Adolescent In-patient Unit, St Vincent's Hospital

Annual Inspection Report 2024

Promoting Quality, Safety and Human Rights in Mental Health

ADOLESCENT IN-PATIENT UNIT, ST VINCENT'S HOSPITAL

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

Date of Publication: 5th March 2025

ID Number: AC0077

2024 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
29 January 2024

Registered Proprietor:
St Vincent's Hospital, Fairview

Registered Proprietor Nominee:
Mr Eoin Culliton, Chief Executive

Inspection Team:
Shayne Wilson, Lead Inspector
Barbara McGeough
Barbara Murphy

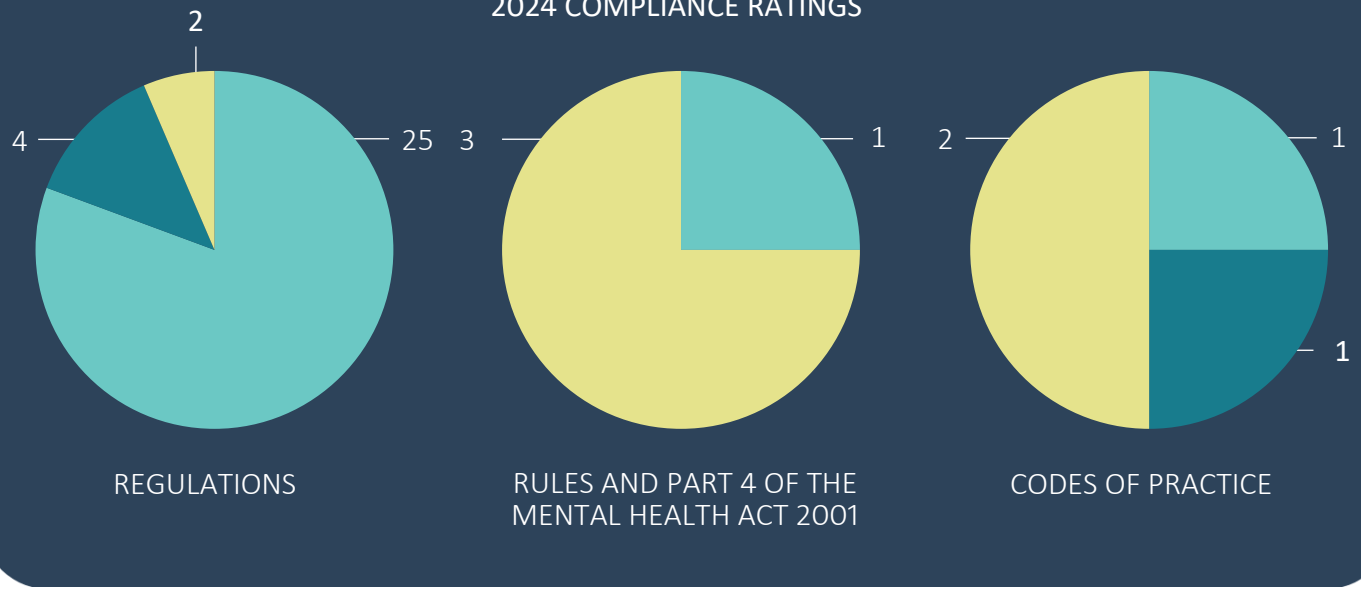
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
9 – 12 July 2024

Previous Inspection date:
3 – 6 October 2023

Inspection Type:
Unannounced Annual Inspection

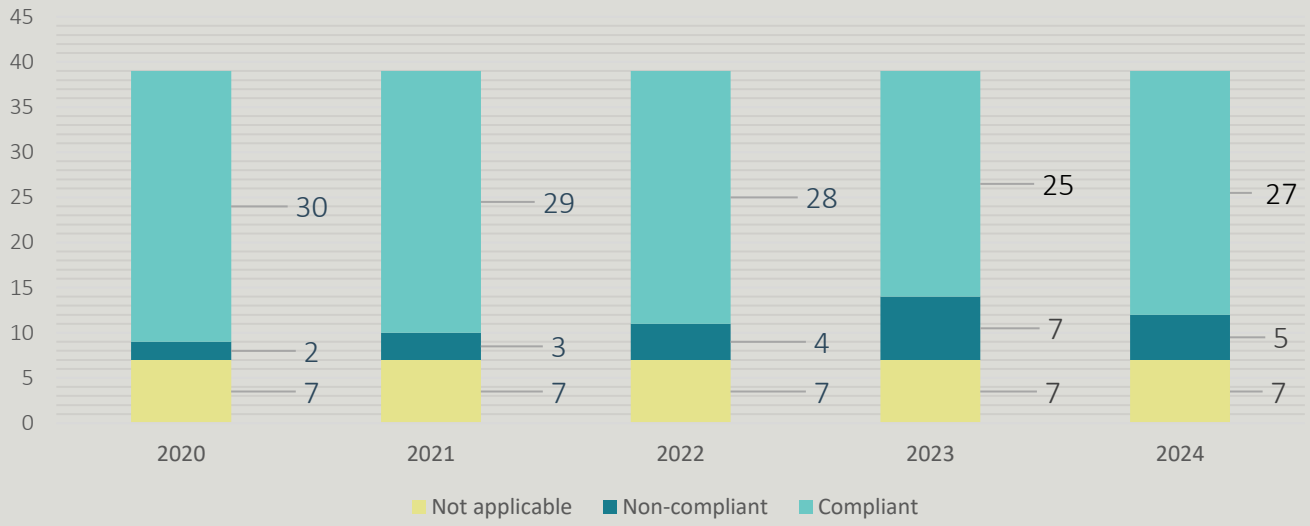
2024 COMPLIANCE RATINGS



RATINGS SUMMARY 2020 – 2024

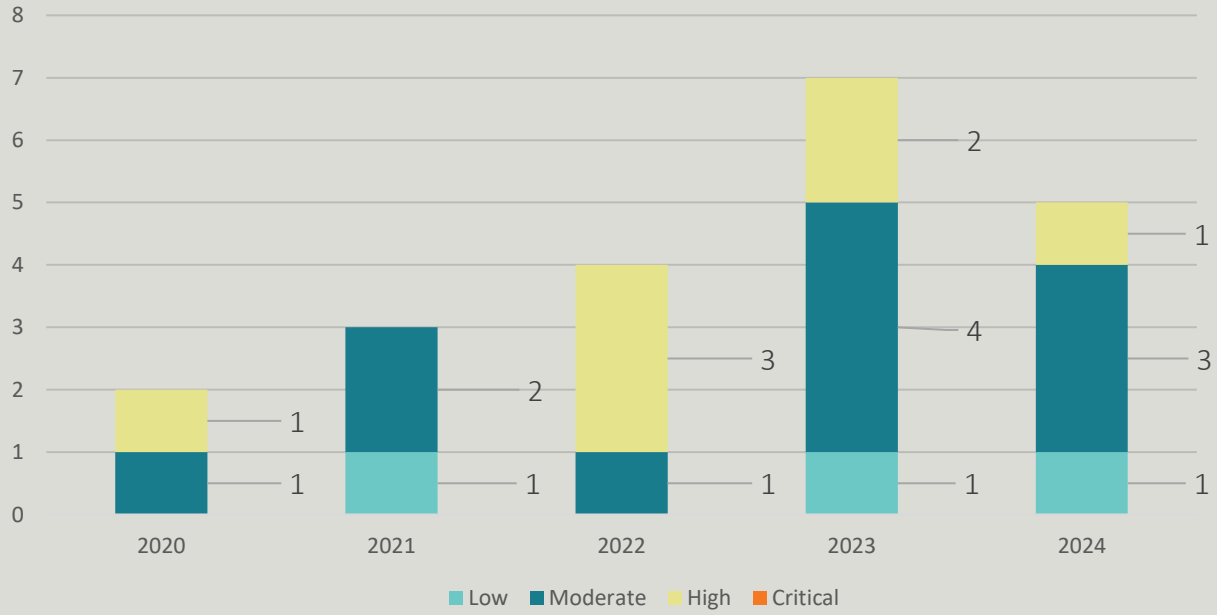
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2020 – 2024



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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

The Adolescent Inpatient Unit (AIPU) was located in St Joseph's Unit, and is part of St Vincent's Hospital Fairview, a public voluntary mental health service. The AIPU is registered with the Mental Health Commission as an Approved Centre with an occupancy capacity of 12 beds. However, for operational purposes the AIPU currently maintains a current capacity of 10 beds. The 2024 inspection took place on the 9th of July to the 12th of July and this report is reflective of this timeframe only.

Admissions were accepted from the Dublin Northeast area, Dublin North City and County, Meath, Louth, Cavan, and Monaghan. Admissions were also accepted from other areas depending on need and availability. The approved centre accepted admissions for ages 15 years to 18 years. Findings on this inspection included the provision of discharge information, nutritional assessments, mandatory training for some staff, a small number of areas within operating policies and procedures, and individual care plans, were identified areas of concern. However, there have been improvements since the 2023 Inspection to restrictive practice processes and levels of staffing, which have contributed to positive recovery orientated outcomes for residents and are reflective of St Vincent's Hospital Fairview's commitment to person centred, recovery focused human rights-based care.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	94%	91%	87%	78%	84%

Conditions of registration

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

Conditions	Findings
Condition 1: *The registered proprietor shall develop and implement a Quality Improvement Plan to*	The approved centre was in not in breach of Condition 1 at the time of inspection.

comprehensively address areas of non-compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006), as identified by the Inspector of Mental Health Services, during the inspection which was conducted between 3 October 2023 to 5 October 2023 The plan must detail how corrective actions will be overseen and sustained on a continuing basis. This plan must be submitted on a date specified by the Mental Health Commission. The registered proprietor shall submit updates in a form and frequency specified by the Mental Health Commission.	
Condition 2: *The registered proprietor shall develop and implement a costed, funded, timebound plan to address the risk presented by ligature points throughout the premises of the approved centre, on a date specified by the Mental Health Commission. The plan shall address the removal and minimisation of ligature points. The registered proprietor must submit updates on the progression of this plan in the form and frequency specified by the Mental Health Commission.*	The approved centre was in not in breach of Condition 2 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:

- Regulation 19: General Health
  - Essential Physical Health Care Skills; a programme jointly developed by Saint Vincent's Hospital Fairview, Centre for Nursing and Midwifery Education and Nurse Practice Development Coordinators; in Dublin North City Centre & Dublin North County Healthcare services. A Five day programme reviewing anatomy and physiology systems and the nursing management of medical conditions co-existing in the service user population, encompassing Mental and Physical Health wellbeing
- Regulation 20: Provision of Information to Residents
  - The eating disorder information booklet ''A Journey Through Your Eating Disorder Recovery Programme'' was reviewed by the Implementation team of the Approved Centre, and was amended to include more information for the young person about the programme in AIPU. It also now includes recovery-based worksheets and tools for the young person to complete to promote a successful road to recovery.
  - The parents' handbook provides information about eating disorders, the eating disorder refeeding programme, instructions and advice in regards meal times and rest periods and managing the transition home.
  - The Information leaflet wall which has been updated since the 2023 Inspection, in the reception area of AIPU, for young people and their families. It contains leaflets with helpful information to support the young person experiencing mental health difficulties and useful voluntary organisations.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Adolescent In-Patient Unit (AIPU) in the St Joseph's complex, is part of the Saint Vincent's Hospital Fairview Service. The approved centre was registered for child and adolescent mental health care and mental health care for people with intellectual disability. The AIPU is located in a separate building to the main St. Vincent's hospital, which was clearly signposted and has a separate entrance from Richmond Road if required. The AIPU is located above the ground floor reception and school classroom areas. The classroom is a well resourced open learning space. The resident accommodation on the first floor was well maintained and decorated, is accessed by a lift or stairs and comprised of 12 en suite single rooms. All bedrooms were bright and spacious with ample safe storage, and those occupied were creatively decorated with personal items by the residents.

There were relaxation areas and therapeutic spaces, along with a large dining area. It was registered to accommodate 12 beds; however, the Approved Centre have reduced this number to 10 for operational purposes. On the day of the 2024 inspection there were 5 residents. The Seclusion Room en suite was recently renovated, to ensure a person's safety whilst maintaining their dignity. The AIPU had access to large outdoor spaces, with well-maintained garden areas for relaxation or exercise, accessible by the stairs or lift. During the inspection, the following was noted: the premises required scheduled maintenance, a process which was well managed by a proactive team. There was one Consultant led multi-disciplinary team(MDT) which accepts admissions of young persons, aged 15 years to 18 years from the Dublin Northeast area, Dublin North City and County, Meath, Louth, Cavan, and Monaghan. Admissions were also accepted from other areas depending on need and availability.

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

Resident Profile	
Number of registered beds	***12***
Total number of residents	**5**
Number of detained patients	0
Number of wards of court	0
Number of children	5
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

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

The QPS committee convened quarterly and provided oversight for continuous quality improvement of AIPU, via sub-committees which reported to the QPS. These sub-committees included the infection prevention and control group, the health and safety committee, the drugs and therapeutic committee and the policy committee, all which met quarterly. The approved centre had an audit programme in place.

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

An oversight and review committee, of restrictive practice was in place which met quarterly. The assistant director of nursing was the named senior manager with responsibility for the approved centre's reduction in restrictive practices of physical restraint and the consultant psychiatrist was the named senior manager with responsibility for reduction in seclusion.

All clinical staff had received training on clinical risk management procedures appropriate to their role and function. Key personnel were responsible for risk management in the approved centre. The person with overall responsibility for risk was identified and known by staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre. The approved centre had a risk register which the QPS Committee reviewed, monitored, and any necessary updates were made to the risk register. Risk management was also on the agenda for the EMT meeting and the board of governors meeting, with a process of escalation to the Health Service Executive if required. The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and were reviewed to identify any trends or patterns occurring in the service. Analysis of incidents took place at the QPS meeting and feedback was given to staff of AIPU through the relevant line managers. The approved centre maintained a record of all incidents and the six monthly summary was due for submission to the MHC by the end of August 2024.
An organisational chart clearly identified the structures of leadership and the lines of responsibility and accountability within the approved centre. Completed Governance questionnaires were received by the Consultant Psychiatrist and Principal Clinical Psychologist. Respondents provided a clear overview of the governance within their respective roles, issues of risk or specific concerns and strategic goals for the service. Heads of Disciplines reported they frequently attended the approved centre and regularly met with their staff. Risks identified by the heads of discipline included; the need for recurrent training of NCHD's on six-monthly rotations and the lack of a dedicated budget for the Allied Health Professional department which limits CPD and the purchase of psychometric testing tools.

One multi-disciplinary team was responsible for the care and treatment of the residents within the approved centre. The team included medical, nursing, social work, occupational therapy, speech and language therapist and psychology staff, all of whom were based in the approved centre. Dietetics were privately sourced and provided by approved and qualified health professionals. Not all staff were up to date on mandatory training. The mandatory training progress record provided by the approved centre indicated shortfalls in basic life support, fire safety, management of violence and aggression, and the Mental Health Act 2001. There was a plan and schedule in place to address the deficits in training.

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

The process of making complaints and the complaints officer's contact details were displayed within the approved centre and were accessible to residents and their representatives within resident information booklets. Minor complaints that had been dealt with by staff were documented. All formal complaints were reviewed and dealt with by the nominated complaints officer of the approved centre and were documented with clear actions and outcomes detailed in the complaints log. There had been no formal complaints made since the last inspection.

Residents were involved in the development and review of their individual care plans. Weekly resident community meetings took place in the approved centre, and this provided an opportunity for residents to raise concerns or make suggestions. A review of the meeting minutes indicated that activity planning and concerns about Wi-fi connectivity from residents were discussed. These concerns were escalated to the appropriate service area. A representative from the Mental Health Advocate Services' Youth Advocate Programme (YAP) was available weekly to the residents. Their contact details were displayed in the approved centre. The service continues to provide, where required, a combination of weekly in-person group support, individual support and virtual or phone support for the residents.

The approved centre had child protection policies and procedures, in line with relevant legislation and regulations. Policy and procedure regarding staff training were in place. The approved centre was proactive in managing issues concerning COVID-19 through the approved centre's risk management processes. An Infection Control Committee met quarterly to ensure oversight of all related practices and procedures. The Management of COVID-19 was also discussed at the EMT and QPS meetings. A number of Nursing Staff had completed the Infection Prevention and Control Link Practitioner training. AIPU had a policy on the prevention and management of the Infection, in line with national best practice guidelines from the Health Protection Surveillance Centre.

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 2020 and 2024 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2020		2021		2022		2023		2024	
Regulation 5: Food and Nutrition	✓		✓		✓		✓		✗	Moderate
Regulation 15: Individual Care Plans	✗	High	✓		✓		✓		✗	High
Regulation 22: Premises	✗	Moderate	✗	Moderate	✗	High	✓		✗	Moderate
Regulation 26: Staffing	✓		✗	Moderate	✗	Moderate	✗	High	✗	Moderate
COP: Admission Transfer, Discharge	✓		✓		✓		✗	Moderate	✗	Low

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 25: Use of Closed-Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy (ECT)	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment.	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a CAMHS unit this code of 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 Peer Advocacy in Mental Health Service was contacted to ascertain if they had received any residents' feedback about the approved centre. The Youth Advocacy Programme did provide the Approved Centre with a quarterly report of any supportive interactions provided to residents..

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.

3 residents requested to meet with the Inspection team. Comments included:

- Staff were very kind, they look after you. Not sure if I got the booklet (resident information booklet). Feel safe, looked after here. Can have visits. There are activities like arts, crafts, garden and basketball.
- Happy here. I know the MDT and meet the doctors weekly. Have a copy of the care plan and am involved in setting goals. Room is comfortable and have privacy. Feel safe. Have access to a portable phone if I need. Staff are kind, caring and helpful. I didn't get the information booklet when I arrived but was shown around. Food is nice, you have choices and can get snacks. I can have visitors.
- I have my own bedroom but the pillow and blankets are not very comfortable. Food is very good, get a menu with choices, but you can get something else if you don't like the menu. I don't know how to make a complaint, I don't know my doctor only met him once. There is enough to do on weekdays and at weekends, I attend groups for yoga and meditation. There are community meetings. I have a care plan, I've signed it I think, I'm involved in my care plan and discharge plan. There's nothing I would change.
-

3 Questionnaires were completed (summary of responses).

1. I am happy how staff talk to me. I know who my keyworker is. I feel my privacy and dignity are respected. There are enough talking therapies if I need them. *The most positive aspect of their experience is* – The staff here are lovely and they all have positive attitudes. *The overall experience of care and treatment here is rated as* 10/10

2. I am happy how staff talk to me. I know who my keyworker is. I feel my privacy and dignity are respected. There are enough talking therapies if I need them. There are enough leisure activities for me during the day. *The most positive aspect of your experience is* – being able to go places. *The overall experience of care and treatment here is rated as 8/10*
3. When I arrived a member of staff did not explain what was happening in a way I could understand. Sometimes staff give you information about your diagnosis in a way you can understand. I am involved in setting goals for my individual care plan. I know who my multi-disciplinary team/mental health care team members are. I am always able to discuss worries or concerns with a member of staff. *The most positive aspect of your experience is* – Getting better. *The overall experience of care and treatment here is rated as 10/10* .

5.2 Advocacy

The approved centre had an advocacy service report, provided by the Youth Advocacy Programme (YAP) of their activity (Quarter 1 - from January 1st to March 31st 2024) which was obtained by the inspection team. The Inspection Team did not meet with this service during the inspection The YAP report detailed an interaction with a young person who was newly admitted, self-referred as they were unsure of their environment and requested support. The advocacy support lasted 3 weeks and assisted the person to achieve the following: gain information on services; improve their relationship with staff; improve communication with the care team; improved living arrangements and environment; and, that they felt listened to.

6.0 Feedback Meeting

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

- Registered Proprietor, A/CEO
- Clinical Director
- Director of Nursing
- Consultant Psychiatrist
- Principal Clinical Psychologist Manager
- Personal Assistant to CEO
- Chaplin
- ADON
- CNM3
- CNM2
- Senior Pharmacist
- Mental Health Act Administrator
- Social Worker
- Medical Records 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.

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, appropriate to the resident group profile and individual residents' needs. These were resident name, date of birth and medical record number and the identifiers were checked 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 had a process in place for the identification of residents with the same or similar names.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

NON-COMPLIANT

Risk Rating MODERATE

(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, and menus were on a three week cycle. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre.

Nutritional and dietary needs were not assessed with the use of an evidence-based nutrition assessment tool, which was not aligned with the approved centre's policy on food and nutrition.

The approved centre was non-compliant with this regulation as residents' nutritional and dietary needs were not assessed with the use of an evidence-based tool, 5(2).

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

Meals were prepared in the canteen and transported to the kitchenette in the approved centre in a food trolley. There was dietitian input into the meals. There was suitable and sufficient catering equipment in the approved centre and proper facilities for the refrigeration, storage, preparation, cooking 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.

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 breaches cold chain parameters.

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 that took account of their preferences, dignity, bodily integrity, and religious and cultural practices.

Night clothes were not worn by residents during the day unless specified in their individual care plan. Each resident was supported to manage and maintain their own laundry through the provision of internal or external laundry services.

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 an operational policy and procedures relating to residents' personal property and possessions which was last reviewed in May 2024.

Residents' 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 access to and use of resident monies was overseen by either two members of staff or the resident and two staff members. There was a process to record, secure and manage the personal property and possessions of the resident, including money.

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. There was a wide range of recreational activities available to the young people both on an individual and group basis. Activities included jigsaws, books, DVDs, a video game console, arts and crafts, board games, foosball table, music, self-care products, TV (including some subscription services), piano, computer, movie day, yoga, relaxation, walks, outings to places such as the zoo, baking, and guided meditation by the chaplain. The young people had access to a basketball court, table tennis and outdoor exercise equipment.

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. Interfaith ministers were arranged by 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 operational policy and procedures in relation to visits. The policy was last reviewed in June 2023. Visiting times were appropriate and reasonable. There was a visitors room available where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting rooms 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 operational policy and procedures relating to communication. The policy was last reviewed in July 2024.

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 postal mail, e-mail, Internet, and telephone for the sending or receiving messages or goods unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Residents had access to six portable phones and a smart phone which they could take to their bedrooms, or an office, and other rooms such as the relaxation room and family room.

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 July 2024, and included all requirements related to:

- The management and application of searches of a resident, their belongings and the environment in which they are 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.

Three searches had taken place since the last inspection and the clinical files of these 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 search, and due regard was shown to the resident’s dignity, privacy and gender. At least one of the staff members conducting the search was 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. Residents were given the opportunity to give feedback regarding their experience of the search in relation to their dignity and privacy.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents with allocated sections for needs, goals, treatment, care, resources required and space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes.

All ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The ICPs were discussed, agreed where practicable and drawn up with the participation of the resident and their representative, family and next of kin, as appropriate.

One individual care plan did not identify appropriate goals for the resident. Four out of five ICPs inspected were not updated following a review by the multi-disciplinary team (MDT), which meant the ICPs did not reflect any changes to the goals, treatment, care, and required resources.

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

a) **One individual care plan did not identify appropriate goals for the resident.**
b) **Four out of five individual care plans inspected were not updated following a review by the multi-disciplinary team (MDT), which meant the individual care plan did not reflect any changes to the goals, treatment, care, and required resources.**

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's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

Therapeutic services were a mixture of residents receiving individual one to one therapy and group therapy, based on the assessed needs of residents. Professions which worked together in the delivery of therapies were social work, occupational therapy and psychology staff.

Group therapies included: psychoeducational, values, decider skills, stress management, and occupational therapy activity groups. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

Residents were assessed in relation to their educational requirements, with consideration of their individual needs and age on admission. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities and sufficient personnel were available for provision of education to the child residents in the approved centre. The approved centre had a classroom and a large activity room for education purposes.

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 March 2024.

The clinical file of one resident who had been transferred from the approved centre in an emergency situation 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.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which was last reviewed in July 2024. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

No resident was in the approved centre for six months at the time of the inspection. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programs that were available as applicable to resident needs, age and gender. These included: breast check, cervical screening and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in May 2024.

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 residents' 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.

Each resident had their own single en suite bedroom. 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 and take private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and residents 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 lighting and heating in day areas and bedrooms. Rooms were centrally heated. All private and communal areas were adequately sized and furnished to remove excessive noise. Appropriate signage and sensory aids were provided to support residents in finding their way around the approved centre.

Sufficient spaces were provided for residents to move about, including outdoor spaces. The young people had supervised access to a garden area and basketball court. All resident bedrooms were single with an en suite bathroom and were appropriately sized to address the resident needs.

The condition of the outdoor physical environment did not offer maximum opportunity to maintain and improve residents mental and general health status. While the approved centre was clean on the inside, it was not clean on the outside: the entrance to the approved centre required power hosing, the garden paths required power hosing and weeding, the garden fence needed paint, and the astro turf was damaged and required cleaning. This meant residents spending time outdoors in the approved centre, had a view of faded paint, and unkempt and unclean outdoor spaces.

Ligature points were minimised to the lowest practicable level, based on risk assessment. Hazards were not minimised: the garden paths had a build up of moss.

Though there was a programme of maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, the approved centre was not kept in a good state of repair on the inside and outside. There were marks on the corridor floor, and pen marks on the sofa in the de-escalation room.

The approved centre had suitable furnishings to support resident independence and comfort, and enough toilets and showers for residents, with at least one assisted toilet. The centre provided assistive devices and equipment to address resident needs.

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

a) **The registered proprietor did not ensure premises were clean maintained in good structural and decorative condition: the pathways in garden area required power hosing and weeding, the garden fencing required painting, the astro turf was damaged and dirty, there were markings on the corridor floor and pen marks the sofa in the de-escalation room, 22(1)(a).**
b) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, staff and visitors, as not all hazards were minimised, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in September 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 had 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 August 2021.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in July 2024 and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. All staff were trained in safeguarding, and the Mental Health Act 2001. All mandated persons in the approved centre are trained in Children First. Not all staff were trained in basic life support and the management of violence and aggression.

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 number and percentages of staff trained in the different aspects of mandatory training:

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (10)	10	100%	10	100%	10	100%	10	100%	10	100%	10	100%
Medical (4)	3	75 %	4	100%	3	75 %	3	75 %	3	75 %	2	50%
Occupational Therapist (1)	0	0%	1	100%	0	0 %	1	100%	1	100%	0	0 %
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100 %
Psychologist (1)	1	100%	1	100%	1	100%	0	0 %	1	100%	1	100%
Speech & Language T (1)	1	100%	1	100%	0	0 %	0	0 %	0	0 %	1	100%

	#	%	#	%	#	%	#	%	#	%	#	%
	#	%	#	%	#	%	#	%	#	%	#	%

The approved centre was non-compliant with this regulation as not all staff had undertaken mandatory training in basic life support, and the Management of Violence and Aggression and Safeguarding, 26(4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in January 2024. Resident records were kept in good order, and were up to date with no loose pages present. All records were maintained in a manner to ensure security, completeness, accuracy, and ease of retrieval. Residents' records were developed and maintained in a logical sequence. 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 an electronic register of all residents admitted to the approved centre. 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 written operational policies and procedures of the approved centre were reviewed within the required timeframe of 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 a written operational policy and procedures on the complaints process. The policy was last reviewed in February 2023 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible and available for dealing with all complaints who was available to the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family and next of kin were informed of all methods by which a complaint could be made. There were no formal complaints since the last inspection. 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 of a resident was not adversely affected by reason of the complaint being made. Minor complaints were 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 series of written operational policies and procedures in relation to risk management. The risk management policy was last reviewed in August 2021. The risk management policy addressed all requirements including:

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

The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

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.
All clinical, health and safety and organisational risks were identified, assessed, treated, reported, monitored and documented in 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 at resident transfer and resident discharge, and prior to and during physical restraint, and seclusion.

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 within the approved centre were appropriate and implemented as required.

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate and indemnity scheme statement was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity and property. There was an indemnity scheme statement available for inspection or on request by the Mental Health Commission.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, with two conditions attached which were displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

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

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

The policy addressed:

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

The approved centre also had a restrictive practice reduction policy which was last reviewed in April 2023 which:

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

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

Monitoring: A multi-disciplinary review and oversight committee, accountable to the registered proprietor nominee, met quarterly at the approved centre to analyse in detail every episode of seclusion. The committee determined if there was compliance with the rules governing the use of seclusion and with the approved centre's own policy and procedures for each episode of seclusion reviewed. The committee also identified areas for improvement and consequent actions, the persons responsible, and the timeframes for completion of those actions.

The committee also provided assurance to the registered proprietor nominee that each use of seclusion was in accordance with the Mental Health Commission's rules and produced a report following each meeting. This report was made available to staff to promote on-going learning and awareness, as well as to the Mental Health Commission.

Evidence of Implementation: The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There were no ligature points or electrical fixtures. The seclusion room allowed for staff to be able to clearly observe the person within the seclusion room. The seclusion room included limited furnishings including a pillow, mattress and blanket or covering, all of which met current health and safety requirements.

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 seclusion room did have an anti-barricade door. The seclusion room had externally controlled heating and air conditioning, which enabled those observing any person in seclusion to monitor the seclusion room temperature. The seclusion room did have a clock that displayed the time, day and date visible to a person in seclusion. The seclusion suite provided access to suitable sanitary facilities.

Order of Seclusion: Three episodes of seclusion were reviewed on inspection. Each episode inspected, reflected that seclusion was only used in rare and exceptional circumstances and in residents' best interests when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated by a registered medical practitioner (RMP) or the most senior registered nurse (RN) on duty, following as comprehensive an assessment of the patient, and after all other interventions to manage the residents' unsafe behaviour had been considered. This included a risk assessment; the outcome of which was recorded in the clinical file. The RMP or RN recorded the seclusion order both in the clinical file and on the seclusion register. Where seclusion was initiated by a RN, a RMP was notified of the seclusion episode as soon as practicable.

The RMP medically examined each resident in seclusion as soon as practicable, except in one episode when the resident refused to receive a medical examination. This examination included an assessment and record of any physical, psychological or emotional trauma caused by the seclusion. Following the medical examination, the RMP contacted the patient's consultant psychiatrist (CP) or the duty CP to inform them of the episode of seclusion. The RMP recorded this consultation in the clinical file and indicated on the seclusion register that the CP ordered or did not order the continued use of seclusion.

Where the CP ordered the continued use of seclusion, they also advised the duration. The RMP recorded this information on the seclusion register. No seclusion order was made for a period of time longer than

four hours from the commencement of the seclusion episode. The treating Consultant Psychiatrist examined the resident and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The examination was recorded in the clinical file. The resident was informed of the reasons for, likely duration of, and circumstances which lead to the discontinuation of seclusion, and this was recorded in the person's clinical file. Where it was the person's wish in accordance with their ICP, the resident's representative was informed of their seclusion and a record of this communication was entered in the clinical file. The registered proprietor notified the Mental Health Commission of the start time and date, and the end time and date of each episode of seclusion.

Each resident was secluded in their own clothing which respected the right of the person to dignity, bodily integrity and privacy. The resident was directly observed by a RN for the first hour following the initiation of seclusion. After the first hour, a RN kept the resident under continuous observation and stayed within sight and sound of the seclusion room. Every 15 minutes, the RN recorded the resident's level of distress, their behaviour, their level of awareness, their physical health and whether their bodily needs were being met. Following risk assessment, a nursing review of the resident took place every two hours. During this review, a minimum of two staff members entered the seclusion room and assessed the resident to determine whether to end the episode of seclusion. This assessment and decision was recorded.

A medical examination was carried out by a RMP every four hours. The decision to end or continue seclusion was recorded. For each episode of seclusion, a seclusion care plan for the resident was developed by a RN. The seclusion care plan included personal details, known clinical needs, how de-escalation strategies would continue to be used, the resident's preferences in relation to seclusion if known, signs that the resident's behaviour is no longer deemed an unmanageable risk towards themselves or others, how potential risks may be managed, specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion. The care plan also included how the resident's bodily needs would be met, medication reviews, monitoring of physical observations and a strategy for ending seclusion.

Ending of Seclusion: Seclusion was ended by a RMP at any time following discussion with the resident and relevant nursing staff, or by the most senior RN on the ward in consultation with the resident and the RMP. The CP responsible or the duty CP was notified, and the resident was informed of the ending of an episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date seclusion was ended.

An in-person debrief followed every episode of seclusion. This debrief was person-centred and gave the resident an opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved in their care. The debrief occurred within two working days of the episode unless the resident preferred otherwise. Where the resident refused to participate in a debrief, this wish was respected and recorded. The debrief included a discussion regarding alternative de-escalation strategies and the resident's preferences that could be applied in the case of future restrictive interventions.

The resident was given the option of having a representative or a nominated support person attend the debrief with them. A record was kept of the offer of debriefing, whether it was accepted and the outcome.

The resident's individual care plan was updated to reflect the outcome of the debrief. A record of all attendees at the debrief was recorded in the clinical file. The resident's representative was informed of both the start and ending of the seclusion, except where it was the resident patient's wish otherwise. Appropriate emotional support was provided to the resident directly after the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion.

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 of the Mental Health Act 2001: Consent to Treatment was not applicable.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in February 2024 and addressed the following:

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

Training policies and procedures included all of the requirements for this code of practice.

The approved centre had a reduction of physical restraint policy on the reduction of restrictive practices; thus the policy included the following:

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

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

Monitoring: The approved centre had established a multi-disciplinary review and oversight committee. They met at least quarterly and they covered all of their responsibilities including the review of compliance with the code of practice on physical restraint, and compliance with the approved centre's own policies and procedures, specific to each episode reviewed. They produced a report following each meeting of the review and oversight committee.

Evidence of Implementation: Three 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 residents' 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 had been completed no later than two hours after the start of each episode of restraint.

The orders for physical restraint did not exceed a duration of 10 minutes. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode, and signed by the CP, or duty CP, within 24 hours. The residents were informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical files as soon as was practicable.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the residents' individual care plans pertaining to their 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.

Ending of Physical Restraint: The physical restraint in each instance was ended by the person who had lead it. The time, date, and reason for ending the physical restraint was recorded in the clinical files on the date that each episode 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 to have the debrief outside of this timeframe. There was a record of all attendees who were present at the debrief and this was included in the clinical file. Appropriate emotional support was provided to the residents following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

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

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

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

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating LOW

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 a series of separate written policies in relation to admission, transfer and discharge. The admission policy was last reviewed in September 2023, the transfer policy in March 2024 and the discharge policy in March 2022.

Training and Education: Relevant staff had signed the policy log to indicate that they 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 was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker and an admission assessment was completed. The resident's family member was involved in the admission process with the resident's consent. The resident received an admission assessment which included their presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, current mental health state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge meeting was held and attended by the resident and their key worker, and relevant members of the multi-disciplinary team (MDT). A comprehensive pre-discharge assessment was completed which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs and a comprehensive risk assessment and risk management plan.

The discharge assessment included the following: psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs, and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was not issued within 14 days.

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

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

Appendix 1: Corrective and Preventative Action Plan

Regulation 05 Food and Nutrition					
Reason ID : 10005822		**Residents' nutritional and dietary needs were not assessed with the use of an evidence-based tool, 5(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Liaised with Unit Dietician. SANSI assessment tool identified as the most appropriate evidence based tool. Same agreed with treating Consultant. SANSI tool utilised on all current inpatient YP. Same tool added to the Admission pack.	Admission Audit schedule in place	Achievable	30/09/2024	ADON/Consultant Psychiatrist/Medical Records Manager.
Preventative Action	Added to the admissions process checklist. Same information disseminated at CNM meetings, Service Development Meetings, Staff nurse meetings, IQPS committee meetings. Added to 6 weekly interim risk assessment documents to ensure nutritional assessment	Added as General Health audit as well admissions audit	Achievable	31/12/2024	ADON/Consultant Psychiatrist/ Medical Records Manager

	is repeated throughout the duration of admission.				

Regulation 15: Individual Care Plan					
Reason ID : 10005824		**Four out of five individual care plans inspected were not updated following a review by the multi-disciplinary team (MDT), which meant the individual care plan did not reflect any changes to the goals, treatment, care, and required resources. One individual care plan did not identify appropriate goals for the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	MDT meeting changed to a Thursday to account/ensure for 7 day review period (ie Bank Holiday). HSE guidelines regarding Writing a person-centred Individual Care Plan + local ICP policy disseminated to the MDT. Audit results displayed on noticeboard.	Quarterly Audits repeated to capture data	Achievable	31/12/2024	ADON, Psychology Manager, Consultant Psychiatrist
Preventative Action	Additional In-service training completed Nov 2024, induction manual to be distributed among Medical + AHPs upon commencement of duty. MHC report feedback disseminated at Service Development meetings, IQPS Committee, Nursing staff meetings, CNM	Audit increased to monthly, evaluate in conjunction with Young People at Community meetings to ascertain that their needs/goals are being met.	Achievable	31/03/2025	ADON, Psychology Manager, Consultant Psychiatrist

	meetings. Audit results displayed on noticeboard. ICP champion x2 identified within the clinical team. Memo of outlining the nature of the non-compliance regarding the regulation shared amongst the clinical team.				

Regulation 22: Premises					
Reason ID : 10005825		**The registered proprietor did not ensure premises were clean maintained in good structural and decorative condition: the pathways in garden area required power hosing and weeding, the garden fencing required painting, the astro turf was damaged and dirty, there were markings on the corridor floor and pen marks the sofa in the de-escalation room 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Area was powerhosed Weeding was done Astro turf is scheduled to be removed in 2025. Plans are to use internal resources, but might need external support.	Path was clear The astro-turf will have to be removed.	The internal works was done quickly, but there can be delays in availability of contractors.	31/03/2025	Portering, Tech Services (contractors), A/CEO
Preventative Action	Powerhosing now scheduled monthly The work being carried out by Tech Services will hold for a number of years.	The path area will be maintained in a moss-free state.	The internal works can be scheduled, but there can be delays in availability of contractors.	31/03/2025	Portering, Tech Services (contractors), A/CEO
Reason ID : 10005826		**The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, staff and visitors, as not all hazards were minimised, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The floor coverings will be replaced. We have a quote for the works and the HSE are supporting us on the cost	New floor covering has been ordered, but will not be done until end January 2025.	New lino might not be done until end January 2025. Contractor services are very difficult to secure.	31/01/2025	Tech Services, A/CEO
Preventative Action	Greater scrutiny of environment for Quality Walkarounds.	Next Quality Walkaround will take place in January 2025	Achievable and ongoing	31/01/2025	Tech Services, A/CEO

Regulation 26: Staffing					
Reason ID : 10005827		**Not all staff had undertaken mandatory training in basic life support, and the Management of Violence and Aggression and Safeguarding, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff have be notified of expired certs and pushed to bring them up to date. Fire Safety, BLS and Children First all at 100%. Physical training is being scheduled for January 2025. Online training certs are being sought for staff with expired certs.	Achievable.	Periodic nature of availibilty of training courses can mean that the certs of some staff could lapse into a expiry for the physical training ie BLS & TMVA Also, if staff are on leave, it can create timing difficulties.	31/01/2025	CNM3, PA to Adult CD, A/CEO, Adolescent CD
Preventative Action	Staff will be notified of expiring certs ahead of schedule	Achievable, but ongoing. We have already notified our Social Worker, who has renewed one cert due to expire in January 2025 and has booked herself into the in-person training for the other cert.	Periodic nature of availibilty of training courses can mean that the certs of some staff could lapse into a expiry for the physical training ie BLS & TMVA Also, if staff are on leave, it can create timing difficulties. NCHDs transitioning into our service could have expired certs.	31/01/2025	CNM3, PA to Adult CD, A/CEO, Adolescent CD

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10005820		**A comprehensive discharge summary was not issued within 14 days, 38.3(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Memo sent to all clinical/clerical staff highlighting Code of Practice, each D/C summary compliance being tracked on HCR monthly report. Discussed at Service Development meeting, IQPS Committee.	Quarterly audit completed, Healthcare records publishing monthly compliance report.	Quarterly audit completed, Healthcare records publishing monthly compliance report.	31/12/2024	ADON, Consultant Psychiatrist, Psychology Manager, Healthcare record Manager
Preventative Action	Discharge Protocol completed, same discussed and agreed at Executive management Team meetings and Service Development meeting. All medical, nursing, multidisciplinary staff to sign that they have read and understand the relevant policies.	Audit frequency increased to Monthly. Also NIMs to be completed by relevant discipline if the agreed protocol is not adhered to.	Realistic	31/03/2025	ADON, Consultant Psychiatrist, Psychology Manager, Healthcare Records Manager

Appendix 2: Background to the inspection process

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

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

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

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

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

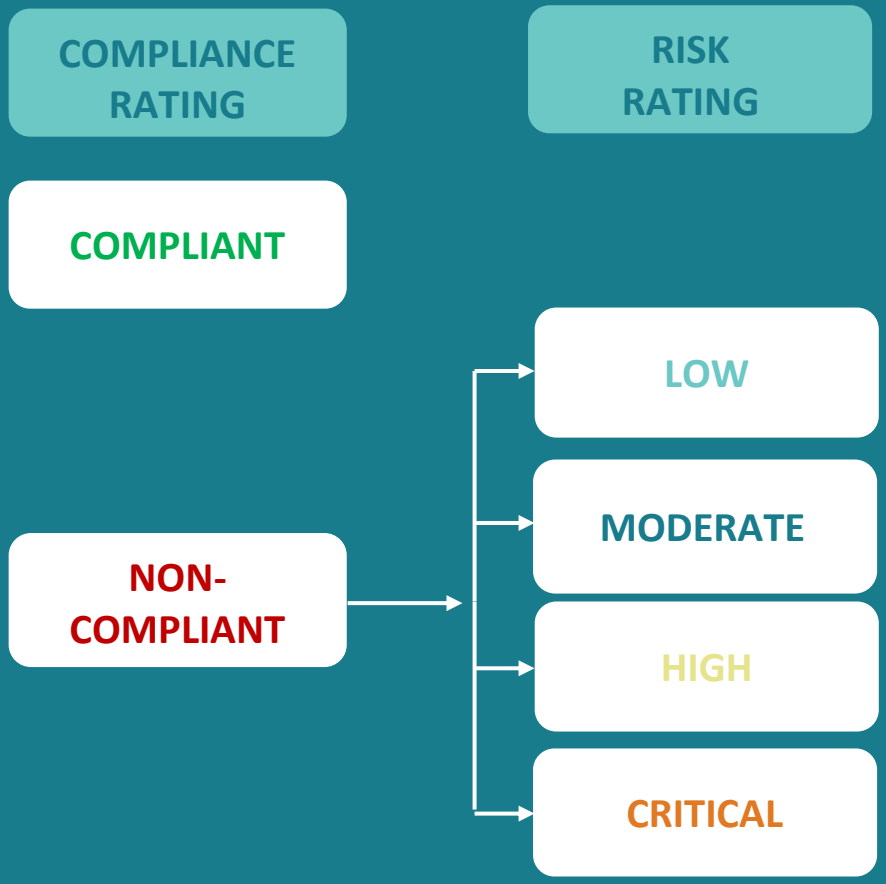
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

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



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

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

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

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