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

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

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

Merlin Park University Hospital, Merlin Park, Galway

Date of Publication:
13 December 2023

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2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
9 December 2022

Registered Proprietor:
HSE

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

Inspection Team:
Sarah Jones, Lead Inspector
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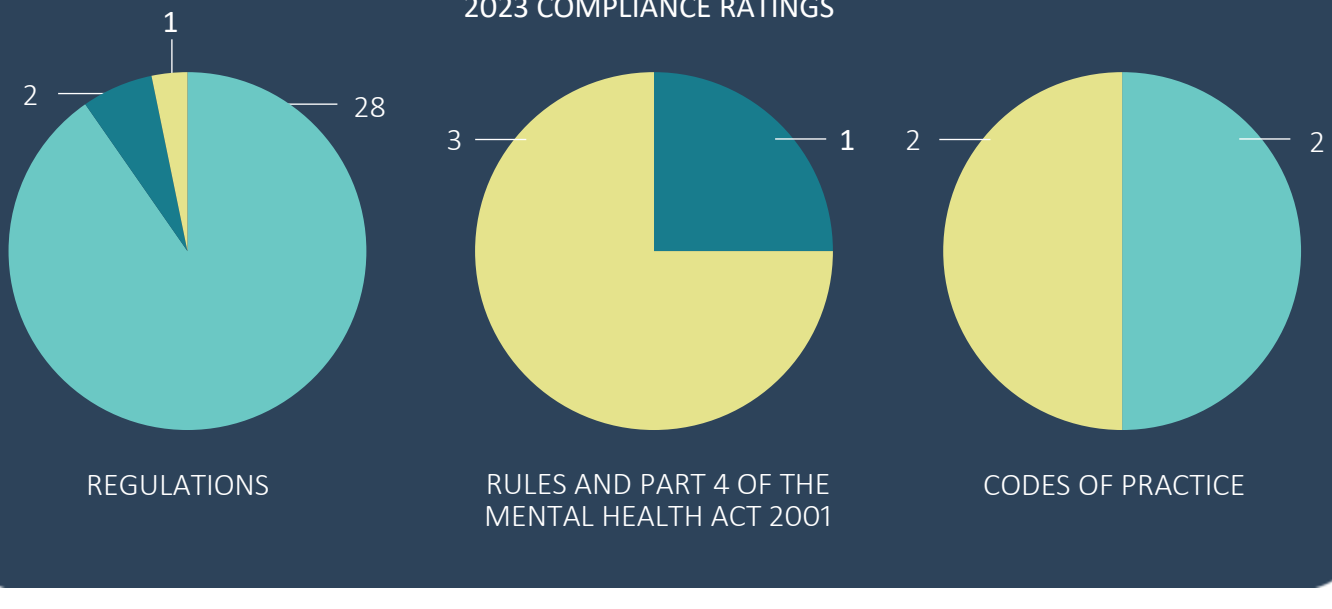
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
25 – 28 April 2023

Previous Inspection date:
26 April – 3 May 2022

Inspection Type:
Announced Annual Inspection

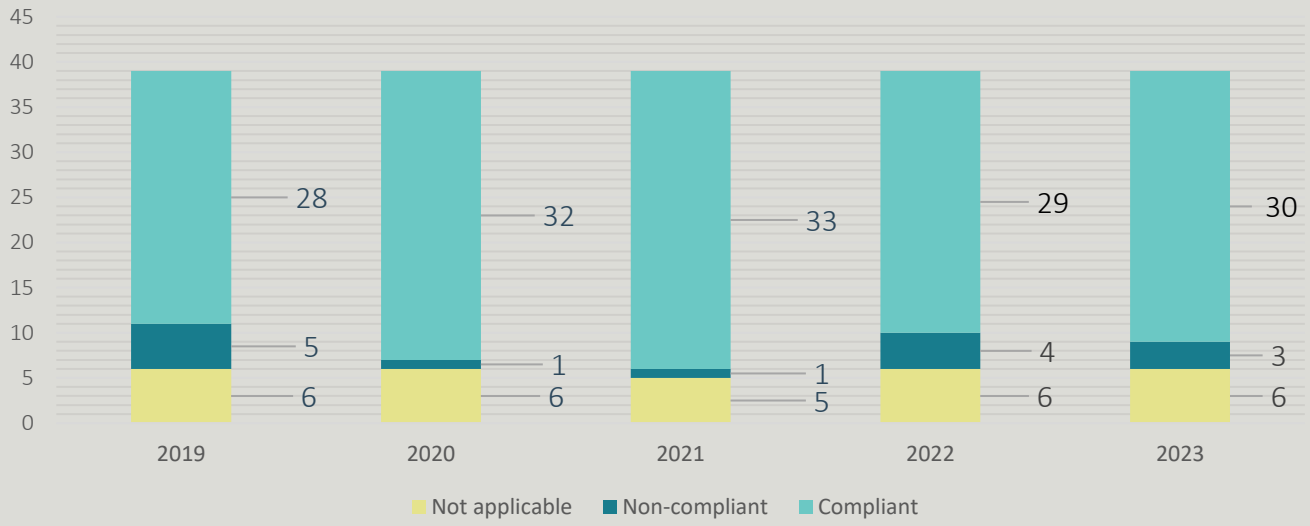
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

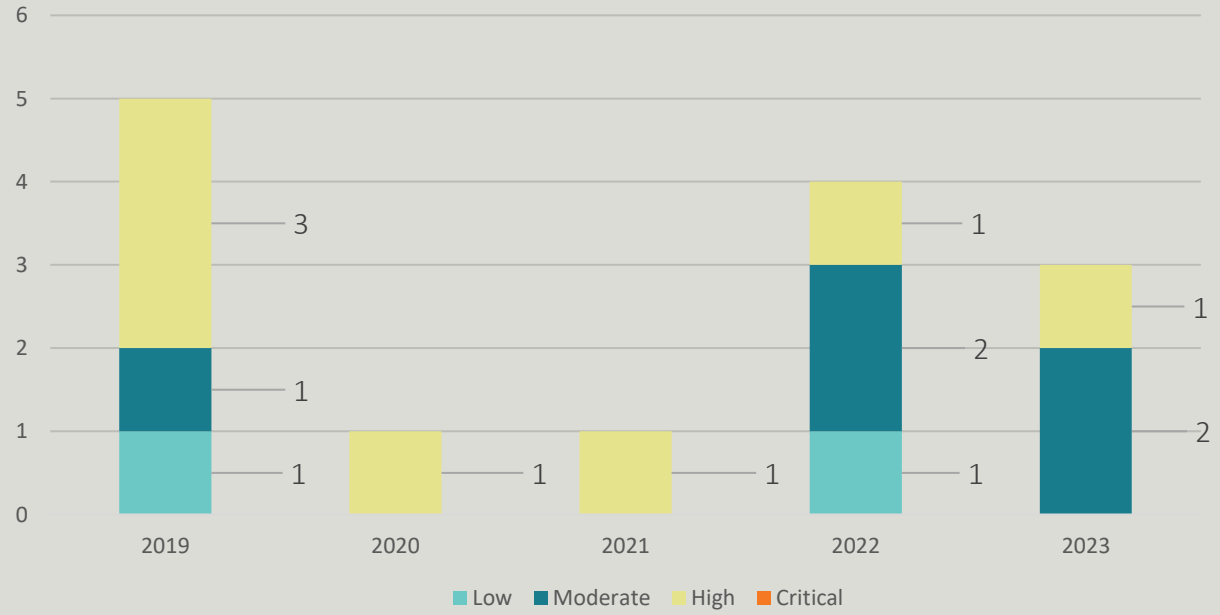
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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 2019 – 2023



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

In brief

The approved centre was located within the campus of Merlin Park University Hospital in Galway. It was a purpose-built inpatient facility for the Child and Adolescent Mental Health Service (CAMHS). The approved centre was registered for 20 beds and comprised of two individual units: Woodsend (6 beds) and The Willows (14 beds). Due to nine nursing post vacancies, the bed capacity was reduced to 14 at the time of inspection and the use of The Willows unit only. Bed capacity for the previous three months prior to inspection indicated there were no more than ten young people residing in the unit on any given day.
The Willows incorporated a high dependency suite, with three bedrooms. A seclusion facility was also located in the Willows. This was separate from the high dependency suite.
The approved centre had two multi-disciplinary teams (MDTs). It served the catchment area of Clare, Limerick, North Tipperary, Galway, Roscommon, Mayo, Sligo, Leitrim, and Donegal and was also a national referral centre.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	85%	97%	97%	88%	91%

Conditions to registration

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

Conditions	Findings
Condition 1: *Condition: The Health Service Executive must implement the costed, funded and timebound plan for the new seclusion room submitted to the Mental Health Commission on 3 November 2022.*	The approved centre was not in breach of Condition 1 at the time of inspection. The approved centre had one condition attached to its registration with the Mental Health

The approved centre shall provide a progress update on the costed, funded and timebound plan to the Mental Health Commission in a form and frequency prescribed by the Mental Health Commission.	Commission, which pertained to the use of the seclusion facility. The Rule on the Use of Seclusion was a reoccurring non-compliance, which had been assigned a high-risk rating since 2018. The non-compliance applied to the structure of the seclusion facility. The Mental Health Commission had received the approved centre's costed, funded and time-bound plan to replace the current seclusion facility. This is planned to commence in June 2023 and the provisional completion date within the first quarter of 2024.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

The approved centre demonstrated that they provided safe care in the following areas:

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** A high number of staff were trained in fire safety, safeguarding, basic life support, management of violence and aggression, and the Mental Health Act. More training requires to be completed.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Safeguarding:*** Staff were aware of safeguarding procedures.
- ***Access to essential information*****:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Alarms*****:** Staff were provided with alarms that were in working order.

- ***Infection control*:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:
Ligature anchor points: Ligature anchor points were not minimised to the lowest level, based on individual risk assessment.

Appropriate care and treatment of residents

The approved centre demonstrated that they provided appropriate care and treatment in the following areas:

- **Appropriateness of environment:** The layout and the decoration of the approved centre met the needs of the young people. New furniture was evident throughout the approved centre. Residents within The Willows had access to internal courtyards and a large well-kept garden.
- ***Initial assessments**:* All young people had a comprehensive initial assessment on admission.
- ***Physical assessment**:* Each young person had a physical examination on admission. Young people had access to the local hospital for assessment and any treatment required.
- ***Individual care plans:*** Each young person had an individual care plan that documented their needs; goals that had been decided with the young person's input; and appropriate interventions to address those goals. There was evidence of significant engagement with the young people in respect of their ICP. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** There were two multi-disciplinary teams. Each team included a consultant psychiatrist, social worker, psychologist, dietitian, and nursing staff. Both teams utilised one occupational therapist. The speech and language therapy post was vacant at the time of inspection. There were nine nursing vacancies for the approved centre at the time of inspection.
- ***Therapeutic interventions:*** The young people had access to occupational therapy (OT), social work, and clinical psychology dietetics, physiotherapy, and speech and language therapy on an individual basis as required. The attendance and progress at the various therapeutic services and programmes were evaluated at the weekly MDT meetings. Individual care plans were updated to reflect the residents' progress.

  The approved centre's therapeutic services and programmes included pet therapy, a life skills group, a wellness recovery action plan (WRAP) group, a decider skills group, a self-esteem group, a relaxation group, an anxiety management group, an interpersonal skills group, an art therapy group, a health promotion group, a compassion focus group, a self-care group, a Tibetan sound bowls group, and a social club for young people with an eating disorder. There was also a parents support group.
- ***Access to other medical services:*** Specialist therapeutic interventions were provided if required.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

Respect for residents' privacy, dignity and autonomy

The approved centre demonstrated that they respected young people's privacy, dignity and autonomy in the following areas:

- ***Sleeping accommodation:*** Woodsend was a six bedded facility with one double bedroom and four single bedrooms. The Willows accommodated up to fourteen young people within two double bedrooms and ten single bedrooms.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the young people. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the young person's condition or treatment needs.
- ***Privacy and dignity:*** There was evidence that young peoples' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and young people were facilitated to make private calls. Noticeboards did not show young peoples' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the young person could go if they wanted privacy as well as areas for socialising. Clinical files were securely stored.
- ***Use of restrictive practices:*** At the time of the inspection, four episodes of physical restraint occurred since January 2023. Staff had carefully considered the use of physical restraint in the circumstances and risk assessments had been completed. All the elements required by the new rule were evident within the clinical file. No occurrences of mechanical restraint or seclusion occurred since the previous inspection. The seclusion room was due to be replaced, starting in June 2023 as it was not fit for purpose.
- ***Rights-based care:*** The young people were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

Responsiveness to residents' needs

The approved centre demonstrated that they were responsive to people's needs in the following areas:

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. 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.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.

- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: The activities programme included gardening groups, upcycling activities, arts and crafts, forest bathing/walks, circuit training, Dance Fit, and Couch to 5K (a running programme for beginners). Weekly outings included cinema, bowling, the aquarium, shopping, summertime barbeques, and an annual sports day. Other activities included music, TV, badminton, soccer, tennis, basketball, football, table tennis, pool, football, board games, jigsaws, quizzes, and outdoor games. The activities coordinator reviewed the activities schedule with resident participation on a regular basis. Young people had access to an occupational therapy (OT) kitchen, OT group room, quiet rooms, activity rooms, a gym, garden, and playground.
- ***Support groups:*** Bodywhys (Eating Disorders Association of Ireland) group was available to parents and carers of the young people.
- ***Young Peoples' feedback:*** The young people were very complimentary about the environment and the care they received. They found their rooms comfortable and were happy with the staff, the food, the activities and privacy to make phone calls. No concerns were voiced. All young people felt safe, could communicate freely, and were happy with how staff spoke with them. All young people reported they knew what their individual care plan was and three indicated they sometimes were involved in setting goals, all individuals reported they knew who their keyworker was. All reported they felt there were enough activities during the day. Three young people indicated they did not know how to make a complaint.

Governance, Leadership and Accountability

The approved centre had the following governance structures and processes in place:

- ***Structure in place:*** The approved centre was part of Community Healthcare West, Galway Roscommon Mental Health Service and the governance structure encompassed two core monthly meetings: an Area Management Team meeting and a Quality and Patient Safety (QPS) meeting. Membership for both meetings included relevant heads of service and discipline. An Area Quality and Patient Safety committee, which meets monthly, reported into the Area Management Team. Within the approved centre, governance was further enhanced by local business meetings.
- ***Leadership:*** An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. There was evidence of strong leadership within the service.
- ***Clinical governance:*** The approved centre had an established program of audit towards continuous quality improvement.
- ***Restrictive practices reduction:*** A new restrictive practices policy and a suite of policies relating to seclusion, physical restraint and mechanical restraint commenced in March 2023, following the commencement of the new rules and codes from 1st January 2023. The registered proprietor had appointed a senior manager responsible for the approved centre's reduction in restrictive practices.

- ***Risk:*** The approved centre had a standardised process for the management of risks and incidents. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. Risks were identified, assessed, treated, reported, and monitored. Identified risks were documented in the risk register.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement.
- ***Policies:*** All policies were up-to-date.
- ***Complaints***: The approved centre's complaints process was publicised and accessible to young people and their representatives. No formal complaints had been submitted since the last inspection.
- ***Staff training:*** Training had been undertaken by clinical staff, including behavioural family therapy, trauma-informed practice development, cognitive behavioural therapy skills, venipuncture and wound care to enhance skills and practices for care and treatment of young people.
- ***Residents' involvement:*** Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement.
- ***Advocacy services:*** The approved centre worked with the Youth Advocate Programme (YAP). YAP did not raise any concerns voiced by the young people and informed the inspection team the young people were happy with the increased activities, especially during the weekends.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last 5 years of 92% .The approved centre had one condition attached to its registration with the Mental Health Commission, which pertained to the use of the seclusion facility. The condition was not breached.

However:

Staff training: Not all staff disciplines had completed mandatory training in fire safety and the management of violence and aggression.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A new sensory room was in progress at the time of inspection with a planned completion date in summer 2023.

2. The reception area was redeveloped with new furniture and a coffee machine, directed under the trauma informed committee to provide a welcoming space.

3. New vehicles were procured for the young people to support outings.

4. A therapy dog was reintroduced that attends weekly.

5. Training had been undertaken by clinical staff, including behavioural family therapy, trauma-informed practice development, cognitive behavioural therapy skills, venipuncture and wound care to enhance skills and practices for care and treatment of young people.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

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

The approved centre consisted of 20 beds. Woodsend was a six bedded facility with one double bedroom and four single bedrooms. The Willows accommodated up to fourteen young people within two double bedrooms and ten single bedrooms. Due to nine nursing post vacancies, the bed capacity was reduced to 14 at the time of inspection and the use of The Willows unit only.

Residents within The Willows had access to internal courtyards and a large well-kept garden. The Willows incorporated a high dependency suite, with three bedrooms. A seclusion facility was also located in the Willows. This was separate from the high dependency suite.

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

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**7**
Number of detained patients	2
Number of wards of court	0
Number of children	7
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Community Healthcare West, Galway Roscommon Mental Health Service. The Galway Roscommon Mental Health Service governance structure encompassed two core

monthly meetings: an Area Management Team meeting and a Quality and Patient Safety (QPS) meeting. Membership for both meetings included relevant heads of service and discipline. An Area Quality and Patient Safety committee, which meets monthly, reported into the Area Management Team. Standing agenda items for the Area Management Team Meeting included: finance, human resources, QPS, health and safety, service user engagement and COVID-19. Within the approved centre, governance was further enhanced by local business meetings. An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.

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

The Child and Adolescent Mental Health Service (CAMHS) inpatient service comprised of two multi-disciplinary teams. Each team included a consultant psychiatrist, social worker, psychologist, dietitian, and nursing staff. Both teams utilised one occupational therapist. The speech and language therapy post was vacant at the time of inspection. There were nine nursing vacancies for the approved centre at the time of inspection. Therefore, the bed capacity was reduced from 20 to 14 to accommodate this alongside the use of overtime and agency nursing staff, when required. Bed capacity for the previous three months prior to inspection indicated there were no more than ten young people residing in the unit on a given day. Not all staff disciplines had completed mandatory training in fire safety and the management of violence and aggression.

Governance questionnaires were returned to the inspection team by the executive clinical director, principal social worker, psychology director, the acting area director of nursing, speech and language therapy manager in Primary Care and the manager of dietetics. There was no OT manager in post at the time of inspection, however, this post was being managed by the general manager for administrative purposes. Clinical supervision was provided to the occupational therapist by an independent senior occupational therapist on a contractual basis. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. However, as there is no dedicated CAMHS Speech and Language Therapy manager, the primary care manager for SLT was responsible for clinical line management and supervision only. Performance was measured through the regular review of key performance indicators; comments, compliments and complaints; incident reports and audit findings. The approved centre's policies were developed by the Policies, Procedures, Protocols and Guidelines (PPPG) committee. The approved centre had an established program of audit towards continuous quality improvement.

A new restrictive practices policy and a suite of policies relating to seclusion, physical restraint and mechanical restraint commenced in March 2023, following the commencement of the new rules and codes from 1st January 2023. The registered proprietor had appointed a senior manager responsible for the approved centre's reduction in restrictive practices. At the time of the inspection, four episodes of physical restraint occurred since January 2023. Staff had carefully considered the use of physical restraint in the circumstances and risk assessments had been completed. All the elements required by the new rule were

evident within the clinical file. No occurrences of mechanical restraint or seclusion occurred since the previous inspection.

The approved centre had one condition attached to its registration with the Mental Health Commission, which pertained to the use of the seclusion facility. The Rule on the Use of Seclusion was a reoccurring non-compliance, which had been assigned a high-risk rating since 2018. The non-compliance applied to the structure of the seclusion facility. The Mental Health Commission had received the approved centre's costed, funded and time-bound plan to replace the current seclusion facility. This is planned to commence in June 2023 and the provisional completion date within the first quarter of 2024.

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

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 2019 and 2023 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 22: Premises	✗	High	✓		✓		✗	Moderate	✗	Moderate
Regulation 26: Staffing	✗	High	✓		✓		✗	Moderate	✗	Moderate
Rules on the Use of Seclusion	✗	High	✗	High	✗	High	✗	High	✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent facility, this code of practise was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. 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.
- The Youth Advocacy Programme representative was contacted to obtain residents' feedback about the approved centre.

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

Inspectors spoke with three young people. Young people found their rooms comfortable and were happy with the staff, the food, the activities and privacy to make phone calls. No concerns were voiced.

Four questionnaires were received with overall very positive feedback. All respondents felt safe, could communicate freely, and were happy with how staff spoke with them. All individuals reported they knew what their Individual Care Plan was and three indicated they sometimes were involved in setting goals, all individuals reported they knew who their keyworker was. All reported they felt there were enough activities during the day. Three young people indicated they did not know how to make a complaint. On a scale of one - ten, ten being excellent, respondents scored their experience of the care and treatment a six respectively.

5.2 Advocacy

The approved centre had an advocacy service. The approved centre worked with the Youth Advocate Programme (YAP). YAP did not raise any concerns voiced by the young people and informed the inspection team the young people were happy with the increased activities, especially during the weekends.

6.0 Feedback Meeting

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

- Executive Clinical Director
- General Manager
- Clinical Nurse Manager III
- Acting Area Director of Nursing
- Principal Social Worker
- Business Manager
- Senior Psychologist
- Senior Social worker
- Director of Nursing
- Consultant Psychiatrist x 2
- Dietitian manager
- Senior Psychologist
- Activation Nurse
- Catering Manager
- Clinical Nurse Manager II
- Clinical Nurse Manager II
- Senior Registrar

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 which were 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. 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. Lunch and evening meals were delivered from St. Francis Home. 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. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in April 2021. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. Each resident had a locked cupboard in the property room to hold personal property. The approved centre also provided a safe where resident valuables could be stored.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. The activities programme included gardening groups, upcycling activities, arts and crafts, forest bathing/walks, circuit training, Dance Fit, and Couch to 5K (a running programme for beginners). Weekly outings included cinema, bowling, the aquarium, shopping, summertime barbeques, and an annual sports day. Other activities included music, TV, badminton, soccer, tennis, basketball, football, table tennis, pool, football, board games, jigsaws, quizzes, and outdoor games. The activities coordinator reviewed the activities schedule with resident participation on a regular basis. Residents had access to an occupational therapy (OT) kitchen, OT group room, quiet rooms, activity rooms, a gym, garden, and playground.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable.

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

Visiting times were appropriate and reasonable. The gym, corner room, and life skill room were used for visiting. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents did not have access to their personal mobile phones, but a landline phone was available in the nurses' office and quiet room, and a mobile phone was provided for resident use. It was the approved centre's policy that 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. There was no restriction on communication for any resident at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. As per the approved centre's search policy, routine searches were conducted on all residents when they returned from leave and from visits. The approved centre's search policy was based on the requirement to maintain a safe and therapeutic environment for all residents, but this process did not include an assessment of individual risk. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due

regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Five ICPs were inspected. All 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. 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. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident on a weekly basis. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The 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). Residents had access to occupational therapy (OT), social work, and clinical psychology on an individual basis as required. Clinical files examined on inspection also showed evidence of the provision of dietetics, physiotherapy, and speech and language therapy as required. Therapeutic services and programmes were delivered on an individual or group basis by the multi-disciplinary team (MDT) and staff in the activities department. Residents' attendance and progress at the various therapeutic services and programmes were evaluated at the weekly MDT meetings. Individual care plans were updated to reflect the residents' progress.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. The recovery-orientated therapeutic programme was facilitated by appropriately qualified professionals. The therapeutic activity programme was planned, delivered and co-ordinated by the MDT. It included pet therapy, a life skills group, a wellness recovery action plan (WRAP) group, a decider skills group, a self-esteem group, a relaxation group, an anxiety management group, an interpersonal skills group, an art therapy group, a health promotion group, a compassion focus group, a self-care group, a Tibetan sound bowls group, and a social club for residents with an eating disorder. There was also a parents support group and a Bodywhys (Eating Disorders Association of Ireland) group available to parents and carers of the young people. The multi-disciplinary therapeutic programme was reviewed on a continuous basis with staff and residents through written and verbal feedback.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

All the young people admitted to the approved centre were assessed in relation to their educational requirements with consideration of their individual needs and age on admission. Residents were referred for enrolment in the school by the multi-disciplinary team (MDT). All the young people had an Individual Education Plan (IEP) and were allocated a key teacher who coordinated their attendance at the education curriculum as documented in their IEP.

Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. A daily record of work was completed in each class and evaluation of the young person's presentation was maintained and recorded in the student's education file. The young person's attendance was recorded in their clinical file. A progress report on each student was written weekly and recorded in their individual care plan.

Appropriate facilities were available for provision of education to child residents in the approved centre: there were four classrooms in the school. Sufficient personnel resources were allocated to the education of child residents in the approved centre: the educational staff team comprised four teachers, four special needs assistants, and two social care workers.

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 June 2020. 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 March 2022. 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. Residents' general health needs were monitored and assessed as indicated by their specific needs. There were no residents in the approved centre for six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access the national screening programme of retina check (for diabetics only), where applicable to their needs.

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 July 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, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to 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

COMPLIANT

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

INSPECTION FINDINGS

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

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 fitted with blinds, curtains, or opaque glass. 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 compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. 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. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points, however, were not minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. Rooms in the approved centre had underfloor heating. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs, and furnished to support resident independence and comfort.

The approved centre was non-compliant with this regulation because ligature points were not minimised to the lowest practicable level, based on risk assessment, 22 (4).

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; 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, and included the signature of the medical practitioner or nurse prescriber for each entry. 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. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified, and Scheduled 2 and 3 controlled drugs were secured separately from other medications to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

The inspection found that there were clear signs in prominent positions where CCTV cameras were utilized throughout the approved centre. The approved centre's use of CCTV was disclosed to residents, residents' representatives, and the Mental Health Commission. CCTV in the approved centre were incapable of recording or storing a resident's image on tape, disc, or hard drive.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in September 2022, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. 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.

There were two multi-disciplinary teams both consisted of medical, nursing, social work, psychology and dietetics. Both teams utilised one occupational therapist. There was a vacancy for speech and language therapy at the time of inspection however cross cover was available.

Not all healthcare staff were trained in Fire Safety, and the Management of Violence and Aggression. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (33)	33	100%	32	97%	31	94%	33	100%

Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%
Medical (2)	1	50 %	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%
Other MDT; Dietetics (2)	2	100%	2	100%	2	100%	2	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 not all staff were up to date with mandatory training in Fire Safety and the Management of Violence and Aggression, 26 (4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in March 2023, 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 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

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. No formal complaints had been received by nominated person since the last inspection. The registered proprietor ensured that the quality of service, care, and treatment was not adversely affected by reason of the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in July 2020, and included the following:

- 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. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

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 assessments were also completed in conjunction with medication requirements or administration, and prior to and during

resident seclusion, physical restraint, resident transfer, and resident discharge. 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 compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in three separate locations: in the main reception of the approved centre, and in the window of the nurse's station at the entrances to both the Willows and Woodsend units.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was last reviewed in March 2023.

The policy addressed the following:

- Who may initiate, and who may carry out, seclusion.
- The provision of information to the resident, including information about the resident's rights, presented in accessible language and format.
- The safety, safeguarding and risk management arrangements that must be followed during any episode of seclusion.

The approved centre had a policy on the reduction of seclusion (*Restrictive Practice Reduction Strategy*). It was last reviewed in March 2023, and addressed the following:

- Clear documentation of how the approved centre aims to reduce or, where possible eliminate, the use of seclusion.
- The role of leadership and the use of data to inform practice, the specific reduction tools in use, the development of the workforce, and the use of post incident reviews to inform practice.
- How the approved centre planned to provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion.

The policy and procedures for training all staff involved in seclusion documented who would receive training (based on the identified needs of persons who are secluded and staff), and the identification of appropriately qualified persons to give the training.

The areas addressed in the training included the following:

- Trauma Informed Care.
- Cultural Competence.
- Human rights, including the legal principles of restrictive practices.
- Positive Behaviour support, including the identification of causes or triggers of the resident's behaviours).
- Alternatives to seclusion or/restraint.

Evidence of Implementation:

There had been no episodes of seclusion since the last inspection.

Seclusion Facilities: The seclusion facilities were furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's privacy was respected. The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There were no ligature points or electrical fixtures. The room allowed for staff to clearly observe a resident in the seclusion room when in use.

The seclusion room did not have an anti-barricade door. The seclusion room did not have externally controlled heating and air conditioning, which meant that those observing a resident could not monitor the room temperature.

The seclusion room had limited furnishings, which included a pillow, mattress, and a blanket or covering, all of which met current safety requirements. The room was large enough to support a resident and staff who may be required to use physical interventions during transition to seclusion. There was a clock displaying the time, day and date available for a residents use. As far as practicable, the seclusion room was in an area away from communal sitting rooms and the main sleeping accommodation.

The seclusion facilities did not have access to suitable showering/bathing facilities. All furniture and fittings in the seclusion room were not of such a design and quality as ensure the safety of a resident in seclusion, due to hard flooring. Seclusion facilities were not used as bedrooms. Bedrooms were not used as seclusion facilities.

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

a) **The seclusion room did not have externally controlled heating and air conditioning to enable those observing the resident in seclusion to monitor the room temperature, 8.1 (v).**
b) **The seclusion room did not have an anti-barricade door, 8.1 (iii).**
c) **The seclusion suite did not provide access to suitable sanitary facilities, 8.2.**
d) **The seclusion room was not of a design and quality as not to endanger the safety of a resident in seclusion, 8.3.**

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 *Physical Restraint and the Management of Aggression and Violence* policy was last reviewed in March 2023, and included a policy on the reduction of restrictive practices. The main policy addressed the following:

- The provision of information to the person which should include information about the resident's rights presented in accessible language and format.
- Information regarding who can initiate and who may carry out physical restraint.
- Information regarding the safety, safeguarding and risk managements that should be followed during an any episode of physical restraint.

Policies and procedures regarding staff training included the following:

- Who will receive training based on the identified needs of residents who are restrained and staff.
- The identification of appropriately qualified person(s) to give the training.
- The mandatory nature of training for those involved in physical restraint.

The areas to be addressed within the training programme were specified, and they included the following:

- The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
- Alternatives to physical restraint.
- Trauma informed care.
- Cultural competence.
- Human rights, including the legal principles of restrictive interventions.
- Positive behaviour support, including the identification of causes or triggers of the person's behaviours (social, environmental, cognitive, emotional, or somatic).
- The monitoring of the safety of the person during and after the physical restraint.

The approved centre's policy on the reduction of restrictive practices addressed the following:

- Clear documentation of how the approved centre aims to reduce, or where possible eliminate, the use of physical restraint.
- The role of leadership and the use of data to inform practice, specific reduction tools in use, and the use of post incident reviews to inform practice.
- How the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint.

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. All staff who participate, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures. Mandatory training was delivered every 12 months at a minimum. A record of attendance at training was maintained.

Monitoring: The approved centre had a multi-disciplinary review and oversight committee, responsible for the following:

- To determine if there was compliance with the code of practice on the use of physical restraint for each episode reviewed.
- To determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint.
- To identify and document any areas for improvement.
- To identity the actions, the persons responsible, and the timeframes for completion of any actions.
- To produce a report following each meeting of the review and oversight committee which should be available to the Mental Health Commission upon request.

Evidence of Implementation: Three separate episodes of physical restraint, all three involving the same resident, were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN) in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there were no other less restrictive methods available to manage the resident's presentation. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the resident had been completed no later than two hours after the start of each episode of restraint.

In one of the three episodes, the physical restraint was extended by a renewal order for a period which did not exceed ten minutes, with the continuous period of restraint not exceeding 30 minutes. This episode of physical restraint, the reasons were renewing the order, and the time that the medical examination took place, were clearly recorded in the clinical file. The other two orders for physical restraint lasted for a maximum of 10 minutes. The clinical practice forms 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.

The resident was informed of the reasons for, and the circumstances which would lead to the discontinuation of physical restraint, unless the provision of such of information was prejudicial to the resident's mental health, well-being, or emotional condition. This was recorded in the resident's clinical file as soon as was practicable.

In accordance with the resident's wishes and their individual care plan (ICP), the resident's representative was informed of the episodes of physical restraint as soon as was practicable. This was recorded in the resident's clinical file. The Mental Health Commission was notified via Comprehensive Information System (CIS) of the start time and date, and the end time and date, of each episode of physical restraint in the correct format and within three days of each episode.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the resident's ICP pertaining to the person's specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy.

The person was continuously assessed throughout the uses of restraint to insure their safety, and there was documented evidence that:

- The resident's head and neck were protected and supported where necessary.
- The resident's airway and breathing was not compromised.
- The resident's physical and psychological health was monitored for as long as clinically necessary after using physical restraint.

Ending of Physical Restraint: The physical restraint in each instance was ended by the person who had lead it. The time, date, and reason for ending the physical restraint was recorded in the clinical file on the date that each episode ended. An in-person debrief with the resident followed each episode of physical restraint. The resident was given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. This occurred within two working days of each episode of physical restraint, unless it was the preference of the resident to have the debrief outside of this timeframe.

The debrief included:

- A discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future.
- A discussion regarding the resident's preferences in the event where a restrictive intervention is needed in the future, for example preferences in relation to which restrictive intervention they would not like to be used.

The resident's ICP was updated to reflect the outcome of the debrief, noting in particular the resident's preferences in relation to restrictive interventions going forward. There was a record of all attendees who were present at the debrief and this was included in the clinical file. Appropriate emotional support was provided to the resident following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

Recording of the Use of Physical Restraint: The episodes of restraint were recorded in the clinical file. The episodes of restraint were clearly recorded in the clinical practice form in accordance with Provision 3.7. There was a copy of the clinical practice form in the clinical file and it was available to the Mental Health Commission on request.

Clinical Governance: The episodes of physical restraint were reviewed by members of the multi-disciplinary team within five working days from the date of each episode. The review included the following:

- The identification of the trigger events which contributed to the restraint episode.

- A review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support.
- The identification of alternative de-escalation strategies to be used in future.
- The duration of the restraint episode and whether this was for the shortest possible duration.
- Consideration of the outcomes of the person-centred debrief, if available.
- An assessment of the factors in the physical environment that may have contributed to the use of restraint.

The multi-disciplinary team recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

Children: There was evidence of a documented risk assessment pertaining to physical restraint on admission by a registered medical practitioner or registered nurse. The risk assessment included a determination as to determine whether physical restraint could be safely used or not.

As the resident was a child, the reasons for, and the circumstances leading to the discontinuation of restraint were explained in a way that they could understand and in a format that was appropriate to their age. A record was maintained of this communication, and it clearly outlined how it met the child's individual communication needs. The child's parent or guardian was informed as soon as possible of the child's physical restraint and the circumstances which led to the child being physically restrained. The approved centre had child protection policies and procedures in place which were in line with relevant legislation and regulations made thereunder. The approved centre had a policy and procedures in place addressing appropriate training for staff in relation to child protection.

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

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

Discharge: The discharge policy, which was last reviewed in May 2020 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, 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, risk assessment, 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 risks and early warning signs of relapse, and documented communications with the relevant healthcare

provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

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 relevant healthcare provider 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 22: Premises					
Reason ID : 10004098		**Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(4)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	TV in Willows lounge had been updated , now produced a ligature risk, and same was not placed on ligature audit . Ligature risk has been identified on the ligature audit Staff are aware of same Risk is in an area of constant staff supervision and locked when not in use	Audit	Achievable- no barriers	30/05/2023	Rory Conway CNM2
Preventative Action	Ligature audit is dynamic not static, must be updated as the environment changes, staff completing audits to be aware of this	Audit as required	Achievable	30/05/2023	Rory Conway CNM2

Regulation 26: Staffing					
Reason ID : 10004099		**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 not all staff were up to date with mandatory training in Fire Safety and the Management of Violence and Aggression, 26 (4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To continue to offer out mandatory training to all staff Staff that are out of date to be invited and prioritised to attend mandatory training Staff given opportunities to attend- release from duty etc when safe to do so	Ongoing - continuous offering of training to staff , checking the training register frequently and continuous prompting to staff that are out of date of mandatory training	Barriers include despite numerous training opportunities staff still do not attend training	30/03/2024	Rachel O' Shaughnessy CNM3
Preventative Action	Check in with staff that are not attending to ascertain reasons for same	Ongoing	Barriers include despite numerous training opportunities staff still do not attend training	30/03/2024	Rachel O' Shaughnessy CNM3 or relative line manager

Rules Governing the Use of Seclusion					
Reason ID : 10004094		**The seclusion room was not of a design and quality as not to endanger the safety of a resident in seclusion, 8.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New seclusion room build currently underway which will address the design and quality of the seclusion room	Ongoing until build is completed	Currently underway, achievable	30/01/2024	Registered Proprieter Steve Jackson
Preventative Action	Delays to the works due to weather restrictions, but overall result will be compliant	Ongoing	No barrier to implementation, just delays to end dates due to unforeseen circumstances ie weather etc	30/01/2024	Registered Proprieter Steve Jackson
Reason ID : 10004095		**The seclusion suite did not provide access to suitable sanitary facilities, 8.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New Build currently underway to address the area of non - compliance	Ongoing	Achievable as ongoing all costings and design have been approved	30/01/2024	Registered Proprietor Steve Jackson
Preventative Action	Delays in completion on projected date due to unforeseen circumstances	Ongoing	Build will be complete and is achievable	30/01/2023	Registered Proprietor Steve Jackson
Reason ID : 10004096		**The seclusion room did not have externally controlled heating and air conditioning to enable those observing the person to monitor the room temperature, 8.1 (v).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New build currently underway to address the area of non compliance	ongoing- fortnightly meeting between service contractors and architects	Achievable only barrier may be Delays in the projected completion time due to unforeseen circumstances ie	30/01/2023	Registered Proprietor Steve Jackson

			weather storms heavy rainfall		
Preventative Action	Ongoing meeting to gain updates of where the build is at in terms of timelines and plans	Ongoing communication with Link person	Achievable	30/01/2024	Registered Proprietor Steve Jackson
Reason ID : 10004097		**The seclusion room did not have an anti-barricade door, 8.1(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Current new build will address this area of non compliance	Ongoing fortnightly meetings with Service, contractors, architects and project leads	Achievable	30/01/2023	Registered Proprietor Steve Jackson
Preventative Action	None	Ongoing	Achievable	30/01/2023	Steve Jackson Registered Proporieter

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.

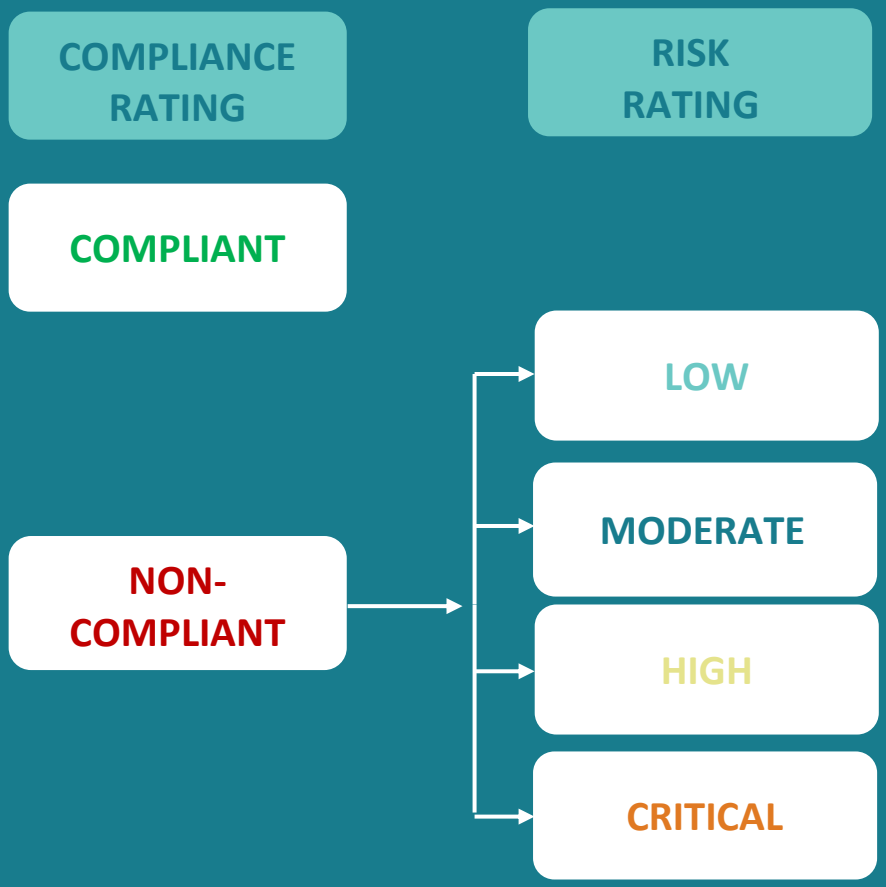
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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