Eist Linn Child & Adolescent In-patient Unit

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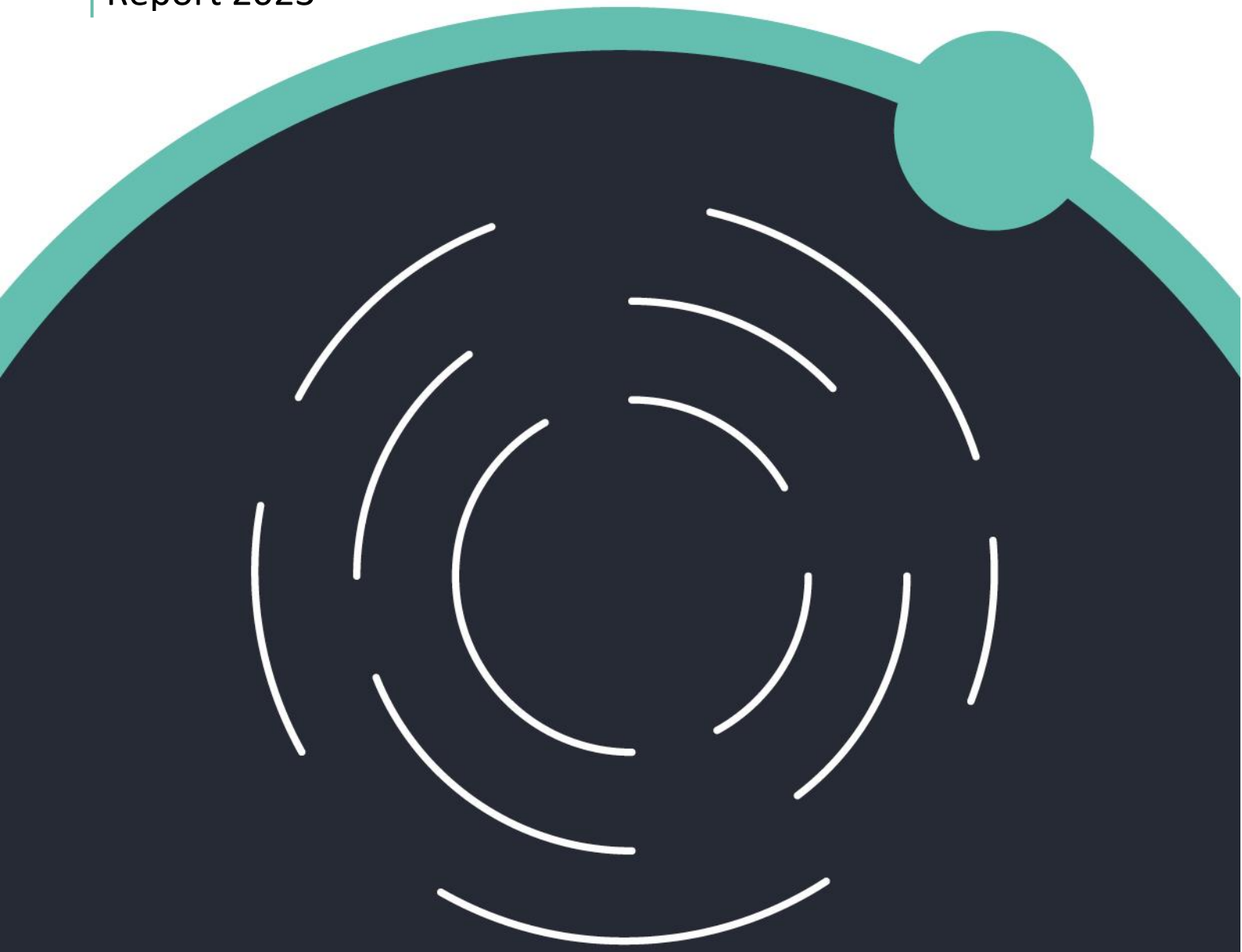
mental health commission

Annual Inspection Report 2023



Promoting Quality, Safety and Human Rights in Mental Health

EIST LINN CHILD & ADOLESCENT IN-PATIENT UNIT

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

Date of Publication: 5th March 2024

ID Number: AC0181

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Conditions Attached:
No

Most Recent Registration Date:
22 December 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Angela O'Neill, Acting General Manager, Mental Health Services

Inspection Team:
Damien Lanigan, Lead Inspector
Mary Connellan
Susan O'Neill

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
9 - 12 May 2023

Previous Inspection date:
28 June – 1 July 2022

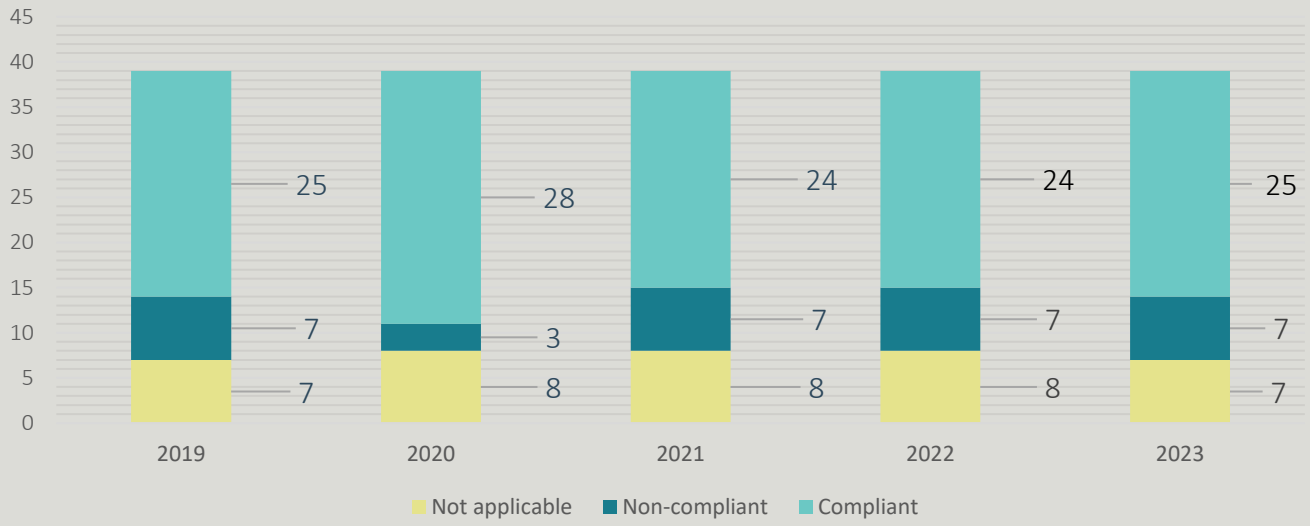
Inspection Type:
Announced Annual Inspection

2023 COMPLIANCE RATINGS

RATINGS SUMMARY 2019 – 2023

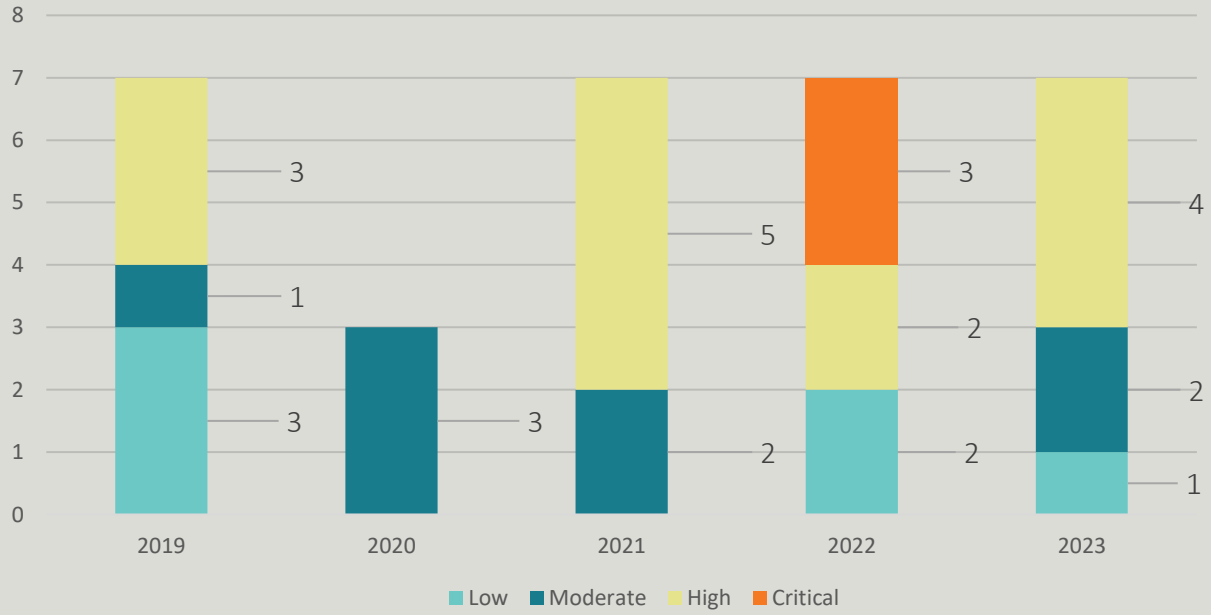
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

Eist Linn Child and Adolescent in-patient unit was located in Blackrock, Co. Cork. It was one of four national in-patient Child and Adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry, and Cork. Seventeen community Child and Adolescent Teams referred young people to the approved centre for admission, nine from Cork and Kerry, which include the Child and Adolescent Regional Eating Disorder Service (CAREDS) team, and eight from the remaining counties.

Two multi-disciplinary teams admitted residents into the approved centre. Eist Linn had a bed capacity of 16, and 7 residents were accommodated at the time of the inspection. Bedroom accommodation was located on the first floor and consisted of 15 en suite bedrooms and the Suaimhneas suite.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	78%	90%	77%	77%	78%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate action notice 10000232	*11/07/2022*	*At the annual regulatory inspection the approved centre was non-compliant with six regulations and three of these were risk rated as critical.*	*Confirmation was provided that many actions required by the IAN were completed. Fire safety works remain ongoing.*

Regulatory compliance meeting10000264	*02/02/2023*	*RCM held in response to Serious Reportable Event in approved centre.*	*Following RCM Inspector carried out focussed Inspection.*
Immediate action notice 10000267	*02/03/2023*	*Following focussed inspection assurances sought on staffing and safeguarding.*	*Plans and assurances provided*

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Regulatory compliance meeting10000270	*24/0/2022*	*Following annual inspection RCM held due to concerns that fire safety works were not completed.*	*Approved centre submitted detailed plan and timeframe.*

Safety of people in the approved centre

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

- ***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:*** Not all staff disciplines were trained in fire safety, basic life support, the management of violence and aggression and the Mental Health Act 2001.
- ***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.
- ***Maintenance:*** There was a maintenance programme.
- ***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 points were not minimised to the lowest level, based on individual risk assessment.
- ***Cleanliness***: While the approved centre was free from odours and was hygienic, there were cobwebs in some parts of the ceiling areas and skylight windows were dirty.

- ***Safety***: One bedroom had no light switch beside the bed to facilitate the resident's operation of the lights at night.
- ***Access to essential information, maintenance of records:*** Resident records were found not to be kept in good order, there were loose pages in two clinical files.

Appropriate care and treatment of residents

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

- ***Physical assessment****:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs, goals that had been decided with the resident's input, and appropriate interventions to address those goals. There was evidence of significant engagement with residents 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:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, a psychologist, social worker, occupational therapist and a dietitian. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan and included an Occupational Therapy (OT) group, dog therapy, baking, music, yoga, breakfast club and weekly outings.
- ***Access to other medical services:*** Access to a dietitian and speech and language therapist were provided internally to residents, and resident access to physiotherapy when needed, was through community referral.
- ***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.

However:

- **Admissions: Initial assessment:** One resident's admission assessment was not completed properly. The resident's psychiatric history, family and medical history, current and historic medications, risk assessment, work situation, education, and dietary requirements, were not recorded.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** Residents were accommodated in single occupancy en suite bedrooms.

- ***Interactions between staff and residents:*** Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. The approved centre was compliant with the Code of Practice on Physical Restraint. The approved centre did not use Seclusion or Mechanical Restraint. The approved centre developed and introduced a new de-escalation tool, to facilitate both staff and young people in de-escalating during more difficult times, thus reducing incidents and use of physical restraints through facilitating an alternative by using a trauma informed and recovery focused response in the most helpful way for each young person.
- ***Rights-based care:*** There was access to advocacy, and relationships with families and friends were encouraged.

However:

- ***Autonomy and Rights based care: Searches:*** In one of the three searches inspected, the registered proprietor did not ensure that the consent of the resident was sought. Documentation relating to the search did not evidence if the resident had consented to the search at the time, only consent on the part of the guardian was evident.
- ***Residents dignity and privacy: Searches:*** In one clinical file containing search documentation there was no evidence or documentation to suggest that the resident had been informed of what was happening, or why, during the search.
- ***Privacy and dignity:*** While staff showed discretion when discussing the resident's condition or treatment needs, there was no window curtain in one bedroom which was occupied at the inspection time and this enabled a view into the room from another room in the building.
- ***Privacy and dignity: CCTV:*** While CCTV was not used to monitor a resident in the event of their dignity being compromised, it was found that there were no clear signs in noticeable places where CCTV cameras were used in the approved centre. Secondly, CCTV cameras in the nurses' station on the ground floor, were visible to any individual from the outside looking in: by looking through the glass panels of the nurses' station. This meant the health professional with responsible for the resident was not the only person able to view the CCTV monitor.

Responsiveness to residents' needs

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

- ***Environment:*** There were positive aspects to the approved centre's environment, it had suitable and sufficient heating and lighting in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise.
- ***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. Residents were supported to access particular faith ministries.

- ***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***: Recreational activities included the following: reading, music, TV, movies, pool, air hockey, jigsaws, boardgames, cycling, basketball, table tennis, boxing, exercise and exercise equipment room, morning 'meet and greet' with staff, Breakfast Club, cooking, yoga, walks, and outings: including bowling, cinema, and visits to Fota Wildlife Park.
- ***Residents' feedback:*** Residents feedback was complimentary toward the staff, treating team and service provided. Residents expressed they could talk to staff. All residents were involved in their care planning. One resident indicated that they always felt safe at the centre, with three residents indicating that sometimes they felt safe in the approved centre. One of three residents who responded to their overall experience of care and treatment, noted it as excellent.

However:

- ***Environment:*** Furnishings were inadequate for residents' comfort: two bedroom windows were missing blinds or curtains. Multiple areas of the approved centre required repainting. Garden areas were not looked after properly, with weeds in the lawns and planted areas. There was no assisted toilet on the first floor of the approved centre.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was under the governance and management of the Cork Mental Health Area Management Team. The area lead for mental health engagement post, who would be a member of the Cork Mental Health Management team, was vacant at the time of the inspection.
- ***Leadership:*** An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The authority and responsibility of line managers for the various disciplines was clear. The Cork Mental Health Area Management Team met monthly. A Quality and Patient Safety (QPS) meeting took place each quarter and representatives from Eist Linn attended this meeting.

  Clinical Governance: Each clinical discipline had its own internal governance structure, with clear line management processes in place. There was a risk/incident management meeting, compliance/restrictive practices meeting, audit group and policy group meetings, group programme and staff nurse meeting. These working groups were made up of members of senior management and members of the multi-disciplinary team (MDT).
- ***Restrictive practices reduction:*** The approved centre had a policy on restrictive practice reduction, a senior manager appointed with responsibility for the reduction in restrictive practices within the service and a multi-disciplinary review and oversight committee for restrictive practices as is required

by the new Code of Practice on Physical Restraint. The approved centre was compliant with the revised Code Of Practice on Physical Restraint and it did not use Seclusion or Mechanical Restraint.

- ***Risk:*** The persons with responsibility for risk was the Registered Proprietor who worked directly in the approved centre and was known by staff. Heads of discipline had received training in risk management procedures. There was a clear pathway and protocol for escalation and ownership of risk. Incidents were reported and risk assessed. There was a monthly risk management meeting that focused on the review of significant incidents and the risk register.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. All disciplines had formal and informal clinical supervision arrangements in place where appropriate.
- ***Policies:*** Polices were up to date at the time of the inspection.
- ***Staff training:*** Not all staff disciplines were trained in fire safety, basic life support, management of violence and aggression and the Mental Health Act 2001. A steering committee on trauma informed care was formed which meet monthly, the committee focused on debriefing, de-escalation, staff supports and supervision, staff wellness and the ward environment.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** A designated advocate from the Youth Advocacy Programme attended on a weekly basis and spoke directly with residents, and advocacy contact details were displayed within the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 80% over the last 4 years. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risks:*** Ligature points were not minimised to the lowest level, based on individual risk assessment.
- ***Autonomy and Rights based care: Searches:*** In one of the three searches inspected, the registered proprietor did not ensure that the consent of the resident was sought. Documentation relating to the search did not evidence if the resident had consented to the search at the time, only consent on the part of the guardian was evident.
- ***Residents dignity and privacy: Searches:*** In one clinical file containing search documentation there was no evidence or documentation to suggest that the resident had been informed of what was happening, or why, during the search.
- ***Clinical governance:*** There were aspects of clinical governance that were not effective, clinical files of residents were not maintained in good order, there was a partially rather than properly completed admission assessment undertaken on a resident, poor documentation of searches, and the privacy of residents was compromised.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The introduction of the Youth Advocacy Programme (YAP) at the approved centre in September 2022. YAP provided Independent Advocacy Services (IAS) to the approved centre and the independent mental health advocate supported young people to understand the service provided to them in the inpatient unit, and enhanced their participation in service provision, helping them to express their views and make informed decisions. The YAP model is evidence-based, achieving positive outcomes with young people and families within their communities, through the employment of community based advocates.

2. The Breakfast Club was an initiative where on a weekly basis staff and young people prepared breakfast in the approved centre. This provided an opportunity for social engagement within the Eist Linn community.

3. Trauma Informed care: Six trauma informed educational sessions were conducted and facilitated by the occupational therapist.

4. A steering committee on trauma informed care was formed which meet monthly, the committee focussed on debriefing, de-escalation, staff supports and supervision, staff wellness and the ward environment.

5. Introduction of a therapy dog to the approved centre. “King” the therapy dog attended the centre weekly on a Tuesday morning and was a valuable tool in animal assisted activation with young people.

6. The approved centre received “PSYCHED” certificate of recognition for ongoing commitment to creating a mental health promoting workplace. “PSYCHED” is an initiative of Cork Healthy Cities and Counties and aims to stimulate conversation that promotes better understanding of mental health and wellbeing in the workplace.

7. The approved centre developed and introduced a new de-escalation tool. This was developed by the occupational therapist and the young people at the approved centre. The tool aimed to provide an individualised approach to facilitate both staff and young people in de-escalating during more difficult times, thus reducing incidents and use of physical restraints through facilitating an alternative by using a trauma informed and recovery focused response in the most helpful way for each young person.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Eist Linn Child and Adolescent in-patient unit was located on the grounds of the Bessborough Centre in Blackrock, Co. Cork. It was one of four national in-patient child and adolescent services. The approved centre served counties Wexford, Waterford, Carlow, Kilkenny, South Tipperary, Kerry, and Cork. Seventeen community child and adolescent teams referred into the approved centre, nine from Cork and Kerry, which include the Child and Adolescent Regional Eating Disorder Service (CAREDS) team, and eight from the remaining counties. Eist Linn was registered to accommodate 16 young people. On the first day of inspection there were 7 young people in the approved centre. Two young people had been in the approved centre longer than six months.

The ground floor of the approved centre provided communal spaces and therapy rooms for the residents. It consisted of staff offices, visiting rooms, an assessment room, a television/sitting room, and a dining room with a servery kitchen. The residents also had access to a pool room and a small computer room on the ground floor. There were also two internal gardens at the approved centre accessible from the ground floor.

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

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

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**7**
Number of detained patients	0
Number of wards of court	0
Number of children	7
Number of residents in the approved centre for more than 6 months	2
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

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

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

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

The approved centre's local management team met monthly. Those present at this forum included the executive clinical director, area director of nursing, assistant director of nursing, clinical nurse specialist, consultant psychiatrists, speech and language therapist, occupational therapist, social worker and clinical psychologist. Agenda items at these meetings included resident feedback, risk management and registers, staffing, infection control, compliance and incident reviews.

Local working groups were active in the approved centre. There was a risk/incident management meeting, compliance/restrictive practices meeting, audit group and policy group meetings, group programme and staff nurse meeting. These working groups were made up of members of senior management and members of the multi-disciplinary team (MDT).

The approved centre's registered proprietor held overall responsibility for the risk management process. Heads of discipline had received training in risk management procedures. The risk register had been reviewed at least quarterly. There was a clear pathway and protocol for escalation and ownership of risk. A monthly risk management meeting was held in the approved centre. This meeting was attended by the Executive Clinical Director, Area Director of Nursing and members of the multi-disciplinary team. Minutes from these meetings evidenced that the risk register was reviewed, and significant incidents discussed.

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

Each clinical discipline had its own internal governance structure, with clear line management processes in place. The inspection team interviewed heads of clinical disciplines as part of the inspection process. Heads of discipline from medical, nursing, psychology, occupational therapy, social work completed a governance questionnaire. This provided a clear overview of the governance issues and current risks within their respective departments. Each head of discipline met with their team members on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the senior management team. All disciplines had formal and informal clinical supervision arrangements in place where appropriate.

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

The approved centre had a policy on restrictive practice reduction, a senior manager appointed with responsibility for the reduction in restrictive practices within the service and a multi-disciplinary review and oversight committee for restrictive practices as is required by the new Code of Practice on Physical Restraint. At the time of the inspection this committee had met in the first quarter of 2023. In September 2022, the Mental Health Commission (MHC) published revised rules governing the use of seclusion and mechanical restraint, and a revised code of practice relating to the use of physical restraint in approved centres. The date of commencement of this code of practice and rules was the 1st of January 2023.

Resident engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, regular resident community meetings, suggestion boxes and engagement with the complaints process were utilised to support service improvement. The approved centre had a complaints policy and an appointed complaints officer. Details of how to make a complaint were displayed in the centre and there was contact information for the nominated complaints officer provided.

A designated advocate from the Youth Advocacy Programme commenced at the approved centre in September 2022 and attended on a weekly basis and spoke directly with residents and advocacy contact details were displayed within the approved centre.

The area lead for mental health engagement post, who would be a member of the Cork Mental Health Management team, was currently vacant.

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 13: Searches	✓		✓		✓		✗	High	✗	Moderate
Regulation 21: Privacy	✗	Low	✗	Moderate	✗	High	✗	High	✗	High
Regulation 22: Premises	✓		✗	Moderate	✓		✗	Critical	✗	High
Regulation 25: CCTV	✗	High		N/A		N/A		N/A	✗	High
Regulation 26: Staffing	✗	High	✓		✗	High	✗	Low	✗	Moderate
Regulation 27: Maintenance of Records	✗	Moderate	✓		✓		✓		✗	Low
Code of Practice: Admission, Transfer, Discharge	✓		✓		✓		✓		✗	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 Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

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

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. 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.
- 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.

The inspectors spoke with one young person and four completed service user experience questionnaires were returned to the inspectors.
Comments made by residents were that the service was good in the approved centre, that the food was nice and that requests for specific dietary wants were catered for, that they were aware of their treating team and that they felt able to ask questions of the staff.
Of the four completed questionnaires, three indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood, and one could not remember. Four respondents indicated that they sometimes received information on their diagnosis. Three respondents indicated that they understood what their care plan was, and one indicated that they did not understand their care plan. Two indicated that they were always involved in setting goals for their individual care plans with two saying sometimes. Three of the respondents indicated that they knew their multi-disciplinary team members and knew their keyworkers, with one respondent indicating no to both these questions. Three respondents indicated that they were always able to discuss worries or concerns with a member of staff with one respondent indicating sometimes. Two felt there was enough activities in the approved centre and two did not. Three respondents were happy with how staff spoke with them, and one was not happy how staff spoke with them. Three respondents felt they had space for privacy, one did not, and all the respondents felt their privacy and dignity was respected during their stay. All four respondents said they could communicate freely with family, friends and the advocate. One indicated that they always felt safe at the centre, with three indicating sometimes to this question. Three respondents indicated that they were always able to give feedback to staff, and to make a complaint when they were not satisfied with any part of their stay, and one respondent indicated sometimes.
On a scale of 1-10, with 1 being poor and 10 being excellent for their overall experience of care and treatment at the approved centre. One resident rated it 6 out of 10, one rated 7 out of 10, one rated 8 out of 10 and one rated 10 out of 10.

5.2 Advocacy

The approved centre had an advocacy service which was provided by the Youth Advocacy Programme.

The inspectors did not receive a report from the Youth Advocacy Programme representative.

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:

- Registered Proprietor
- Principal Social Worker
- Principal Psychologist
- Occupational Therapy Manager
- Executive Clinical Director
- Consultant Psychiatrist
- Interim Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Area Administrator
- Speech and Language Therapy Manager
- Operational support to Executive Clinical Director

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. 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 July 2022. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents could request activities at the morning meeting or weekly community meeting. Self-directed activities included reading, music, TV, movies, pool, air hockey, jigsaws, boardgames, and cycling. A basketball court located in the school building included a table tennis set and boxing bag. A separate exercise room included a treadmill, exercise bike, and cross trainer. Group activities included morning 'meet and greet' with staff, Breakfast Club, cooking, yoga, walks, and outings (including bowling, cinema, and visits to Fota Wildlife Park).

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. Access to particular faith ministries could be facilitated and residents were provided with private space to observe any rituals upon request. Arrangements could be made to observe customs specific to diet upon request and approval by the multi-disciplinary team (MDT).

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in January 2023.

Visiting times were appropriate and reasonable. There were no restrictions on visiting for any resident at the time of inspection. The approved centre provided visiting rooms where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting areas were suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in September 2022.

Residents in the approved centre had access to mail, e-mail, Internet, telephone or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to residents' well-being, safety, and health. It was the approved centre's policy that the clinical director or senior staff member designated by the clinical director would only examine 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 were no restrictions on communication for any resident at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

NON-COMPLIANT

Risk Rating MODERATE

(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 February 2022, and included all requirements related to:

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was not sought prior to all searches: in one of the three searches inspected, the documentation indicated that the resident had refused to sign the consent form but it was not clear whether the resident had or had not consented to the search. Overall consent for searches was sought on admission, and in this particular incident the resident's next of kin was contacted. Also in this particular search incident, it was unclear whether the resident was informed of what was happening during the search, and why. For the other two searches, there was evidence to suggest that this communication had taken place.

General written consent was sought for routine environmental searches. 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.

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. Where applicable, policy requirements were implemented if illicit substances were found as a result of a search.

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

a) **In one of the three searches inspected, the registered proprietor did not ensure that the consent of the resident was sought. Documentation relating to the search did not evidence if the resident had consented to the search at the time, only consent on the part of the guardian was evident, 13 (4).**
b) **In one of the three searches inspected, there was no evidence or documentation to suggest that the resident had been informed of what was happening, or why, during the search, 13 (8).**

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

As 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. The young person's contribution was clearly evident in their care and goals as was communication with the parents of the young people.

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 weekly review by the MDT in consultation with the resident. 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). The weekly activities timetable included an occupational therapy (OT) group, dog therapy, baking, music, yoga, a breakfast club, and outings which occurred at least once weekly. The OT worked on an individual basis with each resident at the time of inspection. There was also evidence that residents had access to social work, psychology, dietitian, and speech and language therapy, on an individual basis.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. The approved centre provided a gym for resident use with staff supervision.

At the time of inspection, all required therapeutic services and programmes were provided internally by the approved centre.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

Residents were assessed in relation to their educational requirements with consideration of their individual needs and age on admission. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum.

Appropriate facilities and sufficient personnel resources were available for provision of education to residents in the approved centre. The approved centre had a separate school which was accessible via a small garden area. At the time of inspection, the school had one full-time principal, one full-time teacher, and two further teachers who worked ten and 11 hours per week respectively. The curriculum included maths, science, French, Irish, geography, English, career guidance, and physical education (PE).

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in July 2022. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in October 2022. The approved centre had emergency equipment and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans.

Two clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, nutritional status, medication review, and body mass-index, weight, and waist circumference.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Access to a dietitian and speech and language therapist were provided internally, and access to physiotherapy via community referral.

Residents could access any relevant national screening programme that was available according to age and gender, including retina check (for diabetics only).

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in March 2023.

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

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress was 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 not fitted with blinds, curtains, or opaque glass: one bedroom, which was occupied at the time of inspection, did not have curtains. Without curtains, this bedroom was directly viewable from the window of another bedroom which was located at a right angle to it. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy was appropriately respected at all times, as there was no window curtain in one bedroom, which enabled a view into the room from another room in the building.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(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 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 not kept in a good state of repair externally and internally. Numerous areas required repainting: marks and scuffs were noted on several doors and walls in the admitting room, pool room, the corridor leading to the visiting rooms, the upstairs corridor, visiting rooms, computer room, art room, and in many of the bedrooms. Lights in the visiting rooms and some lights in the pool room were not working. Externally, the garden areas were clean and the lawns were cut. However, weeds were prevalent throughout the lawns and planted border areas. The ceiling in the school building corridor was chipped and peeling in one part and stained in another, due to old leaks from the heating system which was embedded in the ceiling.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was hygienic and free from odours. However, cobwebs were noted on the high ceilings of the TV room and corridor skylight windows upstairs. The exterior skylight windows in the laundry room, TV room, utility room, and upstairs corridor were dirty.

Current national infection control guidelines were followed. The approved centre provided a sufficient number of toilets and showers for residents. There was an assisted toilet on the ground floor, but none on the first floor. There was a designated cleaning room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs. Not all bedrooms had been provided with suitable furnishings to support resident independence and comfort. One bedroom had no curtains. Another bedroom had no light switch beside the bed to facilitate the resident's operation of the lights at night. In the Suaimhneas suite (not in use at the time of inspection), there were two large windows in the bedroom. Blinds, which were normally fitted externally and remotely controlled, were absent from one of the windows, and not functional on the other due to a missing control panel.

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

- **a) The registered proprietor did not ensure that the premises were maintained in good decorative condition, as multiple areas required repainting, 22 (1)(a).**
- **b) The registered proprietor did not ensure that the gardens were maintained in good condition due to the prevalence of weeds in the lawns and planted areas, 22 (1)(a).**
- **c) The registered proprietor did not ensure that all areas of the premises were clean, as cobwebs were noted in some parts of the ceiling areas and the skylight windows were dirty, 22 (1)(a).**
- **d) The registered proprietor did not ensure that the approved centre had adequate furnishings as window curtains or blinds were missing in two bedrooms, 22 (2).**
- **e) The registered proprietor did not ensure that the condition of the physical structure of the approved centre was developed with due regard to the specific needs and safety of all residents; in one bedroom, there was no light switch in the vicinity of the bed area which would mean a resident would be unable to operate the bedroom lighting as needed, 22 (3).**
- **f) The registered proprietor did not ensure that the condition of the physical structure all areas of the approved centre was developed with due regard to the safety of residents as not all ligature points were minimised based on risk assessment, 22 (3).**

g) **The registered proprietor did not ensure that the approved centre environment was developed with due regard to the specific needs of residents, as there was no assisted toilet on the first floor of the approved centre, 22 (3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All 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 January 2022.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating HIGH

(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 October 2022.

The inspection did not find clear signs in prominent positions where CCTV cameras or other monitoring devices were utilized throughout the approved centre. There were two cameras positioned at either end of the corridors on the ground floor. While a small sign at the nurses' station (located roughly equidistant between the two cameras) indicated CCTV in operation, there were no signs positioned on the corridor in vicinity to the cameras. There were three cameras in operation on the first floor, with two at either end of the corridor which had no sign in their vicinity to indicate CCTV in operation.

The approved centre's use of CCTV and any other monitoring system was disclosed to residents, residents' representatives, and the Mental Health Commission. Residents were monitored solely for the purpose of ensuring their health, safety and welfare. The approved centre did not ensure that monitoring systems were viewed solely by the health professional with responsibility for the resident. On the ground floor, the CCTV monitor was located in the nurses' station and was viewable by others through the glass panels of the station.

CCTV was not used to monitor a resident in the event of their dignity being compromised, and all monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc, or hard drive.

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

a) **The registered proprietor did not ensure that CCTV monitors used to observe a resident were viewed solely by the health professionals responsible for the resident, 25 (1)(a).**
b) **The registered proprietor did not ensure that there were clear signs in prominent positions where CCTV cameras were located throughout the approved centre, 25 (1)(b).**

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.

There was two multi-disciplinary teams that admitted residents into the approved centre. These teams included nursing, medical, psychologists, social workers, occupational therapist, dietitian and speech and language from the teams that provided therapeutic input to residents in Eist Linn. Access to other disciplines such as physiotherapy were available by referral.

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. 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.

Not all healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001. The table below provides 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 (22)	20	91%	22	100%	21	95%	22	100%

Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%
Medical (3)	2	66%	2	66%	2	66%	3	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	1	50%	2	100%	2	100%	2	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	100%

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

a) 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 had received up-to-date mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26 (4).

b) The registered proprietor did not ensure that all staff members were made aware of the provisions of the Mental Health Act and all regulations and rules made thereunder, as commensurate with their role, as not all staff had received up-to-date mandatory training in the Mental Health Act 2001, 26 (5).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating LOW

(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 February 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. Residents' records were developed and maintained in logical sequence. However, not all records were kept in good order, as two loose pages - from two separate clinical files - were observed on inspection.

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 non-compliant with this regulation because the registered proprietor did not ensure that records were in good order, as loose pages were observed in two clinical files, 27 (1).

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

All operating policies and procedures were reviewed within the required three-year time frame, having due regard to any recommendations made by the Inspector or the Commission.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in February 2023, 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 complaint's procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaint's 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. All informal complaints were investigated and dealt with in approximately one-to-two days. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. There had been only one formal complaint since the last inspection. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

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 March 2023, 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

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. The certificate was displayed prominently in the reception area.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

- The provision of information to the resident 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 persons 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 resident's behaviours (social, environmental, cognitive, emotional, or somatic).
- The monitoring of the safety of the resident during and after the physical restraint.

The approved centre had a written policy on the reduction of physical restraint. The policy 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 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. Since the commencement of the new Code of Practice on the Use of Physical Restraint in January 2023, additional training requirements were not inspected as training for all staff involved in the use of restrictive practices was in progress.

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 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 person's presentation. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical flies. A physical examination had been completed no later than two hours after the start of each episode of restraint.

The 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 episodes of physical restraint and the times that the nursing reviews or medical examinations took place were clearly recorded in the clinical file. The resident was informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical file as soon as was practicable.

For each episode of restraint, it was the resident's wish in accordance with their individual care plan (ICP) that their representative be informed of the physical restraint. The representative was informed as soon as was practicable, and 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 person'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 resident 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 were not compromised.
- Effective communication was maintained with the resident, and 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. 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 who was restrained to have the debrief outside of this timeframe. The decision of the resident not to participate in the debrief, if that was their wish, was respected. A record of this was maintained and recorded in the person's clinical file. 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.

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. This risk assessment determined whether physical restraint could be safely used or not.

The reasons for the restraint, and the circumstances which would lead to its discontinuation were explained in a way which they could understand and which was appropriate to their age. The parent or guardian was informed of the episode of physical restraint, and the circumstances which led to the child being physically restrained, as soon as was practicable. The parent or guardian was also informed of when each episode of physical restraint ended. The approved centre had child protection policies and procedures in place which were in line with the relevant legislation and regulations. A policy and procedures which addressed appropriate training for staff in relation to child protection was also in place.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

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 March 2023, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in July 2022, included of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in March 2023, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder. 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. The admission assessment included the resident's social and housing needs and current mental health state. However, in the documentation of the resident's presenting problem, the assessment consent form was incomplete, the risk profile was incomplete/sparsely completed, and the inpatient admission assessment was sparsely completed. The following sections of the admission assessment had not been completed: past psychiatric history, family and medical history, current and historic medications, risk assessment, and all other relevant information (including work situation, education, and dietary requirements). The approved centre was asked to immediately address this issue and the admission assessment was fully completed before the inspection finished.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and risks, and documented communications with the relevant general 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. A timely follow-up appointment was made within one week.

The approved centre was non-compliant with this code of practice because the following sections of a resident's admission assessment had not been completed: past psychiatric history, family and medical history, current and historic medications, risk assessment, and all other relevant information (including work situation, education, and dietary requirements), 15.3.

Appendix 1: Corrective and Preventative Action Plan

Regulation 13: Searches					
Reason ID : 10004162		**In one of the three searches inspected, the registered proprietor did not ensure that the consent of the resident was sought. Documentation relating to the search did not evidence if the resident had consented to the search at the time, only consent on the part of the guardian was evident, 13 (4). In one of the three searches inspected, there was no evidence or documentation to suggest that the resident had been informed of what was happening, or why, during the search, 13 (8)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	As well as obtaining consent from the parent/guardian of the Young Person (YP), the YP is advised of the search and their view noted in the clinical file.	Evidence documented in Clinical File. Will be measured in Clinical Audit on searches.	Achieved. Clinical Audit frequency of every 3 months until full compliance is sustained and then at a minimum annually	31/12/2023	CNS/Chair of Audit Committee.
Preventative Action	Search Log has been updated to include section on consent/view of YP and that of parents/guardian. Review of Policy and amendments made, introduction of Triplicate book (26/09/2023	Evidence documented in Clinical File. Will be measured in Clinical Audit on searches.	Achieved. Clinical Audit frequency of every 3 months until full compliance is sustained and then at a minimum annually.	31/12/2023	CNS/Chair of Audit Committee.
Reason ID : 10004164		**The approved centre was non-compliant with this regulation because two of the clinical files examined did not record a clear risk assessment or reason as to why the search was undertaken, 13(8).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• Audit held on the 14/07/2022 with a result of 84%. • All standards below 100% noted on audit spot checker. •	Next six monthly audit took place on 16/02/2023 and achieved a result of 87%	Completed	16/02/2023	CNM2's

	Email sent to all CNM2s to advise them of the process. • Reg 13 Searches discussed at local policy committee meeting on 20/07/2022 and Regulatory Compliance Meeting on 22/07/2022				
Preventative Action	• Identify search leads from the nursing team to assist with searches/documentation and one lead has been identified to-date. • Peer learning on Regulation 13 provisionally scheduled for 7th March, 2023. • Identify a section for search rationale within the clinical file. • Reg 13 Searches on agenda for next audit meeting scheduled for 7th March, 2023.	Six monthly audit scheduled for September 2023	Achievable	30/09/2023	CNM2's

Regulation 21: Privacy					
Reason ID : 10004186		**The registered proprietor did not ensure that the resident's privacy was appropriately respected at all times, as there was no window curtain in one bedroom, which enabled a view into the room from another room in the building.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The window curtain had been removed at the request of the Young Person occupying the room and was put back in place upon their departure.	Bliinds and curtains in place	Achieved	31/05/2023	Nursing Staff
Preventative Action	New privacy screens have been ordered for all of the bedrooms which have a lead time of up to 2 months for delivery. This is subject to change depending on the supply chain which is outside of our control.	Installation of new privacy screen in each of the bedrooms	Achievable	31/01/2024	CNM3 and Maintenance Officer
Reason ID : 10004187		**Residents' privacy and dignity was not respected at all times. All of the en suite bathrooms in the approved centre did not have locks on the inside of the doors, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Thumb turn locks with override function have been fitted to all the en-suite doors on the unit.	Locks have been installed.	Completed	30/07/2021	Maintenance Department.
Preventative Action	1. Regular reviews of locks to ensure compliance with Regulation 21. 2. Ensure locks are working and	1. To be added to the checklist as part of the quarterly maintenance and estates walk	This is both achievable and realistic.	31/12/2021	1. Maintenance Department. 2. CNM2 with responsibility for Maintenance in Eist Linn/ CNM3.

	provide a proactive approach to those that are found to require repair checklist.	through of Eist Linn. 2. As part of the quarterly proactive maintenance program in place in Eist Linn.			
Reason ID : 10004188		**The registered proprietor did not ensure the resident's privacy and dignity was appropriately respected at all times, as the assessment room was only accessible by passing through the main hub of the approved centre and the assessment room was directly visible from the corridor of the approved centre.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Privacy blind installed Audit on 27/09/2022 result 100%	Audit result	Completed	27/09/2022	Maintenance and Local Audit Committee
Preventative Action	Re-audit scheduled 27/09/2023	Audit Result	Achievable	30/09/2023	Local Audit Committee
Reason ID : 10004189		**Residents' privacy and dignity was not respected at all times. All of the en suite bathrooms in the approved centre did not have locks on the inside of the doors, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Thumb turn locks with override function have been fitted to all the en-suite doors on the unit.	Locks have been installed.	Completed	30/07/2021	Maintenance Department.
Preventative Action	1. Regular reviews of locks to ensure compliance with Regulation 21. 2. Ensure locks are working and provide a proactive approach to those that are found to require repair checklist.	1. To be added to the checklist as part of the quarterly maintenance and estates walk through of Eist Linn. 2. As part of the quarterly proactive maintenance program in place in Eist Linn.	This is both achievable and realistic.	31/12/2021	1. Maintenance Department. 2. CNM2 with responsibility for Maintenance in Eist Linn/ CNM3.

Regulation 22: Premises					
Reason ID : 10004165		**The registered proprietor did not ensure that the condition of the physical structure all areas of the approved centre was developed with due regard to the safety of residents as not all ligature points were minimised based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature audit action plan completed and risk mitigation reviewed on a monthly basis at Eist Linn Management meeting.	Ligature audit action plan reviewed on a monthly basis.	Achievable	31/12/2023	All HODs
Preventative Action	Monthly review of ligature audit action plan. Monthly maintenane walkthroughs to include ligature review.	Ligatures reduced to the lowest level possible on the Unit.	Achievable	31/12/2024	Area Administrator, CNM3 and Maintenance Officer.
Reason ID : 10004166		**The registered proprietor did not ensure that the premises were maintained in good decorative condition, as multiple areas required repainting, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	8 areas on the Eist Linn Unit have since been painted since the date of inspection on 9th May, 2023.	Eist Linn Unit to be freshly painted and maintained in good decorative condition.	Achievable.	30/10/2023	Nursing Staff and Maintenance Team.
Preventative Action	Status of internal and external painting is on the monthly Maintenance walkthrough on the centre for tracking. A schedule of painting works is in place (copy	Completion of all painting on the schedule and thereafter areas are checked on a monthly basis via the monthly Maintenance	Achievable	31/03/2024	Maintenance Officer, Area Administrator and CNM3

	attached) to complete the remainder of area on the Unit.	walkthrough of the Unit.			
Reason ID : 10004167		**The registered proprietor did not ensure that all areas of the premises were clean, as cobwebs were noted in some parts of the ceiling areas and the skylight windows were dirty, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	This area was cleaned post inspection by an external contractor to ensure the high areas could be reached.	Clean and dust free interiors.	Completed	30/06/2023	CNM3, Area Administrator and Maintenance Officer.
Preventative Action	Cleaning audits completed on a monthly basis. External contractor now requested to attend on a regular basis to address the cleaning of the high areas on the Unit.	Analysis of cleaning audits and spot checks.	Achievable.	31/12/2023	CNM3, Area Administrator and Maintenance Officer
Reason ID : 10004168		**The registered proprietor did not ensure that the approved centre environment was developed with due regard to the specific needs of residents, as there was no assisted toilet on the first floor of the approved centre, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A room on the first floor has been identified for conversion into an assisted bathroom. Funding is in place for same.	Completion of assisted bathroom on the 1st floor	Achievable.	31/03/2024	CNM3, Area Administrator and Maintenance Officer.
Preventative Action	A plan is in place to convert a room on the first floor to an assisted bathroom	Installation of an assisted bathroom on the 1st floor.	Achievable	31/03/2024	Area Administrator, CNM3 and Maintenance Officer

Reason ID : 10004169		The registered proprietor did not ensure that the approved centre had adequate furnishings as window curtains or blinds were missing in two bedrooms, 22(2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The blinds in one of the rooms were put down at the request of the young person and put back up upon their departure.	Blinds and curtains in place.	Completed	31/05/2023	Nursing Staff
Preventative Action	New privacy screens ordered for all of the bedrooms which have a lead time of up to 2 months for delivery. This is subject to change depending on the supply chain which is outside of our control.	Installation of new privacy screens in each of the bedrooms	Achievable	31/01/2024	CNM3 and Maintenance officer
Reason ID : 10004170		**The registered proprietor did not ensure that the condition of the physical structure of the approved centre was developed with due regard to the specific needs and safety of all residents; in one bedroom, there was no light switch in the vicinity of the bed area which would mean a resident would be unable to operate the bedroom lighting as needed, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It is noted that there is a night light switch in the room. A request has been submitted to Maintenance for an assessment of lighting in the room and if this can be enhanced.	Output from Maintenance Assessment will determine whether this can be addressed or not.	Achievable.	31/12/2023	Nursing & Area Administrator.
Preventative Action	All bedroom lighting to be reviewed at the next monthly Maintenance walkthrough to ensure it	Output from Monthly Maintenance audit.	Achievable	31/12/2024	CNM3, Area Administrator and Maintenance officer.

	meets the needs of all young persons.				
Reason ID : 10004171		**The registered proprietor did not ensure that the gardens were maintained in good condition due to the prevalence of weeds in the lawns and planted areas, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The lawn was weeded on the day of the inspection and reviewed by the Inspection Team thereafter.	Well-kept weed free grounds.	Achievable	31/05/2023	Maintenance & Area Administrator
Preventative Action	Garden to be included in the monthly Maintenance walkthroughs and any actions required followed up on.	Monthly audits of grounds to track progress and identify area requiring actions.	Achievable	31/12/2024	CNM3, Area Administrator and Maintenance Officer.

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10004184		**The registered proprietor did not ensure that there were clear signs in prominent positions where CCTV cameras were located throughout the approved centre, 25 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CCTV signs now in place in all areas of CCTV. Quarterly audits of CCTV in place. The unit achieved a result of 100% in the last audit. The first 2 audits are scheduled for 2024 as follows: 30th January, 2024 and 30th Feb 2024.	Audit results and action plan to complete any identified works.	Achievable.	31/12/2023	Audit Committee
Preventative Action	Quarterly audit of all CCTV and signage	Compliance with regulation	Achievable	31/12/2023	Nursing Staff
Reason ID : 10004185		**The registered proprietor did not ensure that CCTV monitors used to observe a resident were viewed solely by the health professionals responsible for the resident, 25 (1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A privacy screen is ordered for the CCTV screen in the downstairs nursing station.	CCTV monitors are not visible to any non healthcare professional	Achievable	31/12/2023	Nurse Management
Preventative Action	Staff to ensure that no non healthcare professional can view the CCTV cameras.	Staff to turn off CCTV cameras when not at the nursing station.	Achievable	31/12/2023	Nurse Management

Regulation 26: Staffing					
Reason ID : 10004190		**The registered proprietor did not ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all staff had received up-to-date mandatory training in Basic Life Support, Fire Safety, the Management of Violence and Aggression, 26 (4). The registered proprietor did not ensure that all staff members were made aware of the provisions of the Mental Health Act and all regulations and rules made thereunder, as commensurate with their role, as not all staff had received up-to-date mandatory training in the Mental Health Act 2001, 26 (5)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It is confirmed that all staff did have the mandatory Mental Health Act training completed at the time of the inspection. 1 NCHD was scheduled for PMCB Training. Fire training is booked as required with further dates requested for December 23 and Jan 24.	100% compliance with regulation. 100% compliance with regulation. Mandatory Training for all disciplines is reviewed at each month's Eist Linn Management Meeting with focus on addressing any required training. All staff are asked to request training 3 months prior to expiry. 100% compliance with regulation. All staff are asked to request training 3 months prior to expiry.	Achievable	31/12/2023	All HODs

Preventative Action	Training records for all staff assigned to work on the Eist Linn Unit are reviewed on a monthly basis at the Eist Linn Management Team meeting. New staff have immediate access to all on-line training. Additional training instructors are in placed for BLS and PNCB training which will ensure more timely access to these training	with regulation. All staff are asked to request training 3 months prior to expiry.	Achievable	31/12/2023	All HODs
Reason ID : 10004192		**The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as just 69% of nursing staff had received training in the Management of Violence and Aggression and 97% of nursing staff had received training in Basic Life Support, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1.Training is a standing agenda item on the local monthly management team meeting and mandatory training metrics are reviewed on a monthly basis. 2.Monthly training audit is returned to the Mental Health Commission on a monthly basis. 3. As an update 95% of nursing staff are now trained in	Audit Result	Achievable	31/12/2023	Eist Linn Management Team Area Administrator

	PMCB, 1 is awaiting the first day (due to pregnancy leave) and 2 nurses re scheduled to complete BLS Train the Trainer course.				
Preventative Action	All line Managers have been requested via the Interim Head of Service to review training licences at least 3 months in advance of expiration date. Funding to train 4 additional replacement PMCB trainers is approved at a cost of €4,800 each which will increase the frequency of training. All staff have training plans.	Audit Result	Achievable	31/12/2023	All Line Managers

Regulation 27: Maintenance of Records					
Reason ID : 10004183		**The registered proprietor did not ensure that records were in good order, as loose pages were observed in two clinical files, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The loose pages in the 2 clinical files were re-filed during the inspection.	Documentation filed securely in files.	Achievable	31/05/2023	All members of the MDT Team.
Preventative Action	Maintenance of Records audit now done on a quarterly basis rather than bi-yearly. The most recent audit achieved a result of 94%. The next audit is scheduled for 1st December, 2023.	Monthly audits and analysis of results to identify area of improvement. Administration support sought from Area Administrator for Ward Clerk duties (dependant on the current recruitment embargo)	Achievable	30/06/2024	Audit Committee

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

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10004161		**The following sections of a resident's admission assessment had not been completed: past psychiatric history, family and medical history, current and historic medications, risk assessment, and all other relevant information (including work situation, education, and dietary requirements), 15.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The finding from the Inspectorate is acknowledged however the admission in question was an acute case admitted the night previous to the Inspection. The admission assessment was rectified during the inspection. The Inspecting team acknowledged this was an exception and that all other admissions assessments were 100% compliant.	Audit results. Audits are completed on a quarterly basis. Audit results for Q3 2023 was 100% and Q4 2023 was 94%	Completed	09/05/2023	Admitting Team
Preventative Action	Audit of all admissions to be completed on a quarterly basis. Audits scheduled for the 1st 2 quarters of 2024 as follows: 2024	An analysis of quarterly audit results.	Achievable	31/12/2024	Admitting Team

	1st Quarter 01/02/2024, 2nd Quarter 01/07/2024				

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.

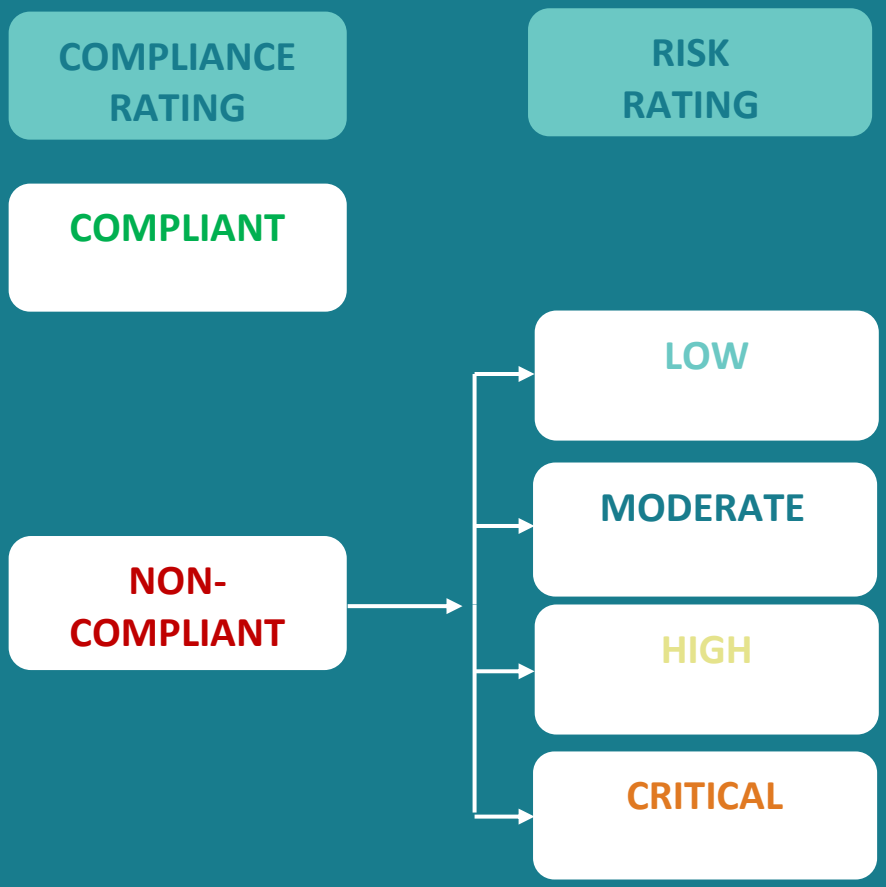
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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