Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

LINN DARA CHILD & ADOLESCENT MENTAL HEALTH IN-PATIENT UNIT, CHERRY ORCHARD

Cherry Orchard Hospital Campus, Ballyfermot Road, Dublin 10

Date of Publication:
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2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child & Adolescent Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
10 December 2021

Registered Proprietor:
HSE

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

Inspection Team:
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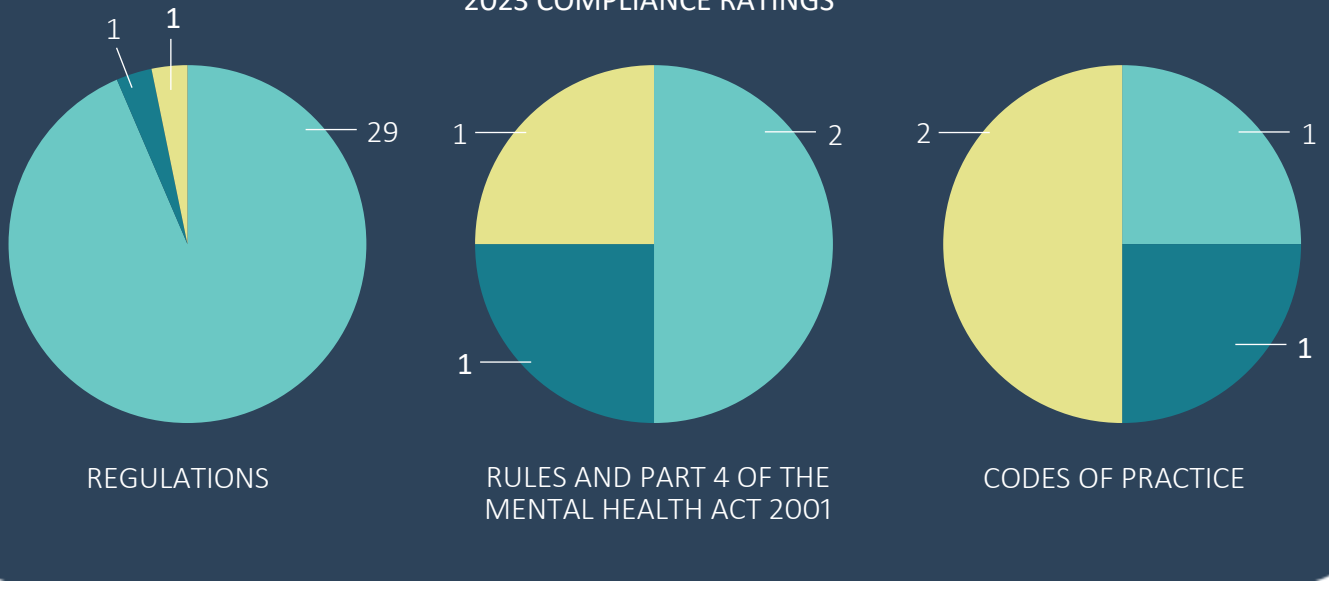
Inspection Date:
29 August – 1 September 2023

Previous Inspection date:
31 March – 1 April 2022

Inspection Type:
Announced Annual Inspection

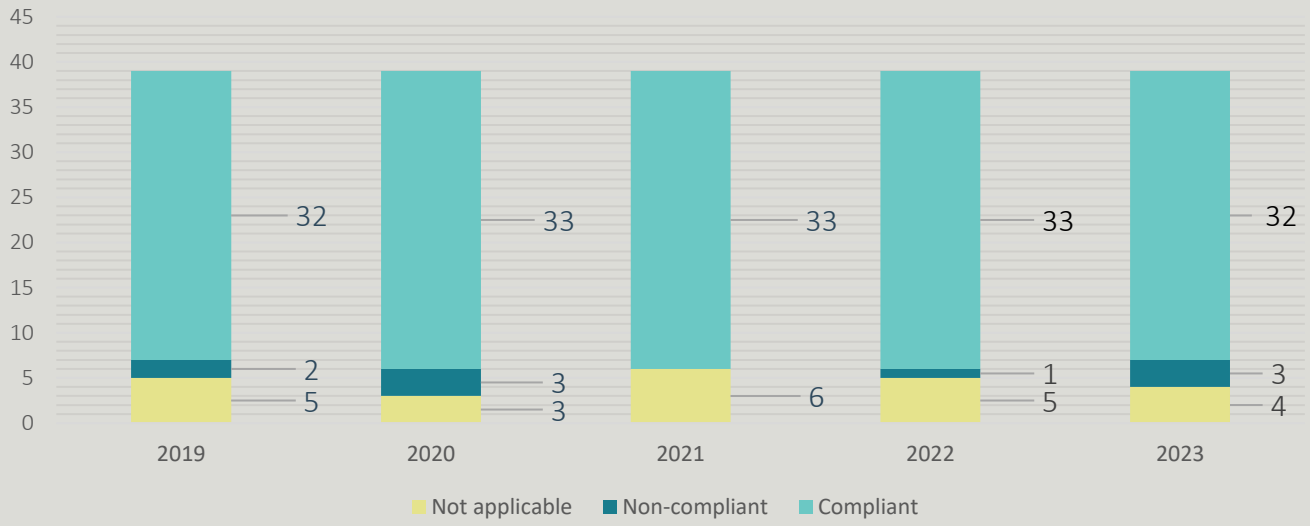
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

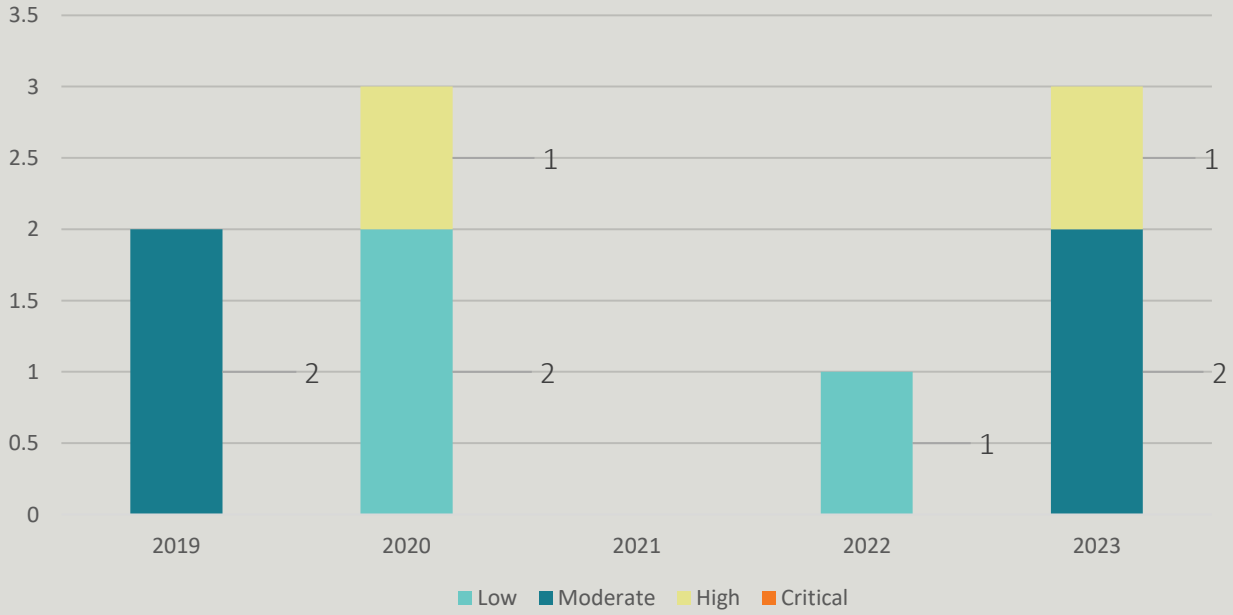
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Professor James V Lucey

In brief

Linn Dara Child and Adolescent Mental Health Services (CAMHS), provided Child & Adolescent Mental Health Care and was part of the national CAMHS network and took referrals mostly from the east and north of the country. Located in Ballyfermot Dublin 10, the HSE (Health Service Executive) was the registered proprietor. It was registered for 24 beds and accommodated 8 residents at the time of the inspection.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	94%	92%	100%	97%	91%

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	*14/4/2022*	*To provide further information on critical risks associated with Regulation 21: Privacy.*	*Approved centre submitted plans which were unsatisfactory.*
Regulatory compliance meeting	*25/5/2022*	*To provide the approved centre with the opportunity to provide plans to mitigate the risks associated with Regulation 21: Privacy.*	*Plans were received at the regulatory compliance meeting. The MHC continued to monitor. The approved centre was compliant with Regulation 21: Privacy during the 2023 annual inspection.*

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** One doctor, two nurses, a psychologist and a dietitian were new to the service and had not yet completed all of their mandatory training. Otherwise all healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***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.

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 Linn Dara CAMHS 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. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.

- ***Individual care plans:*** Each resident had an individual care plan (ICP) and there was evidence of significant engagement with residents in respect of their ICP. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, a psychologist, social worker, dietitian, and an occupational therapist. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan, a selection included: access was provided to a family therapist, play therapist, art therapist, canine therapy, and yoga therapist on a sessional basis.
- ***Access to other specialist medical and therapeutic services:*** Residents had access by referral to physiotherapy, paediatrician, dentist, physicians, and out-patient radiology services where required.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** Each resident had their own en suite bedroom.
- ***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 was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Clinical files were securely stored.
- ***Rights-based care:*** There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Mechanical restraint, and separately seclusion and separately physical restraint were used in the approved centre only when less restrictive alternatives were deemed unsuitable. The approved centre was compliant with the Rule on Mechanical Restraint.

  Use of restrictive practices: Physical Restraint: Rights-based care: The approved centre was not compliant with the Code of Practice on Physical Restraint for seven different reasons in a sample of three physical restraint episodes of children, which were inspected. A selection of reasons included it did not have a policy on the reduction of physical restraint, and in two episodes of physical restraint appropriate emotional support was not provided to the child directly after the child was restrained physically.

Use of restrictive practices: Seclusion: The approved centre was not compliant with the Rule on Seclusion for one reason, it did not have a policy on the reduction of seclusion. Though it was compliant with all other aspects of the Rule on Seclusion in the sample of three seclusion episodes inspected.

However:

- ***Privacy and dignity: CCTV:*** The approved centre's use of CCTV was not communicated to residents and their representatives, clear signage was not displayed in two locations where CCTV cameras were in use: in the approved centre foyer and facing the basketball court.
- **Use of Restrictive Practices: Seclusion:** The approved centre was non-compliant with this rule because the registered proprietor did not ensure that the approved centre had a restrictive practice reduction policy which addressed the requirements of the new Rules Governing the Use of Seclusion.

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 varied, a selection included access to a reading room and an art room, and an outdoor area with games.
- ***Residents' feedback:*** The residents were complimentary about the environment and the care they received, and all residents reported that their rooms were clean and comfortable. The food was described as 'okay'. *(Please refer to section 5.0 of this report 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 part of Community Healthcare Organisation 7 (CHO7) encompassing: Dublin South West, Kildare and West Wicklow. The approved centre also provided a

catchment area service to Laois, Offaly, Westmeath, and Longford. The Executive Management Team (EMT) met on a monthly basis.

- ***Leadership:*** The Linn Dara Governance group reported to the Linn Dara Management team who report to the CHO Executive Management Team, both groups met together twice a month covering agenda areas such as quality improvement issues and building issues and more. Several committees reported to the Governance group including but not only, the Quality Patient Safety Committee. The approved centre had an established culture of quality improvement. This was evident by the ongoing refurbishment of the approved centre. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. The approved centre had a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Training in risk management had been provided to staff.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. The approved centre had implemented seven quality initiatives since the last inspection, including the onsite school's new all-weather multisport area was completed to ensure sports could be played throughout the year. *(Please refer to section 2.0 of this report for the full list of quality initiatives).*
- ***Policies:*** There was a local policy group which provided a multi-disciplinary approach to policy development, review, approval and dissemination, and all policies were up-to-date at the time of inspection.
- ***Staff training:*** All 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:*** Weekly resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints and advocacy process were used to voice resident and family feedback and to inform and support service improvement.
- ***Advocacy services:*** The approved centre had an advocacy service, the Youth Advocacy Programme (YAP). The advocate visited the approved centre on a weekly basis and met residents individually or in a group.
- ***Regulatory compliance and engagement:*** The approved centre has had a high average compliance rate of 95% over the last 4 years. The compliance rate dropped by 6% over the past two years. It was 97% in 2022 and 91% this year in 2023. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Restrictive practices reduction: Rights-based care:*** While the approved centre had a reduction of restrictive practices strategy, it was not compliant with the Code of Practice on Physical Restraint for seven different reasons and it was not compliant with the Rule Governing Seclusion for one reason. It was compliant with the Rule on Mechanical Restraint.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Staff from different disciplines completed multi family therapy (MFT). MFT involved the bringing together of different families in a therapeutic context to work jointly to overcome specific and individual problems. An MFT programme was held for young people and families on the eating disorder programme.

2. Education and regulation skills sessions on working with trauma, were run for staff, to ensure staff delivered the highest standard of care and treatment.

3. Yoga was added to the therapeutic programme for the eating disorder programme.

4. Linn Dara jointly hosted the HSE Rainbow Badge Initiative Pride Conference with Childrens Health Ireland. The objectives of the conference were to improve education and increase awareness of the issues faces by LGBTI+ people and empower staff to be more inclusive in their care.

5. The Occupational Therapist had piloted an Occupational Therapy school inclusion model initiative. The pilot included spending time in the classroom observing to help with assessments and make recommendations. A group relevant to the young peoples identified needs was run during schooltime and 1:1 sessions were held as appropriate.

6. The school's new all-weather multisport area was completed to ensure sports could be played throughout the year.

7. The architecturally designed sensory path was complete in the school's garden, allowing all year-round access to the orchard and wildflower garden areas.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Linn Dara Child and Adolescent Mental Health Services (CAMHS) opened in 2015 and was located on the Cherry Orchard Hospital Campus in Ballyfermot, Dublin 10. The approved centre was registered for 24 beds. Hazel and Rowan ward have 11 beds each and Oak is a high dependency ward with two beds. Hazel ward was closed due to a shortage of staff.

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

The approved centre was part of the national CAMHS network and took referrals predominantly from the east and north of the country. At times, young people from other areas were also referred into the approved centre for treatment.

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

Resident Profile	
Number of registered beds	***24***
Total number of residents	**8**
Number of detained patients	4
Number of wards of court	2
Number of children	8
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

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

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

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

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

Local management held operations meeting twice monthly. Minutes from operations meetings included agenda items such as service activities/KPIs, complaints and compliments, facilities, estates, legal and staffing.

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

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. Health and Social care professionals, including occupational therapy, psychology, social work, physiotherapy, dietetics, and speech and language therapy were accessible to all residents.

Heads of Discipline had not completed and returned a Mental Health Commission Governance Questionnaire. The questionnaires were completed before the end of the inspection. These disciplines included: nursing, medical, social work, psychology, speech, and language therapy (SLT), and dietetics. The post of occupational therapy manager was vacant at the time of the inspection. The lead inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to

monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development.

Annual staff training plans were completed to identify and address training needs. Operational risks highlighted included: staff shortage and recruitment crisis, retention of staff, difficulties releasing staff for training and significant demand for bed availability. Training on trauma informed care had commenced.

The rule for the use of Seclusion and the Code of Practice for the use of physical restraint were revised in January 2023 and required that staff were trained on trauma informed care. The requirements also included that the approved centre had a policy on the reduction of restrictive practice and while this policy was in development it was not complete.

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

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

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 25: Use of Closed Circuit Television	✓		✓		✓		✓		✗	Moderate
Rules Governing the Use of Seclusion	✓		✗	Low	✓		✓		✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✓		✓		✓		✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent mental health facility, the Code of Practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engage with residents in a number of different 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 a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- The Youth Advocacy Programme (YAP) representative was contacted to obtain residents' feedback about the approved centre.

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

Five residents met with the inspection team. Residents knew their treating team and their key workers. They were familiar with their care plans and were aware that they could have a copy if they wanted it. The food was reported to be "Okay" and there was choice. Some residents had a specific eating plan. The weekends were described as "long" although there were some activities. All residents said their rooms were comfortable and clean. One resident said sometimes the nurse forgets "to talk to me" and another said nobody talked to them after a restraint.

5.2 Advocacy

The approved centre had an advocacy service, the Youth Advocacy Programme (YAP). The advocate visited the approved centre on a weekly basis and met residents individually or in a group.

The inspector team received spoke with a representative from the advocacy service who furnished a report detailing advocacy activity in Linn Dara. Issues that arose were that the approved centre was too warm and that a card for streaming to television ceased to be valid. These issues were resolved in a timely manner. Some residents say there was communications difficulties with staff and wanted staff to talk to them more especially if they didn't feel too well.

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:

- Head of Service/Registered Proprietor Nominee
- Executive Clinical Director
- Clinical Director
- Director of Nursing
- Consultant Psychiatrist x 2
- Principal Psychologist
- Principal Social Work
- Speech and Language Therapy Manager
- Assistant Director of Nursing
- Clinical Nurse Manager III
- Clinical Nurse Manager II
- School Principal

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs.

Resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in January 2021. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents had access to a reading/quiet room, art room, table tennis, foosball, keyboards, board games, video games (Xbox), books, television (with Netflix), and art materials. The approved centre also had an outdoor area with games.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. Mass was held on the campus, and notices indicated that all spiritual and religious needs would be considered on request.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Visiting times were appropriate and reasonable: visits were by appointment, and each resident received three to four visits per week. There were no restrictions on any resident's visits at the time of inspection. Visiting spaces were provided throughout the approved centre where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting areas were suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in January 2021. Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents had access to Nokia phones (without cameras) in the approved centre.

It was the approved centre's policy that the clinical director (or senior staff member designated by the clinical director) only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others. There were no restrictions on resident communication at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in January 2021, and included all requirements related to:

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident’s dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both

staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to weekly review by the MDT in consultation with the resident. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals. The educational requirements of child residents were included in their ICPs.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The approved centre had a dedicated occupational therapist (OT), speech and language therapist, psychologist, social worker, and dietitian. A therapeutic programme and one-to-one sessions were carried out. Programme themes were reviewed on a weekly basis, and included assertiveness, friendship, expressing emotions, communication, and conversation skills.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Access was provided to a family therapist, play therapist, art therapist, canine therapy, and yoga therapist on a sessional basis.

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. Residents had access via referral to physiotherapy, paediatrician, dentist, physicians, and out-patient radiology services where required.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in January 2021. The clinical file of one resident who had been transferred from the approved centre was inspected. As it was an emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy and a response to medical emergency policy, both of which were last reviewed in January 2021. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

One clinical file was examined in relation to the provision of general health services during the inspection process. The resident received appropriate general health care interventions in line with their individual care plan. The resident's general health needs were monitored and assessed as indicated by their specific needs, but not less than every six months.

The resident's six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, and body mass-index, weight, and waist circumference. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in January 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's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

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 bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

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

The approved centre was kept in a good state of repair externally and internally. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided

assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs, and furnished to support resident independence and comfort.

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

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible, and included the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in March 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating MODERATE

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

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

The approved centre's use of CCTV was not disclosed to residents and their representatives, as clear signs were not present in prominent positions where CCTV cameras or other monitoring devices were utilised. Signage was not displayed in two locations where cameras were in use: in the approved centre foyer and facing the basketball court.

Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed solely by the health professional with responsibility for the resident. The usage of CCTV or other monitoring systems was disclosed to the Mental Health Commission. CCTV was not used to monitor a resident in the event of their dignity being compromised. All monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc, or hard drive.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the use of closed circuit television or other such monitoring device for resident observation were clearly labelled, 25(1)(b).

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. One multi-disciplinary team (MDT) was based in the approved centre, which included the disciplines of medical, nursing, occupational therapy, social work, psychology, dietetics, and speech and language therapy. The approved centre also had access to family therapy, pet therapy, and an art therapist. There was no dedicated pharmacy service. An appropriately qualified staff member was on duty at all times.

One doctor, two nurses, a psychologist and a dietitian were new to the service and had not yet completed their mandatory training. Otherwise all healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory areas.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (26)	26	100%	24	92%	24	92%	26	100%
Medical (8)	8	100%	8	100%	7	88%	8	100%

Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	0	0%	1	100%	0	0%	1	100%
Dietitian (1)	0	0%	1	100%	1	100%	1	100%
Speech and Language Therapist (1)	1	100%	1	100%	1	100%	1	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in January 2021, and included the following:

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

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

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in January 2021, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

The registered proprietor ensured that the quality of service, care, and treatment was not adversely affected by reason of the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in January 2021, and included the following:

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

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

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during

resident seclusion, physical restraint, mechanical restraint, resident transfer, and resident discharge. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration displayed prominently in the hall. Any changes which had arisen in relation to the information detailed in the certificate were communicated to the Mental Health Commission.

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

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

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

The approved centre did not have a policy on the reduction of seclusion.

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

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

Monitoring: An annual report on the use of seclusion in the approved centre was published on the registered proprietor's website.

A multi-disciplinary review and oversight committee was established to analyse every episode of seclusion in detail.

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. The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There was an anti-barricade door. There were no ligature points or electrical fixtures. The room allowed for staff to clearly observe the resident in the seclusion room. The seclusion room had externally controlled heating and air conditioning which enabled those observing the resident to monitor the room temperature.

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

The resident who was secluded had ready access to sanitary facilities and sanitary items (unless there was a clearly documented reason recorded in the Seclusion Care Plan). Seclusion facilities were not used as bedrooms. Bedrooms were not used as seclusion facilities.

Orders for Seclusion: Three episodes of seclusion were reviewed on inspection. Seclusion was only initiated following as comprehensive an assessment of the resident as practicable. This included a risk assessment, the outcome of which was recorded in the clinical file. Seclusion was initiated by a registered medical practitioner (RMP) and/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 a 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. Upon commencement of each episode of seclusion, a Seclusion Care Plan for the resident was developed by a RN.

There was a medical examination of the resident by a RMP as soon as practicable, and no later than two hours after the commencement of each episode. The examination included an assessment and record of any physical, psychological and/or emotional trauma caused to the resident as a result of the seclusion. The RMP recorded this consultation in the clinical files and indicated on the seclusion register that the consultant psychiatrist (CP) ordered or did not order the continued use of seclusion. Seclusion orders were not made for any period of time longer than four hours from the commencement of each seclusion episode. The orders of the CP confirmed that there were no other less restrictive ways available to manage the residents' presentation.

The CP undertook a medical examination of the residents and signed the seclusion register within 24 hours of the commencement of each episode. As soon as practicable, and at the residents' wishes in accordance with their individual care plans (ICPs), the residents' representatives were informed of the seclusion and a record of this communication was entered in the clinical files.

The residents 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 residents under continuous observation and remained within sight and sound of the seclusion room throughout the episode. A written record of the resident was made by the RN every 15 minutes. This included:

- The resident's level of distress.

- The resident's behaviour.
- The resident's level of awareness.
- The resident's physical health, especially with regard to breathing, pallor, or cyanosis.
- Whether hydration/nutrition needs were met.

Ending of Seclusion: The residents were informed of the ending of each episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date the seclusion was ended. An in-person debrief followed two of the episodes; in the third instance, it was the preference of the resident not to have the debrief at that time.

The debrief was person-centred, gave the two residents the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved with their care and treatment, and included a discussion regarding alternative de-escalation strategies that could be used to avoid future use of restrictive interventions. The residents were given the opportunity of having their representative or nominated person present at the debrief with them; if this person did not attend, a record of the reasons why were recorded in the clinical file. A record was kept of the offer of the debriefing, whether it was accepted and the outcome. The two resident's individual care plans (ICPs) were updated to reflect the outcome of the debrief, and in particular, the resident's preferences in relation to restrictive interventions going forward.

Appropriate emotional support was provided to the residents in the direct aftermath of each episode. Staff also offered support, if appropriate, to other residents who may have witnessed the seclusion.

Seclusion of a Child: Upon admission, a documented risk assessment was carried out by a RMP or RN. The outcome determined if seclusion could be safely used or not. The reasons for, likely duration of, and the circumstances which would lead to the discontinuation of seclusion, were explained in a way that the child could understand and in a format that was age appropriate. A record of this was maintained.

The child's parent or guardian was informed as soon as possible of the child's seclusion, and the circumstances which led to seclusion. The child's parent or guardian was informed when the seclusion ended. Child protection policies and procedures in line with relevant legislation and regulations were in place. The approved centre's policy and procedure addressed appropriate training for staff in relation to child protection.

Clinical Governance: Each episode of seclusion was reviewed by the members of the MDT involved in the resident's care and treatment and documented in the clinical file as soon as practicable and, in any event, no later than five working days after each episode. The MDT review, including recorded actions decided upon and follow-up plans to eliminate or reduce interventions for the resident, was documented.

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 because the registered proprietor did not ensure that the approved centre had a restrictive practice reduction policy which addressed the requirements of the new Rules Governing the Use of Seclusion, 10.5.

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of mechanical means of bodily restraint Part 4 for immediate threat of harm. The policy identified who may carry out mechanical restraint, including a section regarding the provision of information to the resident and a section detailing how the approved centre aimed to reduce the use of mechanical restraint, where applicable.

The written policy on mechanical restraint specified the approved centre's review process for cases of mechanical restraint.

Regarding the mechanical restraint of a child, child protection policies and procedures were line with the relevant legislation, and the approved centre had a policy and procedure which addressed appropriate training for staff in relation to child protection.

The approved centre's policy and procedure for training staff included the following:

- Who will receive training based on the identified needs of residents and staff.
- The areas to be addressed within the training programme, including training in alternatives to mechanical restraint.
- The frequency of training.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in mechanical means of bodily restraint.

Training and Education: The approved centre maintained a written record indicating that all staff involved in mechanical means of bodily restraint had read and understand the policy. The record was available to the Mental Health Commission upon request.

Monitoring: A review of all cases of mechanical means of bodily restraint took place at least on a quarterly basis. All information gathered regarding the use of mechanical means of bodily restraint was held in the

approved centre and used to compile an annual report on the use of mechanical means of bodily restraint at the approved centre. This report was available to the Mental Health Commission upon request.

Evidence of Implementation: One episode of mechanical restraint was examined on inspection. The use of mechanical restraint was initiated and ordered by a consultant psychiatrist (CP). The order confirmed that there were no other less restrictive ways available to manage the resident's presentation. The use of mechanical restraint followed an assessment of the resident, including risk assessment. The episode was recorded in the clinical file and on the *Register for the Mechanical Means of Bodily Restraint.* The *Register* was signed by the CP responsible for the care and treatment of the patient (or the CP), within 24 hours.

The resident was informed of the reasons for, likely duration of, and the circumstances which would lead to the discontinuation of mechanical restraint. The resident's next of kin or representative was informed of the mechanical restraint as soon as was practicable, and a record of this communication was entered in the clinical file.

Where practicable, a staff member of the same gender was present during the initiation of restraint. The resident was continually assessed throughout the use of mechanical restraint to ensure their safety. An assessment of the resident took place before the ending of mechanical restraint. Following the ending of the use of mechanical means of bodily restraint, the resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care and treatment as soon as was practicable.

All uses of mechanical means of bodily restraint were clearly recorded in the resident's clinical file. A copy of the *Register* was placed in the resident's clinical file and a copy made available to the Mental Health Commission on request. The episode of mechanical restraint was reviewed by members of the MDT involved in the resident's care and treatment and documented in the clinical file within two working days of the episode of restraint. As the resident was a child, the approved centre had ensured that the resident's parent or guardian was informed as soon as possible of the child's mechanical means of bodily restraint.

Mechanical restraint was used in a rare and exceptional circumstance and in the best interests of the resident when he or she posed an immediate threat of serious harm to the self or others. The mechanical restraint was used in a professional manner, based on an ethical and legal framework, and was not prolonged beyond the period where it was strictly necessary to prevent immediate and serious harm to the resident or others.

The use of mechanical restraint was based on the best available evidence and contemporary practice. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using mechanical restraint. Consideration had been given on a case-by-case basis as to which approach best met the needs of the resident.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. After a three month period, the administration of medication was only continued after being approved and authorised by two consultant psychiatrists, as set out in the Form 18.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

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 HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in January 2023, and addressed the following:

- Information regarding who can initiate and who may carry out physical restraint.
- Information regarding the safety, safeguarding and risk managements that should be followed during an any episode of physical restraint.

However, the policy did not address the provision of information to the resident, including information about the resident's rights presented in accessible language and format.

Policies and procedures regarding staff training included the following:

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

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

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

The approved centre did not have a written policy on the reduction of physical restraint.

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

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

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

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

The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode, and signed by the CP within 24 hours. For all three episodes of physical restraint, there was no evidence in the clinical notes that the residents were informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation.

In accordance with the residents' wishes, the residents' representatives were informed of the physical restraint as soon as was practicable, and a record of this communication was placed in the clinical files. The Mental Health Commission was notified of the time and date that the physical restraint started and ended for each episode.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the residents' individual care plans (ICPs) pertaining to the residents' specific requirements or needs in relation to the use of physical restraint. There was documented evidence that the principles of trauma-informed care were used during the episodes of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy. The residents were continuously assessed throughout the uses of restraint to ensure their safety, and this was documented.

The physical restraint in each instance was ended by the person who had led it. For all three episodes, the reason for ending physical restraint was not recorded in the resident's clinical file on the date that the restraint ended.

The residents were given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. This occurred within two working days of each episode of physical restraint, unless it was the preference of

the resident who was restrained to have the debrief outside of this timeframe. The debrief included a discussion regarding the resident's preferences in the event where a restrictive intervention was needed in the future, including the resident's preferences in relation to which restrictive intervention they would prefer not to be used.

However, for all three episodes, the in-person debrief did not give the resident the option of having their representative or nominated support person attend the debrief with them, and the clinical file did not record the reason why the resident's representative or nominated person did not attend. In one of the three episodes, the resident's ICP was not updated to reflect the outcome of the debrief. There was a record of all attendees who were present at the debriefs and this was included in the clinical files.

In two of the three episodes, appropriate emotional support was not provided to the resident in the direct aftermath of the episode.

Recording of the Use of Physical Restraint: The episodes of restraint were recorded in the clinical files. The episodes of restraint were clearly recorded in the clinical practice forms. There was a copy of the clinical practice forms in the clinical files and they were available to the Mental Health Commission on request.

Clinical Governance: The episodes of physical restraint were reviewed by members of the multi-disciplinary team within five working days from the date of each episode. The multi-disciplinary team recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the resident. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

Children: In all three episodes, the child did not have the reasons for, and the circumstances which would lead to the discontinuation of restraint, explained in a way that they could understand and in a format that was appropriate to their age. A record was not maintained of this communication.

In all three episodes, the child's parent or guardian was informed when the episode of physical restraint ended. The approved centre had child protection policies and procedures in place which were in line with the relevant legislation and regulations make made thereunder.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **The approved centre's physical restraint policy did not identify the provision of information to the resident, including information about the resident's rights presented in an accessible language and format, 7.2(a)(i).**
b) **The registered proprietor did not ensure that the approved centre had developed and implemented a restrictive practice reduction policy which should have been published on the registered proprietor's website, 7.5.**

c) For three episodes of physical restraint, the resident was not informed of the reasons for, and the circumstances which would lead to the discontinuation of, physical restraint, 3.8.
d) For three episodes of physical restraint, the reason for ending the physical restraint was not recorded in the resident's clinical file on the date that the physical restraint ended, 5.2.
e) For three episodes of physical restraint, the in-person debrief did not give the resident the option of having their representative or their nominated support person attend the debrief with them, and no reason was recorded in the clinical file as to why the representative or nominated support person did not attend, 5.3(vi).
f) For one episode of physical restraint, the resident's individual care plan was not updated to reflect the outcome of the debrief, 5.5.
g) For two episodes of physical restraint, appropriate emotional support was not provided to the resident in the direct aftermath of the episode, 5.7.
h) In three episodes of physical restraint, the child did not have the reasons for, and the circumstances which would lead to the discontinuation of restraint, explained in a way that the child could understand and in a format that was appropriate to their age. A record was not maintained of this communication, 9.2.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in January 2021, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in January 2021, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse or risks, and documented communications with the relevant healthcare provider.

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

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider. A comprehensive discharge summary was issued within 14 days.

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

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10004968		**The registered proprietor did not ensure that the use of closed circuit television or other such monitoring device for resident observation were clearly labelled, 25(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CAMHS Linn Dara will ensure that the use of Close Circuit TV will be clearly labelled and compliant with Reg 25 CCTV and located throughout the approved centre.	A monthly checklist to ensure compliance.	Evidence of monitoring will be available to review and overseen by nursing management.	05/04/2024	Front of desk will monitor and ensure signage is clearly labelled.
Preventative Action	Monthly monitoring	Monthly Checklist.	Ensure signage is in use and same monitored	05/04/2024	Nurse Management

Rules Governing the Use of Seclusion					
Reason ID : 10004977		**The registered proprietor did not ensure that the approved centre had a restrictive practice reduction policy which addressed the requirements of the new Rules Governing the Use of Seclusion, 10.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Restrictive Practices Reduction Policy has been developed and implemented into the Linn Dara Service.	To ensure that all staff have read, signed and understand the Restrictive Practices Reduction Policy.	This Policy is currently available to all staff.	05/03/2024	Registered Proprietor Policy Committee
Preventative Action	The Restrictive Practices Reduction Policy has been developed and implemented into the Linn Dara Service.	To ensure that all staff have read, signed and understand the Restrictive Practices Reduction Policy.	This Policy is currently available to all staff.	05/03/2024	Registered Proprietor Policy Committee

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10004969		**The approved centre's physical restraint policy did not identify the provision of information to the resident, including information about the resident's rights presented in an accessible language and format, 7.2(a)(i).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Update of Physical Restraint Policy to identify the provision of information to the residents, including information about the resident's rights and presented in an accessible language and format. This Policy is currently being updated and section 7.12 of the Policy on Physical Restraint will reflect this.	Clinical professional development Audit are completed after each episode of physical restraint All staff to read sign and understand the policy	All staff working in the approved centre will be made aware of the updated policy	13/05/2024	Policy Committee
Preventative Action	Policy updated to identify the provision of information to the residents, including information about the resident's rights and presented in an accessible language and format.	To ensure all staff have read signed and understand the policy.	Policy will accessible for all staff to read and sign.	28/06/2024	Policy Committee

Reason ID : 10004970		The registered proprietor did not ensure that the approved centre had developed and implemented a restrictive practice reduction policy which should have been published on the registered proprietor's website, 7.5.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Policy has been developed and implemented into the Linn Dara Service.	To ensure that all staff have read signed and understand the restrictive practice reduction policy.	This policy is currently available to all staff.	05/03/2024	Registered Proprietor Policy Committee
Preventative Action	Policy has been developed and implemented into the Linn Dara Service.	To ensure that all staff have read and understand the restrictive practice reduction policy.	This policy is currently available to all staff.	05/03/2024	Registered Proprietor Policy Committee
Reason ID : 10004971		**For three episodes of physical restraint, the resident was not informed of the reasons for, and the circumstances which would lead to the discontinuation of, physical restraint, 3.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Each episode of physical restraint is audited and will continue to be audited to monitor compliance. Regular audits will be completed as part of our restrictive practices monitoring.	Currently our physical restraint audits are completed after every episode of physical restraint and reflect a 100% compliance rating. The findings from the audit documentation did not identify these as a corrective action.	Audits continue to be completed after each episode of physical restraint.	05/04/2024	Clinical Director
Preventative Action	Each episode of physical restraint is audited and will	Currently our physical restraint audits are	Audits continue to be completed after each	05/04/2024	Clinical Director

	continue to be audited to monitor compliance. Further information is required to identify a corrective action to be put in place.	completed after every episode of physical restraint and reflect a 100% compliance rating. The findings from the audit documentation did not identify these as a corrective action.	episode of physical restraint		
Reason ID : 10004972		**For three episodes of physical restraint, the reason for ending the physical restraint was not recorded in the resident's clinical file on the date that the physical restraint ended, 5.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The physical restraint care bundle will be updated to reflect the reason for ending the physical restraint and this will be recorded in the resident's clinical file.	The physical restraint audit will be updated to monitor compliance.	This will be implemented and monitored in the audit schedule.	20/05/2024	Clinical Director
Preventative Action	The physical restraint care bundle will be updated to reflect the reason for ending the physical restraint and this will be recorded in the resident's clinical file.	The physical restraint audit will monitor compliance.	This will be implemented and monitored in the audit schedule.	20/05/2024	Clinical Director

Reason ID : 10004973		For three episodes of physical restraint, the in-person debrief did not give the resident the option of having their representative or their nominated support person attend the debrief with them, and no reason was recorded in the clinical file as to why the representative or nominated support person did not attend, 5.3(vi).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Continue to support staff in relation to the debrief process for each resident and ensure that all documentation reflects the individual choices of the resident.	CPD for all staff to ensure accurate record keeping of individual resident care. Continue to monitor as part of the audit process.	Continue to ensure compliance.	05/04/2024	Clinical Director
Preventative Action	Continue to support staff in relation to the debrief process for each resident and ensure that all documentation reflects the individual choices of the resident.	CPD for all staff to ensure accurate record keeping of individual resident care. Continue to monitor as part of the audit process.	Continue to ensure compliance.	05/04/2024	Clinical Director
Reason ID : 10004974		**For one episode of physical restraint, the resident's individual care plan was not updated to reflect the outcome of the debrief, 5.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure all staff members are aware of the process for updating the ICP to reflect the outcome of the debrief. Also to ensure staff have read and	CPD sessions are provided to staff. Each residents ICP is reviewed at the weekly at the MDT meeting and updated accordingly.	Ensure compliance on the code of practice on the use of physical restraint.	05/04/2024	Clinical Director

	understand the physical restraint policy.				
Preventative Action	To ensure all staff members are aware of the process for updating the ICP to reflect the outcome of the debrief. Also to ensure staff have read and understand the physical restraint policy.	CPD sessions are provided to staff. Each residents ICP is reviewed at the weekly at the MDT meeting and updated accordingly.	Ensure compliance on the code of practice on the use of physical restraint.	05/04/2024	Clinical Director
Reason ID : 10004975		**For wo episodes of physical restraint, appropriate emotional support was not provided to the resident in the direct aftermath of the episode, 5.7.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Without identifying the two episodes of appropriate emotional support therefore a corrective action plan can not be put in place. The current policy on physical restraint and staff training ensure appropriate emotional support is provided to all residents on an individual basis.	Monitor through accurate documentation. Audit to completed after each episode of physical restraint.	To ensure compliance with code of practice on the use of physical restraint.	20/05/2024	Clinical Director

Preventative Action	Without identifying the two episodes of appropriate emotional support therefore a corrective action plan can not be put in place. The current policy on physical restraint and staff training ensure appropriate emotional support is provided to all residents on an individual basis.	Monitor through accurate documentation. Audit to completed after each episode of physical restraint.	To ensure compliance with code of practice on the use of physical restraint.	20/05/2024	Clinical Director
Reason ID : 10004976		**In three episodes of physical restraint, the child did not have the reasons for, and the circumstances which would lead to the discontinuation of restraint, explained in a way that the child could understand and in a format that was appropriate to their age. A record was not maintained of this communication, 9.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The policy is currently being updated to reflect 9.2 of the code of practice on the use of physical restraint. A communication passport has been developed and is in draft format positive feed back was received from the young people.	Ensure compliance with the audit schedule. Ensure staff are familiar with he updated policy and have read , signed and understand the policy	This communication passport will support staff to understand the child's needs.	10/06/2024	Clinical Director

Preventative Action	The policy is currently being updated to reflect 9.2 of the code of practice on the use of physical restraint. A communication passport has been developed and is in draft format positive feed back was received from the young people.	Ensure compliance with the audit schedule. Ensure staff are familiar with he updated policy and have read , signed and understand the policy	This communication passport will support staff to understand the child's needs.	10/06/2024	Clinical Director

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 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.

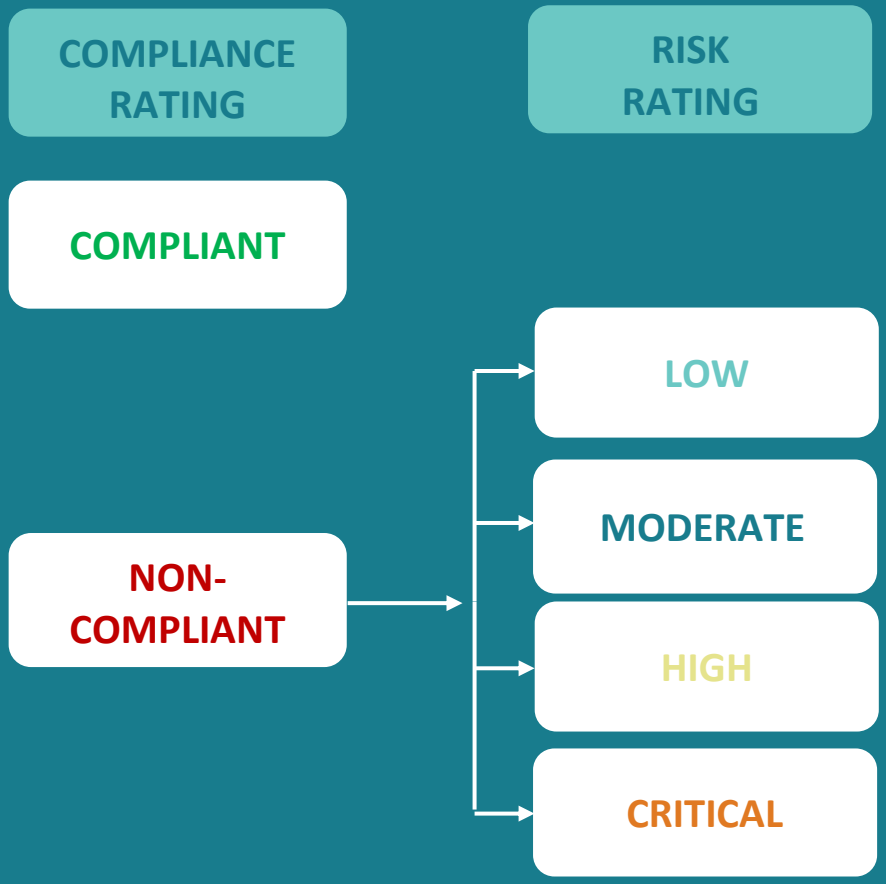
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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