learning on Regulation 13 provisionally scheduled for 7th March, 2023. • Identify a section for search rationale within the clinical file. • Reg 13	Six monthly audit scheduled for September 2023	Achievable	30/09/2023	CNM2's

	Searches on agenda for next audit meeting scheduled for 7th March, 2023.				

Regulation 21: Privacy					
Reason ID : 10003361		**The registered proprietor did not ensure the resident's privacy and dignity was appropriately respected at all times, as the assessment room was only accessible by passing through the main hub of the approved centre and the assessment room was directly visible from the corridor of the approved centre.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Privacy blind installed Audit on 27/09/2022 result 100%	Audit result	Completed	27/09/2022	Maintenance and Local Audit Committee
Preventative Action	Re-audit scheduled 27/09/2023	Audit Result	Achievable	30/09/2023	Local Audit Committee

Regulation 22: Premises					
Reason ID : 10003339	**The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the floor covering was marked and scratched, 22(1)(a). The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the internal walls and ceilings required painting, 22(1)(a). The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the glass facade, skylights and windows required cleaning, 22(1)(a). The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the external walls required cleaning and painting, 22(1)(a). The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because the garden required weeding and cleaning 22(1)(a). The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because there was staining on the ceilings around the ceiling mounted radiators, 22(1)(a). The registered proprietor did not ensure that the overall approved centre was maintained in good decorative condition, because there was dirt inside light fixtures in the home economics and art rooms in the school building, 22(1)(a). The registered proprietor did not ensure that the overall approved centre was adequately heated and ventilated, because there was mould on the wall and ceiling of the art room in the school and in the kids room annex off the art room, 22(1)(b). The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings because resident bedrooms were sparsely furnished, the tables in the bedrooms were marked and scratched and some bed linen was stained, 22(2).**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
The approved centre did not provide acceptable Corrective and Preventable Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.					
Reason ID : 10003346		**The registered proprietor did not ensure that the approved centre was adequately heated, as the heating system in the school was not working and the temperature was below 21 degrees in that area, 22(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Heating system was rectified immediately after the inspection.	Operational Heating system	Completed	18/07/2022	Area Administrator, Maintenance Officer & General Manager
Preventative Action	Schedule regular testing of heating system by Maintenance. Update from 28th Feb 2023, Plumber was on site to	Operational Heating system, Not working heating system to be re-introduced onto risk register.	Achievable	31/12/2023	Area Administrator, General Manager, Maintenance Officer

	review heating system and it was noted that some additional parts are to be ordered The plumber conducted a review of the heating system on 28th Feb 2023 and a report from him is to follow. The plumber noted on his visit that a couple of the "actuator heads" were not opening and closing, this would impact the heating system. He also noted that some of the hoses bringing the water to and from the radiators were kinked which would restrict the flow of water and also impact the efficiency of the heating system. The plumber is ordering these parts and will replace them as a priority in the next two weeks A number of electrical radiators have been installed in the building to supplement the existing system and in particular when the building is not in regular use during school holidays.				

Reason ID : 10003349		The registered proprietor did not ensure that the overall approved centre environment was maintained with due regard to the specific needs of the residents, because residents did not have access to personal space during the day, 22(3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Residents have access to upstairs bedrooms accompanied during the day Personal space is available to patients downstairs and in the garden. Access to sensory room is available under staff supervision. As a CAMHS in-patient unit supervision is required when accessing bedrooms during the day which is a challenge with current staffing levels	Access to relevant space is available on the unit.	Achievable	31/12/2023	Area Director of Nursing CAMHS, CNM2 & CNM3
Preventative Action	as above	as above	as above	31/12/2023	as above

Regulation 26: Staffing					
Reason ID : 10003367		**The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as just 69% of nursing staff had received training in the Management of Violence and Aggression and 97% of nursing staff had received training in Basic Life Support, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
The approved centre did not provide acceptable Corrective and Preventable Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.					

Regulation 29: Operating Policies and Procedures					
Reason ID : 10003350		**The registered proprietor did not ensure that all written operational policies and procedures were reviewed at least every three years, as the Communication policy was last reviewed in July 2018, making it more than three years since the last review at the time of inspection.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Communication Policy reviewed and signed off on the September 2022. An audit of all polices was conducted on the 20/12/2022 with a result of 99%.	All policies have been reviewed to ensure accuracy and appropriate approval.	Completed	30/09/2022	Local Policy Group chaired by CNS
Preventative Action	Policy schedule to track review of all policies in place. Policy group in place which meets monthly to review, standardise and update policies as required. All policy declaration sheets to be updated to record confirmation from all team members that they have read and signed policies. Timeframe for same will be the 28th of February 2023.	In addition to the Policy meetings, the unit CNM3 is responsible to checking and advising in relation to policies. Review of policies form part of the audit schedule in Eist Linn	The Policies which exist are all in date. Policy review is ongoing requirement of the service.	31/12/2023	Local Policy Group chaired by CNS.

Regulation 31: Complaints Procedures					
Reason ID : 10003352		**The registered proprietor did not ensure that a nominated person was available in the approved centre to deal with complaints, because incomplete contact details for the nominated person were displayed, 31(4). The registered proprietor did not ensure that all complaints were investigated promptly, as one letter of complaint was not investigated and one report of a complaint was not investigated, 31(5). The registered proprietor did not en sure that all complaints were investigated promptly and handled appropriately, because one letter of complaint was stored in the residents clinical file, 31(5). The registered proprietor did not ensure that all complaints were investigated promptly and handled appropriately, because one complaint was not escalated to the complaints officer despite a recorded request from the complainant for escalation of their complaint, 31(5). The registered proprietor did not ensure that the nominated person maintained a record of all complaints relating to the approved centre, because one letter of complaint was not recorded and one report of a complaint was not recorded, 31(6). The registered proprietor did not ensure that any resident who had made a complaint was not adversely affected by reason of the complaint being made, because one letter of complaint was stored in the resident's clinical file, 31(8).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	After the Inspection, the Complaints Notice updated to confirm that Ms. Jennie Synnott is the complaints officer for Eist Linn and contact number noted. Training sessions held in July, August & September 2022. ChO4 Complaints Manager facilitated an on site training session on the 15/11/2022.	Effective Complaints Process.	Complete	18/07/2022	Area Administrator
Preventative Action	.Complaints Process training listed in the Induction Policy and all HOD's have been	Audit of training and also the Area Administrator is now the nominated	Completed	31/12/2022	All Heads of Discipline

	advised that all staff must complete same on a yearly basis. To ensure all stage 2 complaints are appropriately managed the complaints Officer role has changed to the Area Administrator. Complaint made' with reference code is written in the clinical entry, no details of complaint, investigations and outcomes to be written into the clinical entry. Continue to audit every entry into the complaints log to improve compliance	complaints officer for the unit.			

Regulation 32: Risk Management Procedures					
Reason ID : 10003363		**Health and Safety risks – heating not working, leaks in the heating system, damaged fire doors, mould in the art room - were not identified, assessed, treated, reported and monitored by the approved centre, 32,2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Heating system was repaired and leak checked, Mould in the art room was treated and painted with anti - fungal paint, additional electric radiators were installed to ensure adequate heat to the room in times when the main school section of the building is not in use. Damaged doors were repaired. Minor works are complete with additional Capital funding sought for larger work orders	Full list of works compiled and actioned, regular maintenance walk-through introduced with maintenance	Achievable. Note timebound date of 31/12/2023 is contingent on receipt of Capital Funding from National.	31/12/2023	HSE Estates, Area Administrator and General Manager.
Preventative Action	Premises identified as a Risk on the local Risk register. Minor Capital request for funding submitted with proactive local maintenance developed to continue works program.	Bi-monthly cross functional walk-through completed with works prioritisation reviewed or amended to manage same	Achievable. Timebound date of 31.12.2023 is contingent upon receipt of Minor Capital funding from National.	31/12/2023	Eist Linn Management Team

Reason ID : 10003364		Clinical risks were not recorded on the risk register, 32.1 Health and Safety risks were not recorded on the risk register, 32.1.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Service has updated its Risk Register using appropriate processes to address the above.	Audit Result	Achievable	25/07/2022	Eist Linn Management Team
Preventative Action	Review of Risk Register added as a standing item to the monthly Eist Linn Management Team. All red risks reviewed on a monthly basis and all other risks reviewed every 3 months.	Audit result	Achievable	31/12/2023	Eist Linn Management Team

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.

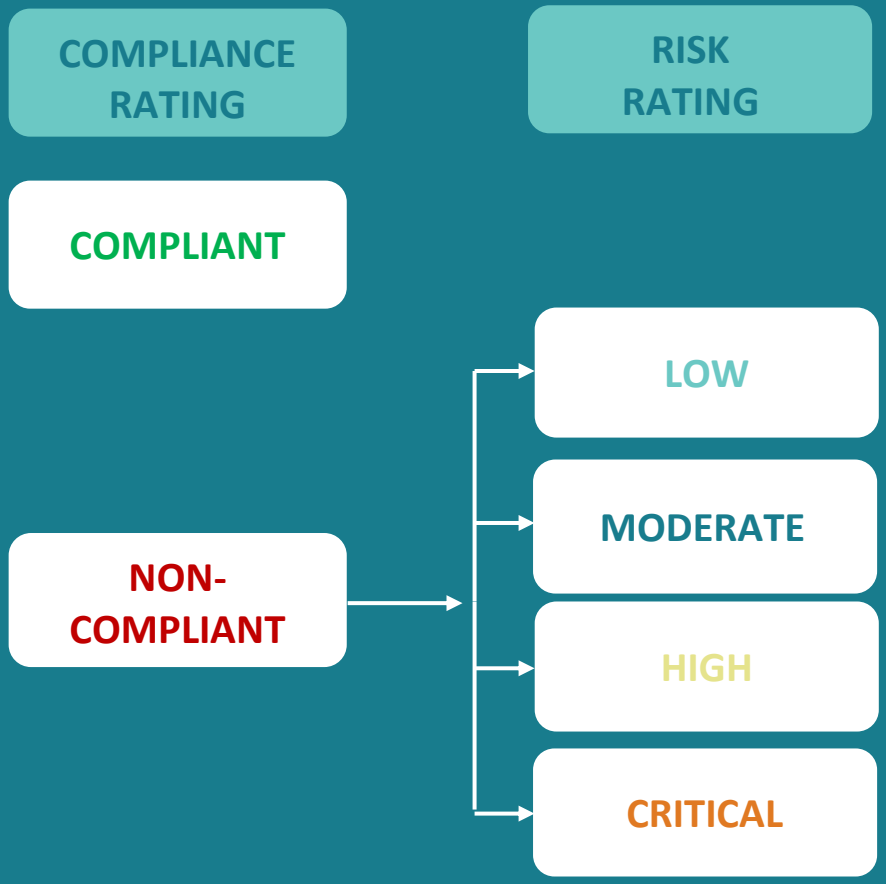
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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