Adolescent In-patient Unit, St Vincent's Hospital

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ADOLESCENT IN-PATIENT UNIT, ST VINCENT'S HOSPITAL

Adolescent In-patient Unit, St Vincent's Hospital, Richmond Road, Fairview, Dublin 3

Date of Publication:
31 May 2024

ID Number: AC0077

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Mental Health Care for People with Intellectual Disability
Child and Adolescent Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
29 January 2021

Registered Proprietor:
St Vincent's Hospital

Registered Proprietor Nominee:
Mr Eoin Culliton, Chief Executive

Inspection Team:
Barbara Murphy, Lead Inspector
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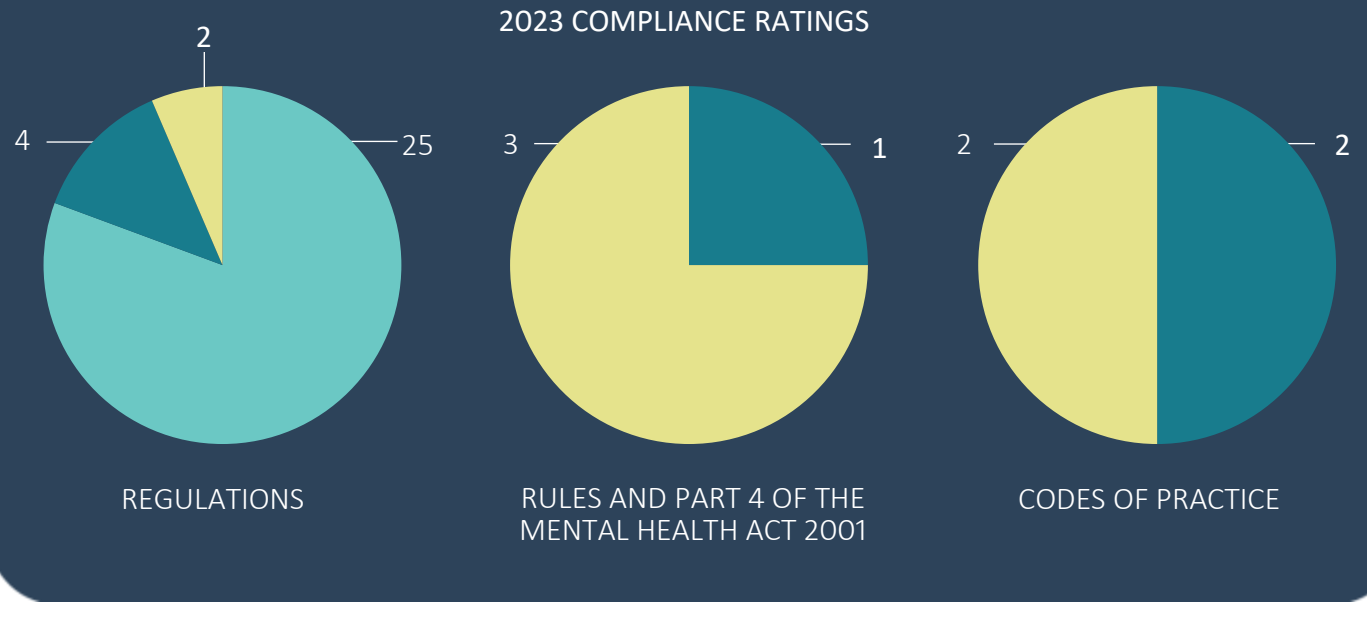
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
3 – 6 October 2023

Previous Inspection date:
17 – 20 May 2022

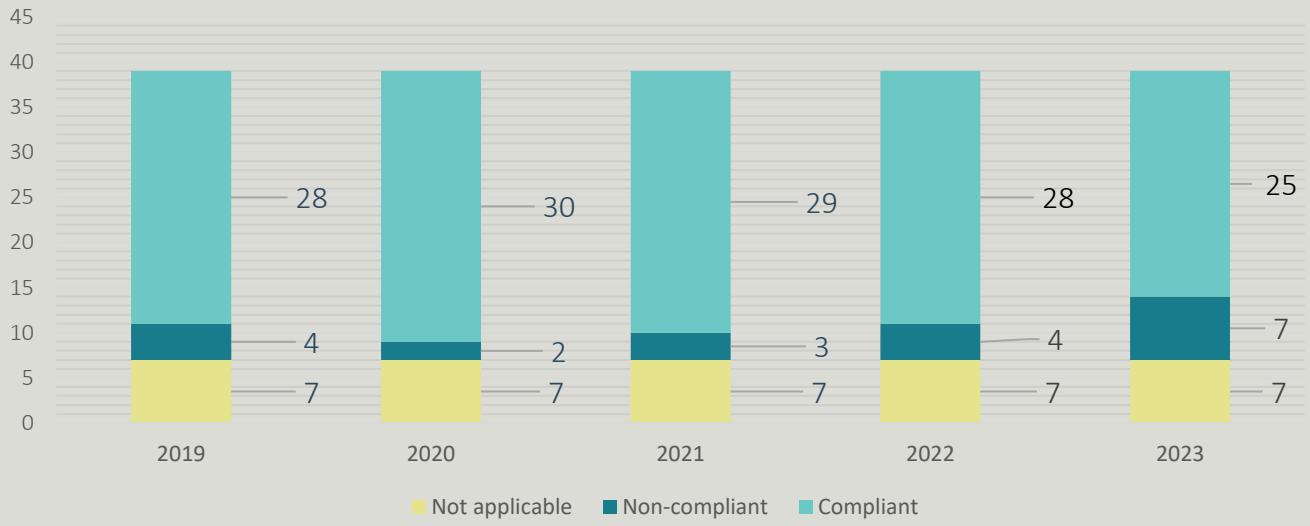
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2019 – 2023

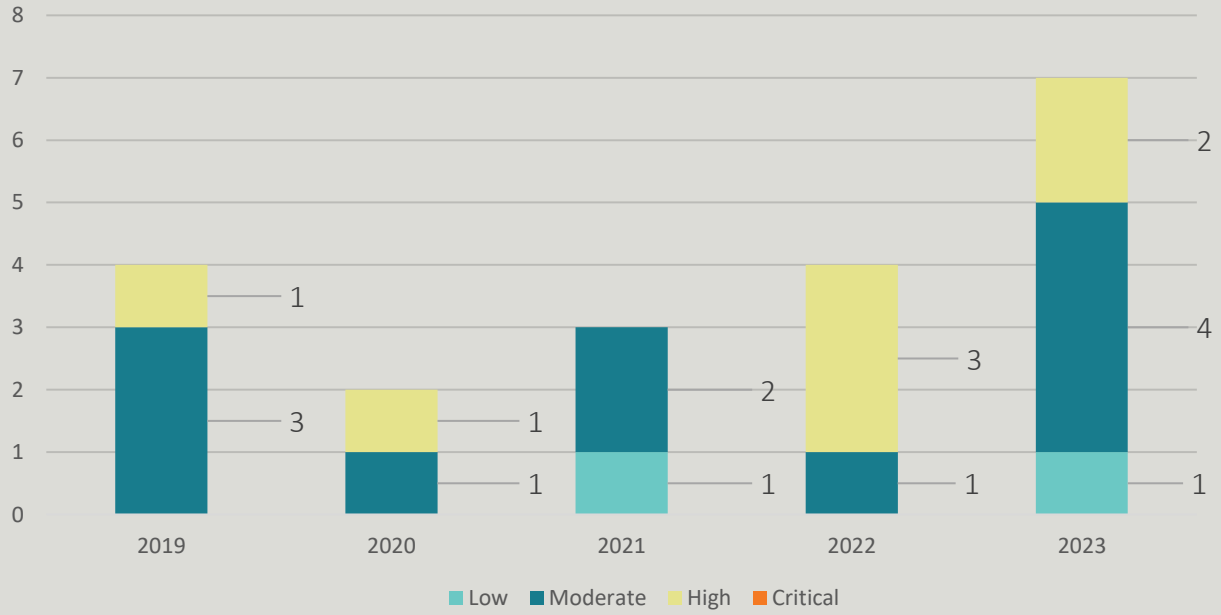
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Professor James V Lucey

In brief

The Adolescent In-Patient Unit (AIPU) was a public voluntary hospital located on the grounds of St. Vincent's Hospital, Fairview. It provided child and adolescent mental health care services, and mental health care for people with intellectual disability. It had an operational bed capacity of 10 and at the time of the inspection the approved centre accommodated 6 residents from 15 to 18 years of age.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	87%	94%	91%	87%	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 enforcement action	*26/05/2022*	*To provide further information on Regulation 12: Communication, Regulation 22: Premises and Regulation 32: Risk Management Procedures have been found to be non-compliant with a risk rating of high following the annual inspection of the approved centre.*	*Approved centre submitted assurances which were unsatisfactory, and the issue was escalated to a regulatory compliance meeting.*
Regulatory compliance meeting	*30/08/2022*	*The MHC did not receive a satisfactory response or adequate assurances in*	*Plans were received at the regulatory compliance meeting which the MHC continue to monitor.*

		relation to this Immediate Action Notice.	

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Ligature anchor points:*** Ligature points were minimised to the lowest level, based on individual risk assessment.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Access to essential information*****:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***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:

- ***Safety: Number and skill mix of staff*****:** The number and skill mix of staffing were not sufficient to meet resident needs. At the time of this inspection the occupational therapist and the clinical nurse specialist positions were vacant. Interviews for the post of the clinical nurse specialist in self-harm were held during the inspection.
- ***Safety: Mandatory training:*** Not all staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Safety: Risk:*** The approved centre had not notified the Mental Health Commission of incidents occurring in the approved centre. From July 2019, the six-monthly summary report of all incidents had not been submitted by the approved centre to the Mental Health Commission.

Appropriate care and treatment of residents

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

- **Appropriateness of environment:** The layout and the decoration of the Adolescent In-Patient Unit (AIPU) was of a high standard and met the needs of the residents.
- ***Initial assessments**:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment**:* Each resident had a physical examination on admission.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) which was appropriately documented, and 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 social worker and a psychologist. There were regular multi-disciplinary team meetings to discuss residents' care plans.

However:

- ***Therapeutic interventions:*** While therapeutic interventions were evidence-based and in line residents' individual care plans, residents did not have access to occupational therapy services at the time of the inspection. This meant that therapeutic programmes and services were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.
- ***Discharges:*** A comprehensive discharge summary was not issued within the stipulated 14 days; instead, it was issued 20 days after the date of discharge.

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:*** There were twelve single en suite bedrooms which were decorated with residents' personal effects and furnished appropriate to each resident's needs.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialising. Clinical files were securely stored.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Privacy and Dignity: Rights-based care:*** There were three deficits in the approved centre's processes around the search of a resident in a sample of four search episodes inspected. In one search undertaken there was no written record of it, consent of the resident was not sought before they were searched, and there was no proof that two qualified staff were present during this search of this resident.
- ***Use of restrictive practices, rights-based care:*** The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of restrictive practices. Mechanical Restraint was not used in the approved centre. Seclusion and separately physical restraint were used in the approved centre only when less restrictive alternatives were deemed unsuitable.

  Restrictive practices: Seclusion: In a sample of three seclusion episodes inspected, the approved centre was not compliant with the Rule Governing Seclusion for 4 different reasons, risk rated moderate.

  Restrictive practices: Physical Restraint: In a sample of three physical restraint episodes of three child residents inspected; the approved centre was not compliant with the Code of Practice on Physical Restraint for one reason, which was risk rated low.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Were appropriate and accessible to residents seven days a week. A selection included a therapy dog, word games, art and crafts, baking, relaxation, jewellery making, garden walks and games,
- ***Residents' feedback:*** The residents were complimentary about the environment and the care they received. Two residents indicated staff 'always' gave them understandable information about their

diagnosis, care, and treatment; three answered this was 'sometimes' the case. One resident comment described the staff as approachable and caring. Another commented said, "I just find it tough being here." *(Please refer to section 5.0 for detailed service user feedback).*

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 of a Board of Governors, of St. Vincent's Hospital who met monthly. The Executive Management Team (EMT) met three times a month and on the EMT team were the following individuals: the Chief Executive Officer (CEO), Clinical Director, and Director of Nursing. At the time of the inspection, and in previous years inspections there was an acting CEO in position, and there were no health and social care professionals on the EMT.
- ***Leadership:*** A service development meeting occurred monthly. Heads of Disciplines reported they frequently attended the approved centre and regularly met with their staff.
- ***Restrictive practices reduction:*** The approved centre had developed a seclusion booklet and physical restraint booklet and engaged in the use of positive behaviour support for residents involved in restrictive practices.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. The approved centre had implemented nine quality initiatives since the last inspection.
- ***Policies:*** The approved centre's policies were all up-to-date.
- ***Staff training:*** Not staff had received mandatory training.
- ***Complaints:*** There was a robust 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. Resident involvement and engagement in service delivery was facilitated by a suggestion box in the approved centre along with a compliments and complaints process to support service improvement.
- ***Advocacy services:*** The approved centre had an advocacy service. A representative from the Mental Health Advocate Services' Youth Advocate Programme (YAP) was available weekly to the residents. Their contact details were displayed in the approved centre. Inspectors did not receive a report from the Youth Advocacy Programme.
- ***Regulatory compliance and engagement:*** The approved centre has had a high average compliance rate of 88% over the last 4 years. Compliance rate has dropped by 9% since last year. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risk: Number and skill mix of staff*:** The number and skill mix of staffing were not sufficient to meet resident needs. At the time of this inspection the occupational therapist and the clinical nurse specialist positions were vacant.
- ***Risk:*** The approved centre had not notified the Mental Health Commission of incidents occurring in the approved centre. From July 2019, the six-monthly summary report of all incidents had not been submitted by the approved centre to the Mental Health Commission.
- ***Restrictive practices reduction:*** The approved centre was not compliant with the Rule Governing Seclusion and with the Code of Practice on Physical Restraint.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A qualified external fitness instructor facilitated a six-week cross-fit programme to promote physical health and wellbeing. The programme was adapted to meet the specific physical and mental health care needs of the young people.

2. A two-day nursing-staff programme, Understanding Autism, was carried out to enhance awareness of and capacity to care for residents diagnosed with pervasive neuro-development disorders.

3. New furnishings and an awning in the external garden were provided to the approved centre, received from government funding.

4. The Youth Advocacy Programme (YAP) was introduced for the approved centre.

5. Members of the nursing staff completed Reinforce Appropriate, Implode Disruptive (RAID) training to better manage challenging behaviour.

6. An advanced nurse practitioner from Child and Adolescent Mental Health Services facilitated workshops titled “Eating Disorders Assessment and Approaches” with nursing staff.

7. The clinical nurse managers put together an eating disorder re-feeding programme workbook.

8. Animal Assisted Therapy was introduced, and as part of the therapy, a therapy dog was brought to visit the approved centre one day a week.

9. Reintroduction of the nursing innovation project titled “Nature Based Therapy/Social and Therapeutic Horticulture” joined adolescent and adult mental health. Residents decorated and planted pots for the Continuing Care Units of the Adult-Approved Centre.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Adolescent In-Patient Unit (AIPU) was a public voluntary hospital located on grounds of St. Vincent's Hospital, Fairview. The approved centre was registered for child and adolescent mental health care and mental health care for people with intellectual disability.

The approved centre was in a separate building to the main St. Vincent's hospital, which was clearly signposted from the entrance. AIPU was located on the first floor and shared a reception area on the ground floor with the designated school for the residents. Access to the approved centre was by lift or stairs from the building's reception area. AIPU was not a purpose-built adolescent facility; however, the premises was bright, very clean and well maintained. Pieces of artwork and projects completed with the residents were displayed on the walls throughout the unit. The approved centre consisted of a nurses station, communal sitting room, dining room and kitchen, seclusion room, relaxation room, family room, laundry facilities and a night nurse station. There were twelve single en suite bedrooms which were decorated with residents' personal effects and furnished appropriate to each resident's needs. The bedrooms were located along one single corridor, with a high observation bedroom near the nurses station. Residents had access to an external garden area and a basketball court.

The approved centre was registered with the Mental Health Commission for 12 beds, however due to the layout and space limitations of the approved centre, the operational bed capacity at the time of inspection was 10. Admissions were accepted from the Dublin Northeast area, Dublin North City and County, Meath, Louth, Cavan, and Monaghan. Admissions were also accepted from other areas depending on need and availability. The approved centre accepted individuals from 15 years to 18 years of age.

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

Resident Profile	
Number of registered beds	***12***
Total number of residents	**6**
Number of detained patients	0
Number of wards of court	0
Number of children	6
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The Adolescent In-Patient Unit was under the governance of a board of governors of St. Vincent's Hospital, who met monthly. The governance processes included the executive management team (EMT) meeting and the quality and patient safety (QPS) committee meeting. The executive management team (EMT) met three times a month which provided governance for AIPU. The attendees comprised the Chief Executive Officer (CEO), Clinical Director and Director of Nursing. At the time of the inspection, there was an acting CEO in position. There were no health and social care professionals on the EMT.

The QPS committee convened quarterly and provided oversight for continuous quality improvement of AIPU via sub-committees which reported to the QPS. These sub-committees included the infection prevention and control group, the health and safety committee, the drugs and therapeutic committee and the policy committee, all which met quarterly. The QPS committee meeting attendees were members of the senior team. The QPS meetings provided quality improvement through risk and incident management and shared recommendations. The approved centre had an audit programme in place.

A service development meeting occurred monthly and comprised of the Clinical Director, Consultant Psychiatrist, Assistant Director of Nursing and Clinical Nurse Managers (CNM's). Operational and clinical functions, service delivery, risk management, service improvements and audits were included on the agenda. A risk-management meeting occurred every two weeks. Attendees included the Consultant Psychiatrist, Assistant Director of Nursing, and Clinical Nurse Manager with the purpose of reviewing all incidents which were reported to the QPS Committee. A quality and safety walkabout occurred quarterly in the approved centre which was part of the quality improvement plan for improving compliance with standards, supporting a proactive approach to minimising risks, increasing staff engagement, identifying and sharing good practices and providing assurance that required improvements were being implemented.

All clinical staff had received training on clinical risk management procedures appropriate to their role and function. Key personnel were responsible for risk management in the approved centre. The person with overall responsibility for risk was identified and known by staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre. The approved centre had a risk register and the QPS Committee reviewed, monitored and updated the risk register. Risk management was also on the agenda for the EMT meeting and the board of governors meeting, with a process of escalation to the Health Service Executive if required. The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and were reviewed to identify any trends or patterns occurring in the service. Analysis of incidents took place at the QPS meeting and feedback was given to staff of AIPU through the relevant line managers. The approved centre maintained a record of all incidents; however, the Mental Health Commission (MHC) had not been notified of incidents that occurred. During the inspection, the approved centre submitted the six-monthly summary report of incidents for January–June 2023 to the MHC.

An organisational chart clearly identified the structures of leadership and the lines of responsibility and accountability within the approved centre. Governance questionnaires were completed by each head of discipline and returned to the inspection team. Respondents provided a clear overview of the governance within their respective roles, issues of risk or specific concerns and strategic goals for the service, and

systems to monitor goal progression. Heads of Disciplines reported they frequently attended the approved centre and regularly met with their staff. Risks identified by the heads of discipline included space limitations due to the design and layout of the premises, and the recruitment and retention of staff. During the inspection, work was being completed to convert a building located on the grounds of St. Vincent's into staff accommodation.

The approved centre had appropriately qualified staff on duty and in charge at all times; however, the numbers and skill mix of staffing were not sufficient to meet residents' needs. There was a vacant clinical nurse specialist post; at the time of the inspection interviews were being carried out. There was a vacant occupational therapy post and 10 vacant nursing posts. The nursing positions were covered through overtime and regular agency staff. One multi-disciplinary team was responsible for the care and treatment of the residents within the approved centre. The team included medical, nursing, social work and psychology staff, all of whom were based in the approved centre. Dietetics and speech and language therapy were privately sourced and provided by approved and qualified health professionals.

Not all staff were up to date on mandatory training. The mandatory training progress record provided by the approved centre indicated shortfalls in basic life support, fire safety, management of violence and aggression, and the Mental Health Act 2001. There was a plan and schedule in place to address the deficits in training.

Adequate supervision structures were in place within the psychology department, which included line management supervision, external and peer supervision. Clinical supervision availability varied across the other departments, ranging from formal to informal groups within their own disciplines and others facilitated by external providers. A lack of line-management supervision and support for the health and social care professions was identified as a gap by members of the senior management team. The approved centre had an annual staff training schedule that included in-service training and workshops.

Resident involvement and engagement in service delivery was facilitated by a suggestion box in the approved centre along with a compliments and complaints process to support service improvement. The process of making complaints and the complaints officer's contact details were displayed within the approved centre and were accessible to residents and their representatives in information booklets. Minor complaints that had been dealt with by staff were documented. All formal complaints were reviewed and dealt with by the nominated complaints officer of the approved centre and were documented with clear actions and outcomes detailed in the complaints log. There had been no formal complaints made since the last inspection. Residents were involved in the development and review of their individual care plans. Weekly resident community meetings took place in the approved centre, and this provided an opportunity for residents to raise concerns or make suggestions. A review of the meeting minutes indicated that activity planning and requests from residents were discussed.

A representative from the Mental Health Advocate Services' Youth Advocate Programme (YAP) was available weekly to the residents. Their contact details were displayed in the approved centre. The service provided was a combination of weekly in-person group support, individual support and virtual or phone support for the residents.

On 28 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 for the code of practice and rules was 1 January 2023. At the time of inspection, the approved centre had used physical restraint and seclusion and had integrated the revised code and rule. The Use of Physical Restraint policy and Use of Seclusion policy had been updated along with the implementation of the Reduction of Restrictive Practices policy. An oversight committee was in place which met quarterly. The assistant director of nursing was the named senior manager with responsibility for the approved centre's reduction in restrictive practices of physical restraint and the consultant psychiatrist was the named senior manager with responsibility for reduction in seclusion. The approved centre had developed a seclusion booklet and physical restraint booklet and engaged in the use of positive behaviour support for residents involved in restrictive practices. The approved centre had child protection policies and procedures, in line with relevant legislation and regulations. Policy and procedure regarding staff training were in place.

The approved centre was proactive in managing issues concerning COVID-19. The risk was managed through the approved centre's risk management processes. An Infection Control Committee met quarterly to ensure oversight of all related practices and procedures. The Management of COVID-19 was also discussed at the EMT and QPS meetings. AIPU had introduced a policy on the prevention and management of the Infection which was reviewed and updated in August 2023 in line with national best practice guidelines from the Health Protection Surveillance Centre.

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	✓		✓		✓		✓		✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✓		✓		✓		✓		✗	High
Regulation 26: Staffing	✗	Moderate	✓		✗	Moderate	✗	Moderate	✗	High
Regulation 32: Risk Management Procedures	✓		✓		✓		✗	High	✗	Moderate
Rules Governing the Use of Seclusion	✗	Moderate	✓		✓		✓		✗	Moderate
Code Of Practice on the Use Physical Restraint	✗	High	✓		✓		✓		✗	Low
Code Of Practice on Admission, Transfer and Discharge	✓		✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

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

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

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engaged with residents in the following ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete service-user-experience questionnaires, which were reviewed by the inspection team in confidence. These were anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- The Peer Advocacy in Mental Health 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.

Residents were given the opportunity to speak with the inspection team and to complete feedback questionnaires.

Three residents availed of the opportunity to speak with the inspection team. Residents found the advocacy service very helpful; they met with the advocate weekly and could call them on the phone.
Residents reported wanting more garden access and more therapeutic and recreational groups, particularly on the weekends and evenings. Residents reported insufficient and unreliable activities. Residents reported that Netflix, Disney and Amazon Prime were available and they appreciated the addition of a Nintendo Switch. Residents knew their multi-disciplinary team and attended weekly meetings with the consultant. Residents reported that the bedrooms and units were comfortable and very clean. Residents reported that the food was good and adapted for their meal plans. Residents reported they had regular visits in the afternoons and evenings and could phone family or friends anytime outside of school hours. Residents reported the staff were approachable and caring, and that they could go to staff with any concerns or issues.

Five completed service-user-experience questionnaires were returned to the inspection team.
Two residents indicated they knew who their multi-disciplinary team members were. One indicated that they did not know yet, one answered no and one was unanswered.
Four residents indicated that they were 'always' involved in setting their individual care plan goals while one indicated they 'sometimes' were. Four residents indicated they understood their care plan, one did not understand. Two residents indicated staff 'always' gave them understandable information about their diagnosis, care, and treatment; three answered this was 'sometimes' the case.

Four completed questionnaires indicated that residents were happy with how staff talked to them. Four residents indicated that they knew who their keyworker was while one resident reported that they did 'not yet' know who their keyworker was. All residents indicated that they 'always' felt safe in the approved centre.
Four residents indicated that when they arrived to the approved centre, a staff member explained what was happening in a way they understood; one resident answered no, a staff member did not explain what was happening. Four residents indicated they could 'always' communicate freely with their family, friends or an advocate; one resident indicated they could 'sometimes' do so.

Three residents indicated there was space for privacy, one indicated there was not space for privacy and one left the question unanswered. Three residents indicated their privacy and dignity was respected, one resident indicated that their dignity and privacy was not respected and one left the question unanswered.

One resident indicated there were enough activities during the day, three answered there were not and one left the question unanswered. Four residents indicated they could 'always' discuss worries and concerns while one resident answered they could 'sometimes' do so.

On a scale of 1–10, with 1 being poor and 10 being excellent, one resident rated 9, one rated 8 and three rated 5 for their overall care and treatment in the approved centre.

One resident comment described the staff as approachable and caring. Another commented said, "I just find it tough being here."

5.2 Advocacy

The approved centre had an advocacy service.

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

6.0 Feedback Meeting

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

- Clinical Director
- Acting Chief Executive Officer
- Consultant Psychiatrist
- Director of Nursing
- Assistant Director of Nursing
- Acting Assistant Director of Nursing
- Clinical Nurse Manager III
- Clinical Nurse Manager I
- Principal Social Worker
- Technical Services Manager
- Personal Assistant to Acting Chief Executive Officer

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

Nutritional and dietary needs were assessed where necessary and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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 an ample supply of 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 operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in March 2021.

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 and was available to the resident.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities, including wardrobes, cupboards, safes and lockers, were provided for the safekeeping of the resident's monies and valuables, as necessary. Residents were supported to manage their own property, as appropriate.

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. Activities included the following: television and streaming services such as Netflix, computer, Nintendo Switch game console, books, jigsaws, board games, music, word games, art and crafts, baking, relaxation, jewellery making, garden walks and games, movie night, therapy dog, self-care and weekly community meetings.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. A chaplain was available to residents in the approved centre for their spiritual/religious needs. The chaplain completed spiritual assessments with all residents and also facilitated a weekly relaxation group. They met with residents on a one-to-one basis when required. Residents had access to a chapel on campus and to other religious chaplains when needed. The chaplain attended the weekly multi-disciplinary team (MDT) meetings.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Visiting times were appropriate and reasonable. Visiting times were displayed in the approved centre and visits outside of the visiting hours were facilitated if required. There was a visitors room available 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 visitors room was suitable for visiting children, and it contained a selection of books and toys.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents had access to postal mail, the internet, six portable phones, two electronic tablets and a mobile phone provided by the approved centre, unless otherwise risk-assessed with due regard to the resident's well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

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 September 2023, 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 four 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 and the reason for the search. The resident search policy and procedure was communicated to all the residents, and relevant staff could articulate the searching processes as set out by the policy.

In relation to a search of one resident which took occurred prior to the resident being placed in seclusion, there was evidence in the seclusion care plan booklet that a search took place. However there was no written documentation regarding the specific search processes such as the minimum of two clinical staff in attendance at all times and the resident's written consent sought prior to being searched. Due to the lack of written documentation on the search it was not guaranteed that a minimum of two appropriately qualified staff were in attendance at all times during a search.

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

a) **The registered proprietor did not ensure the consent of the resident was sought in the search of one resident, 13(4).**
b) **The registered proprietor did not ensure there was a minimum of two qualified staff in attendance at the time when a search of one resident was being conducted, 13(6).**
c) **The registered proprietor did not ensure that there was a written record of every search conducted, as there was no documented evidence that the search of one resident had been conducted, 13(9).**

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in September 2023. As no resident had died in the approved centre since the last inspection, the regulation was inspected against policy requirements only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Five ICPs were reviewed on inspection. All ICPs were a composite set of documents and allocated space for goals, treatment, care, resources required and reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment 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 identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICPs also identified the resources required to provide the care and treatment identified. The ICP was reviewed by the MDT weekly, in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. The ICPs of child residents included their educational requirements.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

(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 young people in the approved centre attended weekday school from 9.30 am to 2.30 pm. Therapeutic groups and one-on-one sessions took place outside of school hours. Psychology staff ran a compassion focused therapy group with meditation exercises and a flexible thinking group to assess and improve psychology flexibility. A religious member delivered a positive energy group. Junior doctors ran a weekly medical group that discussed items such as medication. Social work ran an interpersonal relation group, however this was dependent on availability and on clinical review meetings. Social work ran a 4-6 week closed parent group on eating disorders. A dog therapy group also took place regularly.

The approved centre's therapeutic services and programmes were not directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning, due to a lack of access to occupational therapy services. The occupational therapist had been on leave since May 2023 and the approved centre had not arranged replacement cover.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A dietitian was available through online sessions. While the speech and language therapy (SLT) post was vacant at the time of the inspection, a private SLT was arranged when needed.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, due to a lack of access to occupational therapy services, 16(2).

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 were available for provision of education to the child residents in the approved centre. The approved centre had three classrooms, some office space and an outdoor physical education area. There were four full-time teachers and three part-time teachers who did one day teaching each afternoon. The teachers' time was divided between the day hospital and the approved centre.

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 an operational policy and procedures in relation to transfers. The policy was last reviewed in May 2021. The clinical file of one resident who had been transferred from the approved centre in an emergency was inspected. Complete written information accompanied the resident upon transfer to a named individual, including a list of current medications. A nurse accompanied the resident to the receiving facility at the time of transfer. A resident transfer form was not provided as it was an emergency transfer but a verbal referral was provided and communicated to the receiving facility.

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 and procedures, which included emergency procedures. The policy was last reviewed in May 2021.

The approved centre had an emergency trolley, emergency bag and oxygen. Staff had access at all times to an automated external defibrillator. Residents received appropriate general health care interventions in line with their individual care plans. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

At the time of the inspection, no resident had been in the approved centre for six months or longer. Residents could access a medication review. Access to national screening programmes was not applicable to the approved centre.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in May 2021.

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 had a separate information booklet for parents and carers.

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Staff spoke respectfully to residents. Residents were called by their preferred names, staff appearance and dress were appropriate and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers and toilets had locks on the inside of the door unless there was an identified risk to a resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information.

Residents were able to make and take private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were sufficiently heated and ventilated. 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 comprising a large garden at the back of the approved centre, which was accessible by lift from the first floor. Hazards were minimised in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

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

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

address the resident needs and furnished to support resident independence and comfort. All residents had their own bedroom with en suite attached.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in September 2021. The policy included:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing resident medication.
- The process for the 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. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident; and a clear record of the date of discontinuation for each medication. The MPARs also contained the medical council registration number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition and was documented in the clinical file.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

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 written operational policies and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last approved in August 2021.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was one multi-disciplinary team (MDT) admitting to the approved centre, which included nursing staff, social work, medical and psychology. Dietitian input was once a week via video conferencing.

Though an appropriately qualified staff member was on duty at all times and this was documented, the approved centre had a shortage of nursing staff, with ten vacant nursing posts at the time of the inspection. The vacancies were covered by overtime and agency staff.

The number and skill mix of staffing were not sufficient to meet resident needs. At the time of this inspection the occupational therapist and the clinical nurse specialist positions were vacant. Interviews for the post of the clinical nurse specialist in self-harm were held during the inspection.

Not all healthcare staff had received up-to-date mandatory training in basic life support, fire safety or the management of violence and aggression. Not all healthcare staff had received mandatory training in the Mental Health Act 2001.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre. The following table shows the percentage of staff who had received up to date training in the four mandatory training topics:

Staff Training Table								
Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (10)	9	90%	7	70%	10	100%	10	100%
Medical (4)	2	50%	0	0%	1	25%	3	75%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%

x

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

a) **The registered proprietor did not ensure that the number and skill mix of staff was appropriate to the assessed needs of residents, 26(2).**
b) **The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice as not all staff were up-to-date with training in fire safety, basic life support, management of violence and aggression and the Mental Health Act 2021, 26(4).**

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the creation of, access to, retention of and destruction of records. The policy was last reviewed in September 2021. Resident records were secure, up to date and in good order, and were physically stored together in a secure office. All resident records were reflective of the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of inspections relating to food safety, health and safety and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All policies and procedures requiring a three yearly review had been reviewed and updated as required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in February 2023 and included the process for managing complaints. This included the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

A nominated person responsible for dealing with all complaints was available to the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family and next of kin were informed of all methods by which a complaint could be made.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. All escalated complaints were documented and sent to the Chief Executive's office. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. The registered proprietor ensured that the quality of service, care and treatment was not adversely affected by reason the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating MODERATE

(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 comprehensive written operational policy and procedures in relation to risk management. The policy was last reviewed in August 2021. The risk management policy and associated safety statement addressed all policy requirements, including:

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

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 prior to and during resident seclusion and physical restraint. Individual risk assessments were also completed in conjunction with medication requirements or

administration; at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm; and during 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 and the risk advisor reviewed incidents for any trends or patterns occurring in the services. While the approved centre had not provided a six monthly summary report of all incidents to the Mental Health Commission since 2019, during the inspection a January–June 2023 summary report was submitted to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. An emergency plan specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre notified the Mental Health Commission of incidents occurring in the approved centre. From July 2019, the six-monthly summary report of all incidents had not been submitted by the approved centre to the Mental Health Commission, 32(3).

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 and indemnity scheme statement 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 outside the entrance door of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

The policy addressed:

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

The approved centre had a policy on the reduction of seclusion which covered all the stipulated requirements and clearly documented how the approved centre aimed to reduce seclusion and, where possible, eliminate the use of seclusion. The approved centre had a policy and procedures for training all staff involved in seclusion and it covered all the stipulated requirements.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy. All staff who participated, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

Monitoring: A multi-disciplinary review and oversight committee was established to analyse every episode of seclusion in detail. The committee met at least quarterly and met all stipulated requirements.

Evidence of Implementation: The seclusion facilities were furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's privacy was respected.

Order of Seclusion: Three episodes of seclusion in relation to three different individuals were reviewed on inspection. All the stipulated requirements for seclusion orders were adhered to. Seclusion was only initiated following as comprehensive an assessment of the person as practicable. This included a risk assessment, the outcome of which was recorded in the clinical file. The order of the Consultant Psychiatrist confirmed that there were no other less restrictive ways available to manage the person's presentation.

Seclusion was initiated by a registered medical practitioner (RMP) or the most senior registered nurse (RN) on duty. The RMP or RN recorded the seclusion orders in the clinical files and on the seclusion register. Where seclusion was initiated by an RN, a RMP was notified of the seclusion episode as soon as practicable, no less than 30 minutes following the commencement of the seclusion episode. There was a medical examination of the person by a RMP as soon as practicable, and no later than two hours after the commencement of the seclusion episode.

On one occasion the Consultant Psychiatrist did not undertake a medical examination of the person within 24 hours of the commencement of the seclusion episode.

Dignity and safety: Where close confinement was contraindicated, seclusion was only used when all other options had proven unsuccessful and following risk assessment. The clothing worn in seclusion respected the right of the residents to dignity, bodily integrity and privacy.

Bodily searches were only undertaken in exceptional circumstances, following risk assessment. In two episodes of seclusion bodily searches were undertaken in the presence of more than one staff member, and respected the right of the resident to dignity, bodily integrity and privacy. Gender and cultural sensitivity and the preferences of the persons were respected.

In one episode of seclusion inspected, a bodily search was undertaken but the documentation did not record if the search was in the presence of more than one staff member.

Monitoring and review: The persons placed in seclusion were kept under direct observation by an RN for the first hour following the initiation of seclusion. After the first hour, an RN kept the persons under continuous observation and remained within sight and sound of the seclusion room throughout the episode. The registered nurse made a record of the person every 15 minutes and this record was always complete.

Renewal of Seclusion Orders: All three episodes of seclusion were renewed by an RMP under the supervision of the Consultant Psychiatrist or the duty Consultant Psychiatrist following a medical examination, however the renewal of one episode exceeded four hours.

Ending of seclusion: In all episodes of seclusion, the individual care plan was updated to reflect the outcome of the debrief session and in particular, the person's preferences in relation to restrictive interventions going forward.

Seclusion of a child: A RMP or RN carried out a documented risk assessment to determine if seclusion could be safely used or not. The reasons for, likely duration of and circumstances around the order were explained in a way a child could understand. The child's parent or guardian was informed as soon as possible of the seclusion and the circumstances which led to it as well as when it ended.

Child protection policies and procedures were in place and in line with relevant legislation and regulations. Policy and procedure regarding staff training and child protection were in place.

Clinical Governance: All three episodes of seclusion were reviewed by members of the multi-disciplinary team (MDT) involved in the person's care and treatment, however one episode was not reviewed within five working days after the episode of seclusion.
The MDT review was documented, including recorded actions decided upon and follow-up plans to eliminate or reduce interventions for the person. The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of seclusion.

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

a) **On one occasion the Consultant Psychiatrist did not undertake a medical examination of the person within 24 hours of the commencement of the seclusion episode, 3.10.**
b) **A bodily search was undertaken on one occasion, but the documentation did not record if the search was in the presence of more than one staff member, 4.4.**
c) **The seclusion order was renewed by an order made by a RMP under the supervision of the CP or the duty CP following a medical examination, however the renewal order exceeded four hours, 6.1.**
d) **One episode of seclusion was reviewed by members of the multi-disciplinary team (MDT) involved in the person's care and treatment, however it was not reviewed within five working days after the episode of seclusion, 10.3.**

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2023. It addressed:

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

Policies and procedures regarding staff training included:

- Who will receive training based on the identified needs of persons who are restrained and staff
- The areas to be addressed within the training programme, which included training in:
    - The prevention and therapeutic management of violence and aggression (including 'breakaway' and de-escalation techniques); alternatives to PR; trauma-informed care; cultural competence; human rights, including the legal principles of restrictive interventions; and the monitoring of the safety of the person during and after the PR.
- positive-behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional or somatic.
- The written policy on the use of physical restraint identified appropriately qualified person(s) to give the training.
- The mandatory nature of training for those involved in PR.

The approved centre had a policy on the reduction of physical restraint which:

- Clearly documented how the approved centre aims to reduce, or where possible eliminate, the use of PR within the approved centre.
- Addressed leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.
- Clearly documented how the approved centre will provide positive behaviour support as a means of reducing or, where possible, eliminating the use of PR within the approved centre.

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.

Monitoring: The multi-disciplinary team (MDT) review and oversight committee met at least quarterly at the time of the inspection, and they had:

- Determined if there was compliance with the code of practice on the use of PR for each episode of PR reviewed.
- Determined if there was compliance with the approved centre's own policies and procedures relating to PR.
- Identified and documented any areas for improvement.
- Identified the actions, the persons responsible and the timeframes for completion of any actions.
- Provided assurance to the registered proprietor nominee that each use of PR was in accordance with the MHC's code pf practice.
- Produced a report following each meeting of the review and oversight committee, which was available to the MHC upon request.

Evidence of Implementation: The clinical files of three child residents who were physically restrained in 2023 were reviewed on inspection.

PR was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy on physical restraint. The physical restraint order confirmed that there were no other less restrictive ways available to manage the person's presentation. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified as soon as was practicable and this was recorded in the clinical files. The RMP completed a medical examination of each of the residents no later than two hours after the episodes of PR. The orders for PR lasted a maximum of 10 minutes.

The clinical practice form was signed by the CP within 24 hours. The residents were informed of reasons for, likely duration of, and circumstances leading to discontinuation of PR except where the information was prejudicial to the residents' mental health, well-being or emotional condition.

In all episodes of physical restraint, as soon as was practicable, and as it was the person's wish in accordance with their individual care plan, the person's representative was informed of the person's restraint and a record of this communication was placed in the clinical file. The Mental Health Commission (MHC) was notified through the Comprehensive Information System of the start time and date and the end time and date of each episode of PR in the format specified by the MHC within three days of the restraint.

A same-sex staff member was present at all times during the episodes of PR. In both episodes of physical restraint, the person was continuously assessed throughout the use of restraint to ensure the person's safety, and this was documented. In both episodes of physical restraint the person's head and neck were supported where necessary. In both episodes of physical restraint the person's airway and breathing were not compromised. Observations were conducted, including vital clinical indicators such as the monitoring of pulse, respiration and complexion, with special attention to pallor or discolouration. These observations were documented.

The person who led the physical restraint ended it. The time, date and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended.

An in-person debrief with the person who was restrained followed every episode of PR. This debrief was person-centred and gave each person the opportunity to discuss the PR with members of the MDT involved in the person's care and treatment as part of a structured debrief process.

The debrief included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. The debrief included a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future, such as preferences in relation to which restrictive intervention they would not like to be used. The person's individual care plan was updated to reflect the outcome of the debrief and, in particular, the person's preferences in relation to restrictive interventions going forward. There was a record of all attendees who were present at the debrief and this was recorded in the clinical files.

The episodes of PR were recorded on the clinical practice forms located in the clinical files. Two of the three episodes of PR inspected were reviewed by members of the MDT within five working days from the date of the restraint. In the third episode of physical restraint the episode of physical restraint was reviewed by members of the MDT, but not within five working days from the date of the restraint episode. The review covered everything required to be covered. The MDT recorded actions decided upon and follow-up plans to eliminate or reduce restrictive interventions for the person. A named senior manager was responsible for the approved centre's reduction of physical restraint.

A risk assessment pertaining to PR was documented on admission by an RPM or RN to determine whether PR could be safely used or not. The reasons for the restraint and the circumstances which would lead to its discontinuation were explained in an understandable way appropriate to the child's age? A record was made of this communication that clearly outlined how it met the child's communication needs.

The child's parent or guardian were informed as soon as possible of the PR and the circumstances which led to it. The parent or guardian were informed when the episode of PR ended.

The approved centre had child protection policies and procedures in place that were in line with relevant legislation and regulations. The approved centre had a policy and procedures in place addressing appropriate training for staff in relation to child protection.

The approved centre was non-compliant with this code of practice because in one episode of physical restraint the episode of physical restraint was not reviewed by members of the multi-disciplinary team within five working days from the date of the restraint episode, 7.3.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

Transfer: The transfer policy, which was last reviewed in May 2021, included all the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in March 2022, included all the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

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

A discharge meeting with the appropriate multi-disciplinary team with an input into discharge planning took place. The discharge assessment was coordinated by a key worker and addressed the resident's psychiatric and psychological needs. It contained a comprehensive risk assessment and risk management plan.

A preliminary discharge summary was sent to the general practitioner within three days. A comprehensive discharge summary was not issued within the stipulated 14 days; instead, it was issued 20 days after the date of discharge. The comprehensive discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues and risk issues such as signs of relapse. A family member was involved in the discharge process.

The approved centre was non-compliant with this code of practice because the comprehensive discharge summary was not issued within 14 days, 38.3(b).

Appendix 1: Corrective and Preventative Action Plan

The approved centre did not provide acceptable Corrective and Preventable Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

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.

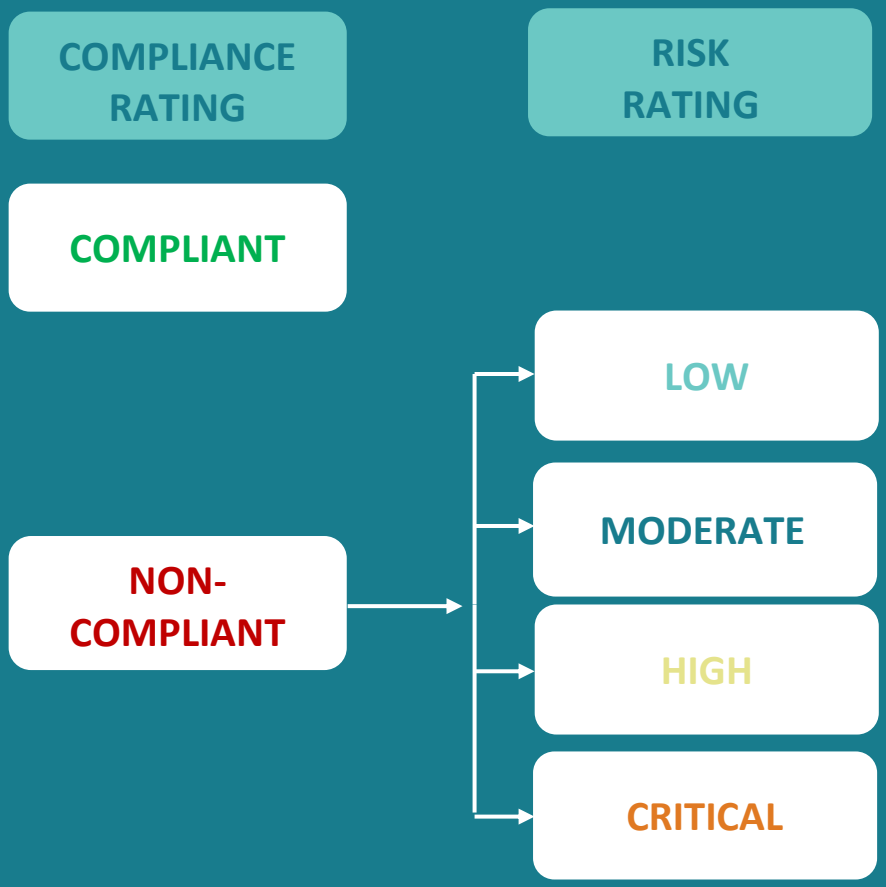
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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