# Willow Grove Adolescent Unit

Annual Inspection Report 2024

*Promoting Quality, Safety and Human Rights in Mental Health*

# WILLOW GROVE ADOLESCENT UNIT

James's Street, Dublin 8, D08 K7YW

**Date of Publication:**
14 November 2024

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## 2024 Approved Centre Inspection Report (Mental Health Act 2001)

**Approved Centre Type:**
Child and Adolescent Mental Health Care

**Conditions Attached:**
None

**Most Recent Registration Date:**
30 April 2022

**Registered Proprietor:**
Mr Paul Gilligan, Chief Executive Officer

**Registered Proprietor Nominee:**
N/A

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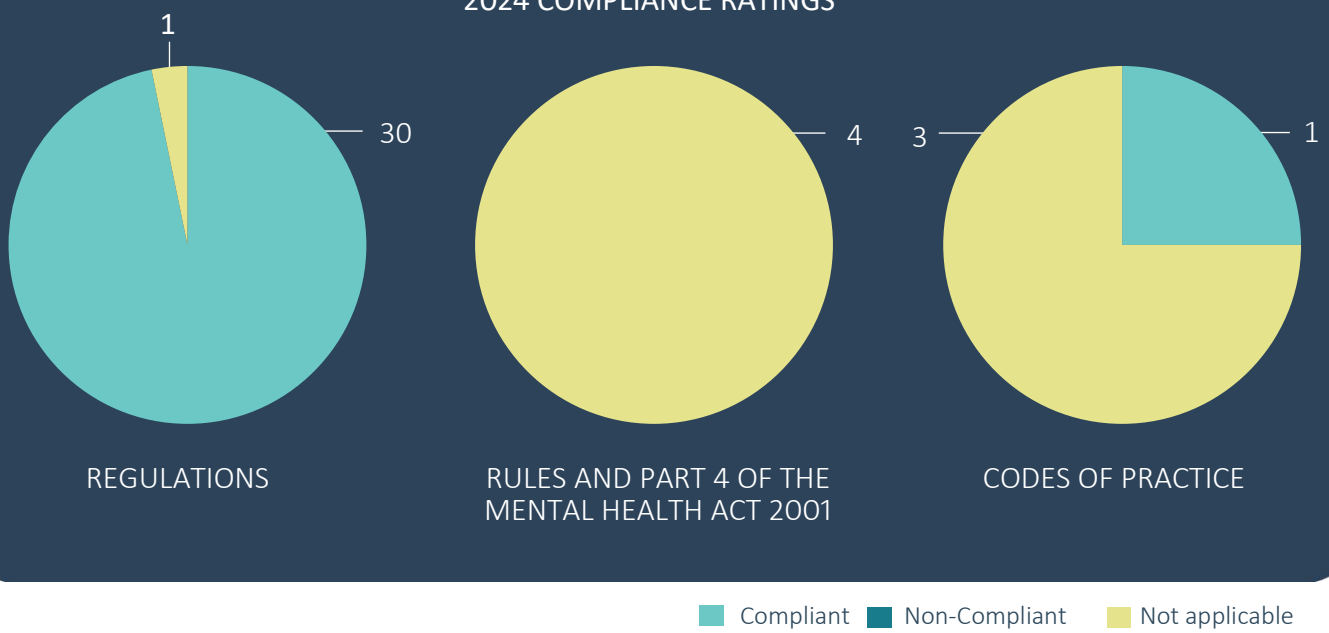
**The Inspector of Mental Health Services:**
Professor James V Lucey MCRN000646

**Inspection Date:**
18 – 21 June 2024

**Previous Inspection date:**
4 – 8 December 2023

**Inspection Type:**
Unannounced Annual Inspection

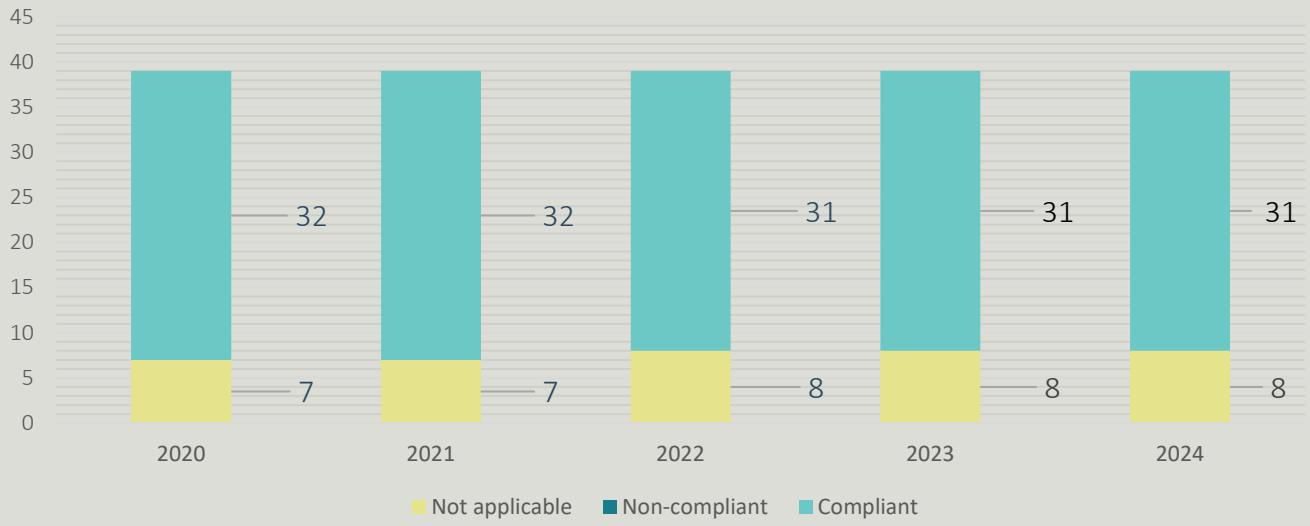
2024 COMPLIANCE RATINGS



## RATINGS SUMMARY 2020 – 2024

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

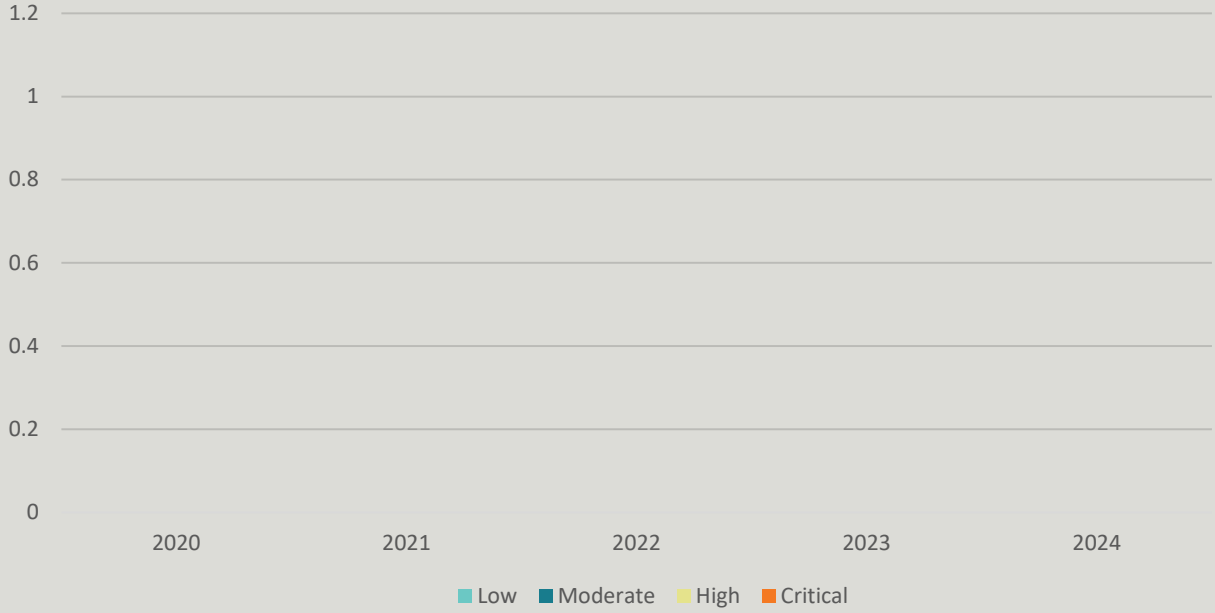
### CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2020 – 2024




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.

***Please note:*** **The approved centre was 100% compliant 2020 - 2024**

### CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2020 – 2024



# Contents


1.0 Inspector of Mental Health Services – Review of Findings ..... 6
Inspector of Mental Health Services Summary ..... 6
Compliance summary ..... 6
Ongoing escalation and enforcement actions at time of inspection ..... 7
Escalation and enforcement actions commenced following this inspection ..... 7
2.0 Quality Initiatives ..... 8
3.0 Overview of the Approved Centre ..... 11
3.1 Description of approved centre ..... 11
3.2 Governance ..... 12
4.0 Compliance ..... 15
4.1 Non-compliant areas on this inspection ..... 15
4.2 Areas that were not applicable on this inspection ..... 15
5.0 Service-user Experience ..... 16
5.1 Service-user feedback ..... 16
5.2 Advocacy ..... 17
6.0 Feedback Meeting ..... 18
7.0 Inspection Findings – Regulations ..... 19
8.0 Inspection Findings – Rules ..... 55
9.0 Inspection Findings – Mental Health Act 2001 ..... 56
10.0 Inspection Findings – Codes of Practice ..... 57
Appendix 1 Background to the inspection process ..... 60

# 1.0 Inspector of Mental Health Services – Review of Findings

## Inspector of Mental Health Services Professor James V Lucey

## Inspector of Mental Health Services Summary

Willow Grove Adolescent Unit is part of St. Patrick's Mental Health Service, located within the grounds of St. Patrick's Hospital. The approved centre provides inpatient care and treatment and an online home care service to young people countrywide and all admissions are planned. Willow Grove is registered for child and adolescent mental health care and has a 14 bed capacity and eight beds were occupied at the time of inspection.

The inspection of Willow Grove was unannounced and occurred over a four-day period; 18th- 21st June 2024. The inspection report reflects findings of the inspection over this period only. In general, the inspection team findings were very positive. The inspection was well co-ordinated by staff and management of the approved centre. The staff were very responsive to the inspection team.

In 2023, the service was compliant with all regulatory areas during the annual inspection. The finding of the inspection team for 2024 was that the approved centre was again fully compliant with all regularly requirements. This was the fourth year that the approved centre had achieved 100 % compliance.

The inspection team observed a high quality of care and treatment delivered to young people that went beyond minimum standards. There was a good teamwork ethos, strong leadership, skilled, caring and dedicated staff and a culture of fostering the development of care in collaboration with the young people. There was a culture of positivity along with robust frameworks and governance structures was evident in Willow Grove and this translated into a recovery focused approach for the young people and their families.

## Compliance summary

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| % Compliance | 100% | 100% | 100% | 100% | 100% |

## Conditions of 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

None.

## Escalation and enforcement actions commenced following this inspection

None.

# 2.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

A parenting support and skill building programme commenced. This was an in person group for the parents of all young people who received inpatient care and was delivered by the social worker and family therapist on a weekly basis. The purpose of the group was to provide support and skilled based training for parents to build on existing skills to help them parent positively.

In addition to the quality initiatives listed, the inspection team also reviewed quality assessments informed by the The National Quality Framework: Driving Excellence in Mental Health Services 2023 in relation to the following specific regulations:

Regulation 11: Visits

- There was a visitors room and family visitors room which were welcoming and designed and nicely decorated.
- Aswell as the visiting facilities in Willow Grove, there was access to the family visiting room in St. Patrick's University Hospital.
- The approved centre had video calling facilities available to the young people.
- The approved centre provided information on visits to the young people and their families or carers in a manner that was understandable.
- The approved centre had flexible visiting hours in place for the young people on the weekends. Visits were accommodated outside of mealtimes.

Regulation 14: Care of the Dying

- No quality assessments were submitted to the inspection team relevant to this Regulation.

Regulation 15: Individual Care Planning

- The approved centre provided the young people with a key worker to facilitate coordination and communication of interventions regarding their Individual Care Plan's. (ICP's)
- The approved centre used an electronic patient record (EPR) system which was inclusive on care planning documentation, and the ICP's could be printed, and a copy given to the young people when required.
- On admission, the young people were supported to complete a patient expectation form, with the purpose of providing the staff with a sense of the young person's treatment expectations.
- Staff received Wellness and Recovery Action Plan (WRAP) training. Through WRAP training staff learned to identify tools and create action plans for managing mental health and overall wellbeing.
- Staff worked with the young people to comprise a WRAP which facilitated a recovery focused setting of short, medium and long-term goals.

Regulation 19: General Health

- The approved centre used the paediatric early warning system (PEWS) to identify the early warning signs of risk for clinical deterioration and to monitor for medical intervention.

- A GP primary care service on site in the St Patricks University Hospital campus was available to the young people of Willow Grove.

Regulation 20: Provision of Information to Residents

- Educational and informational literature was displayed within the approved centre and was available to the young people in a manner that was understandable to all.
- There was an advocacy service available to the young people in the approved centre.
- The Information Centre located on the St Patricks University Hospital campus was accessible to the young people of Willow Grove where they could access a comprehensive library of information about mental illness and well-being.
- There was a comprehensive young person's information booklet and the parents / carers information booklet which was made available to the young people and their families in advance of the young person's admission.

Regulation 21: Privacy

- The approved centre promoted principles of equity, inclusion and respect for diversity.
- The approved centre provided a physical environment and facilities that promoted privacy: all the young people had single en suite bedrooms.

Regulation 26: Staffing

- The approved centre provided access to non-mandatory training courses for staff to ensure best practice and staff upskilling such as gender dysphoria training.
- St Patricks Mental Health Services had rolled out a new 'Dignity at Work' training programme for all staff.
- Staff were supported by management to attend higher education training and courses.
- The approved centre provided access to the Employee Assisted Programme for staff
- The approved centre had an annual training plan in place which incorporated mandatory training.
- All staff had completed assisted decision making training.

Regulation 29: Operating Policies and Procedures

- The approved centre has policies and procedures in place for human resource management including retention of staff.

Regulation 31: Complaints Procedures

- The approved centre had a complaints process which was visible and accessible to young people and their families and in the young person's information booklet.
- Feedback from the young people was gathered through the daily community feedback meeting and suggestion boxes available in the approved centre.
- The approved centre undertook audits aligned with the National Quality Framework (NQF).

Regulation 32: Risk Management Procedures

- The approved centre had processes and procedures for dissemination of learning from incident reviews to all staff.

- The Risk and Safety Committee met monthly and reviewed risk assessments and audits and incidents that occurred.
- There was a strong culture of clinical auditing of compliance with regulations codes and rules evident in the approved centre. Audits were conducted monthly, quarterly, semi-annually and annually by Clinical Nurse Managers of the approved centre and also by the clinical governance department to ensure compliance.
- The approved centre used a web based incident report and risk management software system.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

Willow Grove Adolescent Unit (WGAU) is a child and adolescent approved centre which is part of St. Patrick's Mental Health Service (SPMHS). The approved centre is located on the St. Patrick's Hospital campus and operates independently to the adult service. The approved centre is registered for child and adolescent mental health care. Willow Grove provides both inpatient care and treatment and an online home care service to young people aged from 12 to 17 from all over Ireland. Admissions to the approved centre are planned and pre-admission assessments are completed with the young people and their families. There is one multi-disciplinary team responsible for the care and treatment of the residents. The inpatient treating team consists of child & adolescent consultant psychiatrists, nursing staff, social work, psychology, occupational therapy, family therapy, cognitive behavioural therapy, dietetics, pharmacy and education.

The approved centre is a standalone unit which offers accommodation for up to 14 young people. The accommodation consists of single en suite bedrooms which were decorated with the young person's personal effects and furnished appropriate to meet their needs. Communal areas included a dining room, main tv lounge, a relaxation room, a visitors room, a family visiting room, a training kitchen and group rooms. The young people have access to a court yard, a gym, and both indoor and outdoor recreational equipment and facilities. There is a school attached to Willow Grove.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | ***14*** |
| **Total number of residents** | **8** |
| Number of detained patients | 0 |
| Number of wards of court | 0 |
| Number of children | 8 |
| Number of residents in the approved centre for more than 6 months | 0 |
| Number of patients on Section 26 leave for more than 2 weeks | 0 |

## 3.2 Governance

Willow Grove was part of St. Patrick's Mental Health Services (SPMHS). The approved centre was governed by a Board of Governors which consisted of both ex officio and appointed members. The Senior Management Team (SMT) were accountable to the Board of Governors for the direct operation of the approved centre. Willow Grove had established governance structures in place which included senior management meetings that took place within the approved centre on a regular basis.

The senior management team meeting convened fortnightly, was chaired by the chief executive officer and attended by the medical director, consultant psychiatrists, the director of finance, the director of nursing, the director of human resources, the director of communications, the director of services, the director of human resources, the director of communications and the director of digital health within SPMHS. Meeting minutes were provided to the inspection team and outlined the active governance processes. Standing agenda items included service development, finance, operations, human resources, health and safety, quality, data protection, research and training, information and communication technology, facilities and risk management, including a review of the risk register.

Governance was strengthened by a clinical governance committee meeting which convened weekly and a Risk and Safety committee meeting which was held monthly. The clinical governance meeting was chaired by the director of services and attended by the director of nursing, the clinical director, the assistant clinical director, the programme manager for clinical governance, the nurse practice development coordinator, the clinical audit facilitator, mental health administrator, and the head of social work. Agenda items included clinical audits, quality improvements and review of incidents/near misses. The members of the committee completed an overview of the incidents reported in the approved centre and reviewed any identified issues as part of their risk management strategy. The Risk and Safety committee meeting was chaired by the director of services and attended by the heads of each department. Agenda items included risk assessments and audits, facilities, human resources, finance, occupational safety which included safety training and policy updates. St. Patrick's Mental Health Service had a number of sub committees in place which included input from Willow Grove. These sub committees included the advocacy committee, the quality governance committee, the research ethics committee, the business continuity committee, the drugs and therapeutic committee, the infection prevention and control committee and falls committee. The regularity of these committee meetings included monthly and bi-monthly sessions, and they focused on specific aspects of service governance. Other Willow Grove meetings included a monthly nursing meeting, a business meeting which occurred every six week and a daily handover meeting.

All clinical staff had received training on clinical risk management procedures appropriate to their role and function. There were key personnel with responsibility for risk management in the approved centre. The risk manager was the person with overall responsibility for risk who was identifiable and known by staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre. The approved centre had adequate and appropriate processes to identify, assess, treat, and monitor risks. The approved centre had an integrated risk register which included clinical, corporate, health and safety, facilities and operational risks and each one of these risks was the responsibility of the relevant department head. The SMT had overall responsibility for the monitoring and management of risks. Senior management reviewed and updated the content of the risk registers every quarter. There were defined referral pathways

and processes for escalation and de-escalation of risk from the integrated risk register to senior management team and board of governors where applicable.

The approved centre used the Datix electronic database to record and monitor incidents, accidents, near miss situations and medication errors in the approved centre. Incidents had been reviewed and analysed by the clinical governance committee to identify any trends or patterns occurring in the service. The Datix database was linked to the Electronic Health Record (EHR) of all residents and risk information was populated in the relevant section of the residents' clinical file. Incidents had been reviewed to identify any trends or patterns occurring in the service.

The approved centre was dedicated to improving service quality. There was a programme manager, who worked together with the approved centre management, and oversaw a programme aimed at enhancing quality and regulatory compliance. A scheduled programme of audits, involving all disciplines, was implemented in the approved centre. Clinical audits were conducted quarterly, semi-annually and annually by the clinical nurse manager of Willow Grove and by the clinical governance department.

The organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. Governance questionnaires were completed by the registered proprietor, the clinical director, the director of nursing, the head of psychology, occupational therapy manager, the head of social work, the dietitian and the chief pharmacist and were returned to the inspection team. Respondents provided a clear overview of the governance within their respective roles, issues of risk or specific concerns and outlined strategic goals for the service, and systems to monitor goal progression. A multi-disciplinary approach was fostered within governance structures and clinical care and the ethos of continuous quality improvement was visible. There was evidence of effective multi-disciplinary teamwork and comprehensive individualised care plans developed with residents and their representatives.

At the time of inspection, the approved centre was adequately staffed, and the numbers and skill mix of staffing were sufficient to meet resident needs. All disciplines were up to date with mandatory training in Basic Life Support, Fire Training, Mental Health Act 2001, Management of Violence and Aggression, Safeguarding and Children’s First Training. The approved centre had a comprehensive yearly training schedule in place.

There was evidence of clinical supervision structures in place across all departments. All heads of discipline were in continuous communication with staff members. The availability of clinical supervision varied across departments which included formal, informal, and external supervision. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development which included identifying training needs.

The young people’s involvement in service planning and delivery was facilitated by the use of suggestion boxes in the approved centre and the availability of the compliments and complaints process to support service improvement. The process of making complaints, and the complaints officer contact details, were displayed within the approved centre and in an information booklet. Complaints had been investigated and were documented with clear outcomes detailed in the complaints log. The young people were involved in the development and review of their individual care plans. Daily community meetings occurred which

provided an opportunity for the young people to raise concerns or make suggestions. There was a designated advocate from the Youth Advocacy Programmes (YAP) who visited the approved centre fortnightly and supported the young person's autonomy. The advocate met with the young people in a group and individually if requested. The advocate's contact details were displayed within the approved centre. There were appropriate visiting facilities and arrangements in place and the young people had means of communicating with family, friends, and carers.

Willow Grove was proactive in managing issues concerning infection prevention and control. The approved centre had a suite of policies and practices on infection, prevention and control in place which had been adopted and where relevant implemented the required sections of National Clinical Effectiveness Committee (NCEC) National Clinical Guidelines. The approved centre had an infection, prevention and control committee in place which convened every two months.

# 4.0 Compliance

## 4.1 Non-compliant areas on this inspection

There were no areas of non-compliance on this inspection.

## 4.2 Areas that were not applicable on this inspection

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

# 5.0 Service-user Experience

## 5.1 Service-user feedback

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

One young person was interviewed by the inspection team. The verbal feedback included that the food was good and there were choices, and that nursing staff were nice and helpful. The young person said that on admission, staff were welcoming, that they were introduced to others and was showed around the unit. The young person had met the occupational therapist and was due to meet the multi-disciplinary team involved in the care and was aware that a care plan would be put in place. The young person said they were happy with the accommodation. Regarding areas of improvement, the young person said they were unsure but in comparison to other services, staff were supportive and they were learning and building healthy skills.

The inspection team received one completed questionnaire. The feedback included that the young person knew who their multi-disciplinary team members were, understood their care plan, knew their keyworker and were "always "involved in setting goals for the individual care plan. The young person indicated that staff explained what was happening and "always" gave information on their diagnosis, care and treatment in a way they understood. The young person indicated there were enough talk therapies and leisure and group activities. The young person indicated their privacy and dignity was respected, they could "always" discuss worries and concerns with staff and was happy with how staff talked with them. The young person indicated that they "always" felt safe in the approved centre, and could communicate freely with family and friends.

On a scale of one to ten, with one being poor and ten being excellent, the young person rated the approved centre as 9.

## 5.2 Advocacy

The approved centre had an advocacy service.

The young people had access to advocacy service, the Youth Advocate Programmes (YAP) Ireland.

The inspectors received a report from the Youth Advocate Programmes representative. The report included an overview of the service delivery, the number of groups and individual advocacy sessions delivered, the number of participants, and topics raised in the group sessions which included food choice, living arrangements, outings, communication with the care team, access and visits, conduct of staff and family.

# 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:

- Chiel Executive Officer
- Clinical Director
- Assistant Clinical Director
- Clinical director
- Clinical Nurse manager III
- Director of Services
- Senior Occupational Therapist
- Principal Psychologist
- Principal Social Worker
- Programme Manager for Clinical Governance
- Nurse Practice Development Co-ordinator
- Mental Health Act Administrator

Apologies sent- Occupational Therapy Manager

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. The programme manager for clinical governance thanked the inspection team, the service placed value on the inspection process as it gave an opportunity to identify areas of improvement.

# 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 that were appropriate to the resident group profile and individual residents' needs when administering medication, undertaking medical investigations and providing other healthcare services.

An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

Appropriate identifiers and alerts were used for residents with the same or similar name.

**The approved centre was compliant with this regulation.**

## Regulation 5: Food and Nutrition

**COMPLIANT**

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

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

### INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals.

A source of safe, fresh drinking water was made available to residents at all times in easily accessible locations throughout the approved centre.

Nutritional and dietary needs were assessed with the use of an evidence-based nutrition assessment tool and addressed in the resident's individual care plan. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian.

**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 had suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, preparation, cooking and serving of food.

Hygiene was maintained to support food safety requirements. Food and fridge temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored with clearly identified actions if the temperature breached cold chain parameters.

Residents were provided with crockery and cutlery that is 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 to the resident and considered the residents' preferences, dignity, bodily integrity and religious and cultural practices.

Residents changed out of night clothes during daytime hours unless specified otherwise in their individual care plan.

Residents were supported to manage and maintain their own laundry by sending the laundry home with family members. There was internal laundry facilities available to the residents if required.

**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 written operational policies and procedures relating to residents' personal property and possessions. The policy was last reviewed in February 2024.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Bedroom safes were provided for the safe keeping 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, listing their personal property and possessions. The checklist was updated on an ongoing basis and in line with the approved centre's policy, was kept separate to the resident's individual care plan and was available to the resident.

Residents were supported to manage their own property except where this posed a danger to the resident or others, as indicated in their individual care plan or in accordance with the approved centre's policy.

A process to record, secure and manage the personal property and possessions of the resident was in place.

**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. Recreational activities were available both on weekdays and during the weekend and included television, Netflix, DVDs, music, board games, arts and crafts, mindfulness colouring, relaxation, computer games, books, yoga, quiz games, drama, table tennis, badminton, football, pool, music, baking, gardening, walks and fortnightly community outings. Residents had access to a fully equipped gym and basketball court. External groups such as the Gaiety School of Drama and the Dublin Camera Club provided additional recreational groups.

The recreational facilities provided by the approved centre were appropriately resourced.

**The approved centre was compliant with this regulation.**

## Regulation 10: Religion

**COMPLIANT**

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

### INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. A Catholic mass was held daily in the lecture hall of St Patrick's and residents were supported to attend if they wished. Residents had access to religious representatives.

**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 written operational policies and procedures relating to visits. The policy was last reviewed in January 2024.

Visiting times were appropriate and reasonable. A separate visitors room and a family visitor room were provided where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

The visitors room and the family visitors room were suitable for visiting children.

**The approved centre was compliant with this regulation.**

## Regulation 12: Communication

**COMPLIANT**

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

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

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

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

### INSPECTION FINDINGS

The approved centre had written operational policies and procedures on communication. The policies were last reviewed between January 2023 and April 2024.

Residents had access to a unit phone and computer as well as individual laptops and mobile phones for the purposes of sending or receiving messages or goods, except where the resident was otherwise risk assessed with due regard to their wellbeing, safety and health.

**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 written operational policies and procedures on:

- The searching of a resident, their belongings and their environment.
- Carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
- The finding of illicit substances.

The policy was last reviewed in January 2023.

The clinical files of three residents who were searched were inspected. Risk was assessed prior to a search of a resident, their property or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches. The request for consent and the reply was documented for every search of a resident and every property search. General written consent was sought for routine environmental searches.

The resident search policy and procedure was communicated to all residents. Relevant staff were able to articulate the searching processes as set out in the policy. Residents were informed by those carrying out the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times while searches were being carried out.

The resident’s dignity, privacy and gender were respected during searches and at least one of the staff members conducting the search was the same gender as the resident being searched. Residents were

given the opportunity to give feedback regarding their experience of the search in relation to their dignity and privacy.

A written record of every search of a resident and every property search was available, and 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 written operational policies and protocols for care of residents who are dying. The policy was last reviewed in August 2021.

As there had been no death of a resident 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) and five ICPs were reviewed on inspection. The approved centre used an electronic health record database. The ICPs were a composite set of documents which addressed the resident's goals, mental health care and treatment needs based on a multi-disciplinary team (MDT) assessment of the person and where practicable, in consultation with them. The documents within the ICPs were identifiable and uninterrupted.

The ICPs were developed by the MDT following a comprehensive assessment of the resident within seven days of admission. The ICPs was discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

The ICPs identified appropriate goals for the resident, the care and treatment required to meet the goals, the responsibilities for implementing the care and treatment and the resources required to provide the care and treatment identified.

The ICPs were reviewed by the MDT in consultation with the resident. Following this review, the ICPs were updated contemporaneously to reflect any changes to the goals, treatment, care, best practice and required resources. The ICP of a child resident included their educational requirements.

**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 approved centre provided therapeutic services and programmes that were appropriate and met the assessed needs documented in residents' individual care plans, such as one-on-one sessions, family therapy, psychotherapy, occupational therapy sensory group, decider skills, cognitive behavioural therapy, a wellness and recovery action plan group and relaxation. The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning.

The approved centre arranged therapeutic services for residents when the services was not provided internally. External services were provided by an approved, qualified health professional in an appropriate location.

**The approved centre was compliant with this regulation.**

## Regulation 17: Children's Education

**COMPLIANT**

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

### INSPECTION FINDINGS

Child residents were assessed regarding their individual educational requirements. Their individual needs and age on admission were taken into consideration as part of the assessment.

Appropriate to the needs and age of the child resident, the education provided by the approved centre reflected the required educational curriculum. Educational facilities and staff were available within the approved centre.

**The approved centre was compliant with this regulation.**

## Regulation 18: Transfer of Residents

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures on the transfer of residents. The policy was last reviewed in December 2023.

As no resident had been transferred from 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 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 has written operational policies and procedures for responding to medical emergencies. The policy was last reviewed in October 2023.

The approved centre had an emergency trolley and staff always had access to an automated external defibrillator (AED).

Residents were provided with general health services and received appropriate health care interventions in line with their individual care plans. Although there had been no resident in the approved centre more than six months, general health assessments were undertaken and residents general health needs were monitored.

**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 written operational policies and procedures for the provision of information to residents. The policies were last reviewed between January 2023 and June 2023.

Residents were provided with required information at admission, including the approved centre's information booklet that detailed the care and services provided. The booklet was available in a format that supported resident needs and clear and simple-to-read information was provided on housekeeping arrangements, personal property, mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies and residents' rights.

Residents were provided with the details of their multi-disciplinary team. Residents were provided with written and verbal information regarding their diagnosis, except where the resident's psychiatrist deemed the provision of such information as prejudicial to the resident's physical health, mental health, well-being or emotional condition.

Medication information sheets and verbal information were provided in a format appropriate to the resident's needs. The medication information sheets included information on indications for use of all medications administered to the resident, including possible side-effects. Residents had access to interpretation and translation services as required.

**The approved centre was compliant with this regulation.**

## Regulation 21: Privacy

**COMPLIANT**

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

### INSPECTION FINDINGS

Residents were called by their preferred name based on their self-identification. Staff appeared and dressed professionally and interacted with residents in a professional, engaging and compassionate manner. Staff showed discretion when discussing the resident's condition or treatment needs. Permission was sought before entering a resident's room.

All bathrooms, showers, toilets and single bedrooms had locks on the inside of the door, except where there was an identified risk to a resident. Locks had an override function.

Observation panels on treatment room doors and bedroom doors had blinds, curtains or opaque glass. Rooms were not overlooked by public areas.

Noticeboards did not detail resident names or other identifiable information. Residents were facilitated to make private phone calls. All residents wore clothes that respected their privacy and dignity.

**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 personal space: all resident rooms were adequately sized single en suite rooms. Residents had access to communal areas and rooms. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were sized and furnished to remove excessive noise. Lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs.

Residents had space to move about, including outdoor spaces. Hazards such as 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.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination and repair of assistive equipment. Records were maintained. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Water temperature in taps did not exceed 50°C. Current national infection control guidelines were followed.

There were sufficient toilets and showers for residents in the approved centre, with at least one assisted toilet. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address the residents' needs and furnished to support resident independence and comfort. Assisted devices and equipment were available to address resident needs when required.

**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 appropriate and suitable practices and written operational policies relating to:

- Ordering medicines.
- Prescribing medicines.
- Storing medicines.
- Administering medicines to residents.

The policy was last reviewed in March 2023.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident. The MPARs of five residents were inspected. The MPARs recorded allergies and sensitivities to any medication or recorded that the resident had no allergies. The MPARs detailed medication administration routes, a record of all medications administered to the resident and a clear date of discontinuation for each medication. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was recorded, as was the Nursing and Midwifery Board of Ireland (NMBI) registration number of every nurse prescriber. Each entry was legible and signed by the prescribing medical practitioner or nurse.

The pharmacist was consulted about the type of preparation used for medications. Medication was appropriately stored. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication was stored securely.

**The approved centre was compliant with this regulation.**

## Regulation 24: Health and Safety

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in March 2022.

**The approved centre was compliant with this regulation.**

## Regulation 25: Use of Closed Circuit Television

**COMPLIANT**

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had clear written policy and protocols in relation to the use of CCTV for observing residents. The policy was last reviewed in May 2023.

Clear signs in prominent positions indicated where CCTV cameras or other monitoring systems were located throughout the approved centre. The existence and use of CCTV or other monitoring systems was disclosed to all residents and their representatives. Residents were monitored solely for the purposes of ensuring the health, safety and welfare of that resident.

The use of CCTV, or other monitoring systems, had been disclosed to the Mental Health Commission or the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe residents were incapable of recording or storing a resident's image on a tape, disc, hard drive or in any other form. CCTV cameras or other monitoring systems only transmitted images to a monitor that was viewed solely by the health professional responsible for the resident.

CCTV was not used to monitor a resident if they started to act in a way which compromised their dignity.

**The approved centre was compliant with this regulation.**

## 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 suite of written policies and procedures in place relating to staffing. The policies were last reviewed between April 2022 and May 2024, and included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty and in charge at all times, and this was documented. The approved centre had one multi-disciplinary team who were responsible for the care and treatment of the residents. The inpatient treating team consisted of child & adolescent consultant psychiatrists, nursing staff, social work, psychology, occupational therapy, family therapy, cognitive behavioural therapy, pharmacy, dietetics and education. Access to chiropody, speech and language therapy and physiotherapy was arranged for residents and was on an in-reach basis. Residents had access to a general practitioner (GP) service that was available on the grounds of St. Patrick's University Hospital.

All healthcare staff were trained in fire safety, basic life support, the management of violence and aggression, safeguarding and the Mental Health Act 2001. All mandated persons in the approved centre were trained in Children First.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

**The following table shows the percentage of staff trained in the mandatory training subjects:**

| Staff Training Record | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Profession | Basic Life Support | | Fire Safety | | Management of Violence and Aggression | | Mental Health Act 2001 | | Children First (mandated persons) | | Safeguarding | |
| **Nursing (26)** | 26 | 100% | 26 | 100% | 26 | 100% | 26 | 100% | 26 | 100% | 26 | 100% |
| **Consultant Psychiatrist (2)** | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% |
| **Medical (3)** | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| **Occupational Therapist (2)** | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% |
| **Social Worker (1)** | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| **Psychologist (2)** | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% |
| **Family Therapist (1)** | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| **Cognitive Behavioural Therapist (1)** | 1 | 100% | 1 | 100% | 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 written policies and procedures relating to the:

- Creation of records.
- Access to records.
- Retention of records.
- Destruction of records.

The policies were last reviewed between June 2022 and December 2023.

Resident records were online on the electronic healthcare recording system, and were secure, up-to-date, and in good order, and were electronically stored together. Some residents had a physical file for supplementary documents that were securely stored with access restricted to named staff. All resident records were reflective of the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

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 electronic 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 register of residents was up to date and available to the Mental Health Commission when requested.

**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.

Where regional or national policies were used, the approved centre had a written statement confirming this, which was reviewed at least every three years.

**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 written operational policies and procedures relating to the:

- Making of complaints.
- Handling of complaints.
- Investigating complaints from any person about any aspects of the service, care and treatment provided in or on behalf of the approved centre.

The policy was last reviewed in January 2023.

A nominated person was responsible for dealing with all complaints and was available to the approved centre. The approved centre's processes for managing complaints were well publicised and accessible to residents and their representatives. This included providing information about the complaints procedure to the resident and their representative at admission or soon thereafter.

The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family and next-of-kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment given to a resident were not adversely affected by any complaint made.

Minor complaints were documented. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, and subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. Complainants were

informed promptly of the outcome of the complaint investigation, details of the appeals process were made available to them and this was documented.

**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 comprehensive written policy and procedures in relation to risk management. The policy was last reviewed in March 2022. The risk management policy and the associated risk related policies and the safety statement addressed all policy requirements and outlined the roles and responsibilities for risk management, including:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The responsibilities of the multi-disciplinary team.
- The person responsible for the completion of six-monthly incident summary reports.
- A defined quality and safety oversight and review structure as part of the governance process for managing risk.

The policy also included:

- The process for identifying, assessing, treating, reporting and monitoring risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling specific risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register.
- The record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.

- The process for responding to specific emergencies, including the roles and responsibilities of key staff, the sequence of required actions, the process for communication and escalating emergencies to management.
- The process for the protection of children and vulnerable adults within 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.

Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks, health and safety risks and corporate risks were identified, assessed, treated, reported and monitored. Clinical risks, health and safety risks and corporate risks were documented in the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were also completed at admission and discharge, and in conjunction with medication requirements.

Multi-disciplinary teams (MDTs) were involved in the development, implementation and review of the individual risk management processes. Residents or their representatives were also involved in the individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

The approved centre used the Datix electronic database to record and risk rate incidents. All clinical incidents were reviewed by the MDT and 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.

An emergency evacuation plan was in place that specified responses by the approved centre staff in relation to possible emergencies. 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 for public liability, employer's liability, clinical indemnity, and property.

**The approved centre was compliant with this regulation.**

## Regulation 34: Certificate of Registration

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently at the reception area of the approved centre.

**The approved centre was compliant with this regulation.**

# 8.0 Inspection Findings – Rules

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

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

# 9.0 Inspection Findings – Mental Health Act 2001

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

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

# 10.0 Inspection Findings – Codes of Practice

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

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

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

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

## Admission, Transfer and Discharge

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**Admission:** The admission policy, which was last reviewed in June 2023, included all of the policy-related criteria for this code of practice.

**Transfer:** The transfer policy, which was last reviewed in December 2023, included all of the policy-related criteria for this code of practice.

**Discharge:** The discharge policy, which was last reviewed in August 2022, 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 history, medical history, current and historic medications, current mental health state, risk assessment, and all other relevant information. A full physical examination was carried out. A key worker system was in place, 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 other risks and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, their key worker, relevant members of the resident's multi-disciplinary team (MDT) and a family member or representative, where appropriate.

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

The discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge and outstanding health or social issues. It provided 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 arranged.

**The approved centre was compliant with this code of practice.**

# Appendix 1 Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

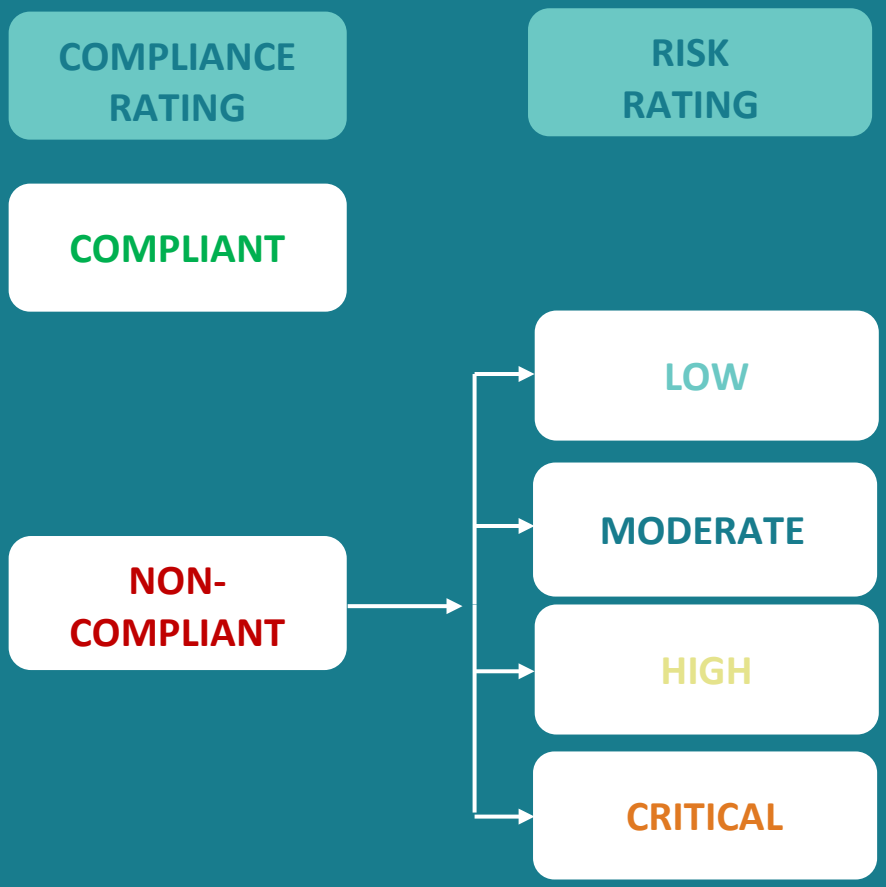
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

## COMPLIANCE AND RISK RATINGS

**The following ratings are assigned to areas inspected:**

**COMPLIANCE RATINGS are given for all areas inspected.**
**RISK RATINGS are given for any area that is deemed non-compliant.**




The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.