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# Eist Linn Child & Adolescent In-patient Unit

Annual Inspection Report 2024

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

# EIST LINN CHILD & ADOLESCENT IN-PATIENT UNIT

Bessboro, Blackrock, Cork

**Date of Publication:** 25th March 2025

ID Number: AC0181

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

**Approved Centre Type:**
Child and adolescent mental health care

**Conditions Attached:**
None

**Most Recent Registration Date:**
22 December 2022

**Registered Proprietor:**
HSE

**Registered Proprietor Nominee:**
Mr Vincent Goggin, Acting General Manager, Mental Health Services

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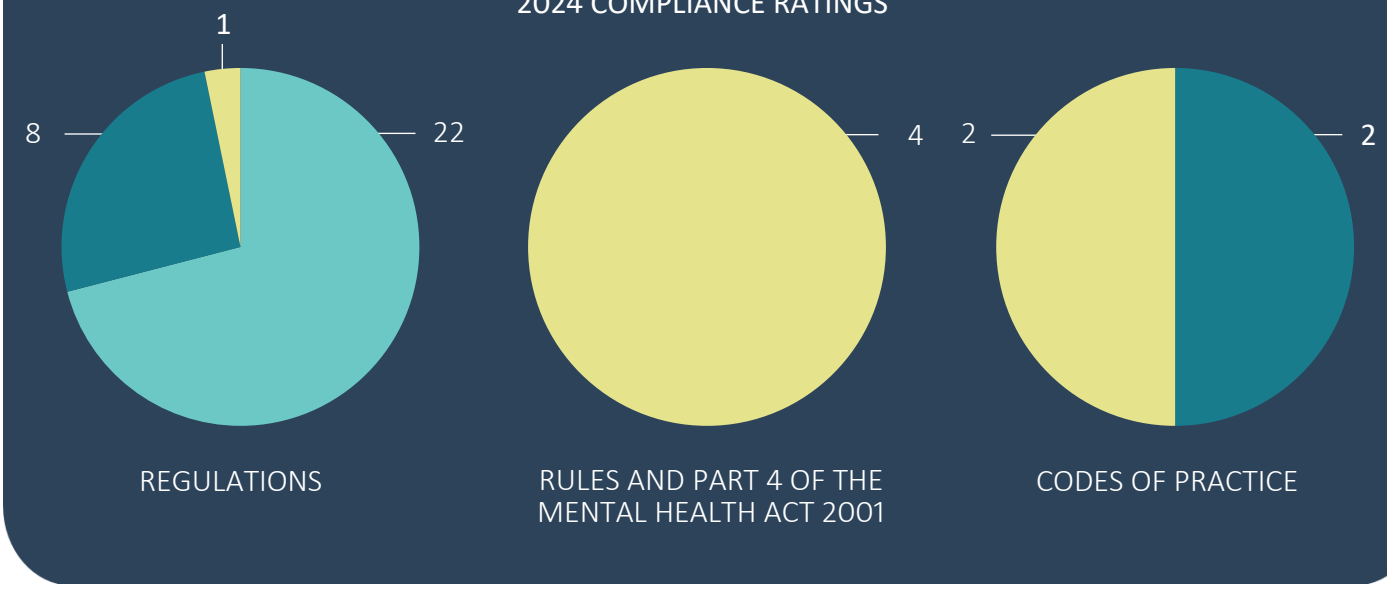
**The Inspector of Mental Health Services:**
Professor James V Lucey MCRN000646

**Inspection Date:**
13 – 16 August 2024

**Previous Inspection date:**
09 – 12 May 2023

**Inspection Type:**
Unannounced Annual Inspection

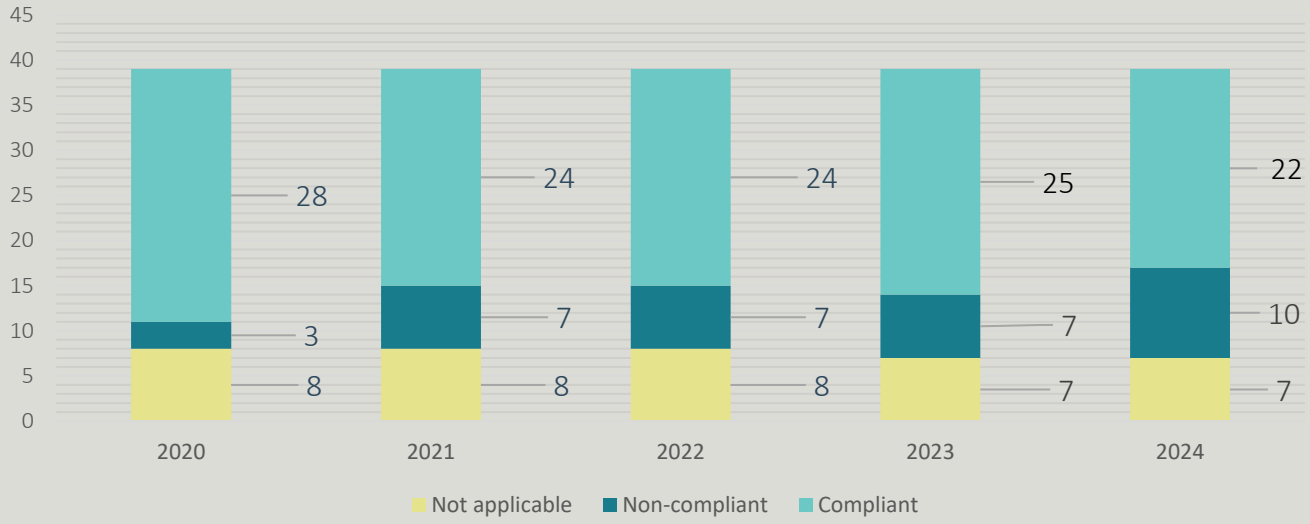
2024 COMPLIANCE RATINGS



## RATINGS SUMMARY 2020 – 2024

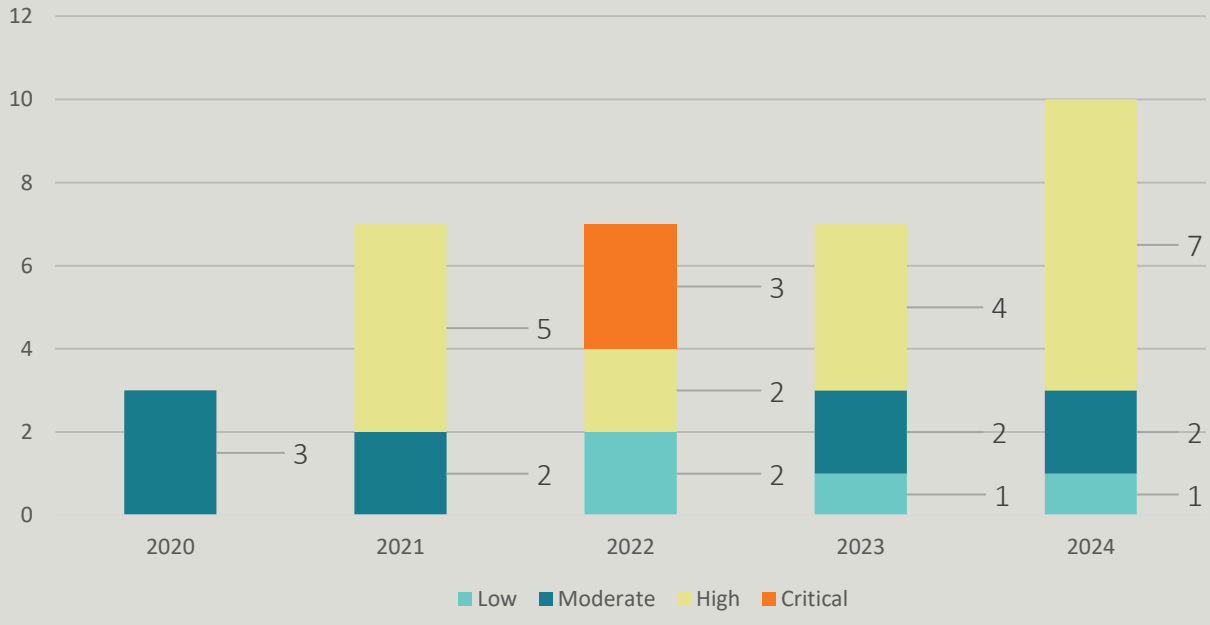
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

### 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

Eist Linn Child and Adolescent Mental Health Inpatient Unit is a two-story building located in the grounds of the Bessborough Centre in Cork. The approved centre consists of a 16-bed inpatient unit and an adjoining school. The inspection of Eist Linn was unannounced and occurred over a four-day period from 13 August 2024 to 16 August 2024. This report reflects the findings at the time of the inspection.

Overall compliance rates in the approved centre had declined since the last inspection. In 2023 the approved centre was non-compliant in seven regulatory areas. In 2024, this increased to nine areas of non-compliance. Regulation 21 (Privacy), Regulation 22 (Premises), and the Code of Practice on Admission, Transfer and Discharge remained non-compliant in 2024 at a high-risk rating. Regulation 26 (Staffing) remained non-compliant and increased from a moderate to a high risk in 2024. Regulation 6 (Food Safety), Regulation 16 (Therapeutic Services and Programmes), Regulation 28 (Register of Residents), Regulation 32 (Risk Management Procedures) and the Code of Practice on the Use of Physical Restraint were also found to be non-compliant on this inspection.

The inspection team were concerned that risk management procedures did not actively reduce all identified risks within the approved centre. There were several staffing deficits identified at the time of inspection and while there were arrangements in place to mitigate some risks associated with the vacant posts, there was a significant impact on service provision resulting in the needs of residents being unmet. The HSE recruitment embargo had impacted staff recruitment within the approved centre.

The approved centre demonstrated commitment to providing a quality service through the development of on-going quality initiatives and the implementation of an annual audit schedule.

### Compliance summary

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| % Compliance | 90% | 77% | 77% | 78% | 69% |

## Conditions of registration

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

## Ongoing escalation and enforcement actions at time of inspection

| Enforcement Action | Date applied | Reasons | Outcome |
|---|---|---|---|
| *Regulatory Compliance Meeting 10000270* | *24 May 2023* | *Following the annual regulatory inspection of 9 – 12 May 2023, the Regulatory Compliance Meeting was held due to concerns regarding the fire safety in the approved centre.* | *Plans were received at the Regulatory Compliance Meeting which the MHC continues to monitor.* |

## Escalation and enforcement actions commenced following this inspection

None.

# 2.0 Quality Initiatives

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

- The social work and psychology departments co-facilitated a family connections group for the parents of service users, to provide education and support to the parents of young people in the approved centre.

- The Eist Linn admission booklet for young people had been revised since the last inspection, based on a survey of service user feedback carried out by the psychology and nursing departments. Additional information was included in the revised booklet including how to contact an independent advocate, information in relation to searches in Eist Linn, and quotes from previous residents. The layout of the booklet was revised to include more images and illustrations for a more engaging layout for the young people admitted to the approved centre.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

Eist Linn Child and Adolescent Mental Health Inpatient Unit is located in the grounds of the Bessborough Centre in the Cork suburb of Blackrock and is part of the national Child and Adolescent Mental Health (CAMHS) Service. The referral pathway is through community CAMHS teams, and the catchment area includes the counties Cork, Kerry, Waterford, South Tipperary, Carlow, Kilkenny and Wexford.

The unit was spread over two floors. The ground floor contained a kitchen, dining room, therapy rooms, staff office space, sitting room, computer room and games room. A large garden area was also available for young people. The unit accommodated young people in single en suite bedrooms. The first floor contained 15 en suite bedrooms, a sitting room, resident property room and laundry facilities. The Suimhneas suite, a low stimulus area, was located on the first floor and consisted of an en suite bedroom, de-escalation room, lounge and dining area, sensory room and access to an enclosed outdoor space. There was a school located on the grounds of the approved centre, along with a gym, home economics room and art room.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | ***16*** |
| **Total number of residents** | **7** |
| Number of detained patients | 1 |
| Number of wards of court | 0 |
| Number of children | 7 |
| Number of residents in the approved centre for more than 6 months | 2 |
| Number of patients on Section 26 leave for more than 2 weeks | 0 |

## 3.2 Governance

The approved centre was under the governance and management of the Cork and Kerry Community Health Care Organisation. Clear leadership and management structures were in place within the approved centre.

The Cork and Kerry Community Health Care Mental Health Services Governance Meeting took place monthly, and Eist Linn was represented at each meeting. This meeting was chaired by the Head of Service and agenda items included service updates, quality and patient safety, finance and service planning, compliance, and risk management. A Cork and Kerry CAMHS Governance Meeting had been established since the last inspection, which focused on strategic planning, risk management, quality improvement, health and safety, service user engagement, training and development, and integration with other networks. Meetings commenced in January 2024 and were held monthly.

Eist Linn Local Management Team meetings took place monthly and were attended by the executive clinical director, area director of nursing, CAMHS practice managers, and representatives from psychiatry, nursing, psychology, speech and language therapy, occupational therapy, social work and teaching. Recurring agenda items included staff training, risk management, compliance, audits and policies, service user feedback, maintenance, health and safety, and school updates.

The Eist Linn Quality and Patient Safety (QPS) meeting took place on a quarterly basis. Meetings were chaired by the executive clinical director and were attended by the QPS manager along with the area director of nursing, consultant psychiatrists, speech and language therapist, occupational therapist, social worker and clinical psychologist. Since the last inspection, a representative from Youth Advocate Programmes Ireland (YAP) has attended QPS meetings. The QPS meeting provided a forum for discussion in relation to complaints management including service user feedback, incident management including incident reviews, trend analysis and learning, risk management, infection prevention and control, health and safety and GDPR.

Several sub-committees were in place and met regularly including incident management and risk register review, Eist Linn regulatory compliance, reducing restrictive practices and audit and policies groups.

Heads of discipline had received training in risk management, incident management and health and safety. A risk register was in place and had been reviewed at least quarterly and there was a clear pathway and protocol for escalation and ownership of risk. Not all structural and clinical risks evident at the time of inspection had been identified and assessed by the approved centre and had been included on the Eist Linn risk register. Incidents were managed in line with an incident management framework using the national incident management system (NIMS).

The treating team in Eist Linn was comprised of psychiatry, nursing, occupational therapy, psychology, social work and speech and language therapy. A vacancy in the dietetics department and several nursing vacancies were identified on the local risk register and had been escalated. Limited dietetics cover was provided by the dietetics manager at the time of inspection, and measures to mitigate the risk relating to the nursing deficit included the use of overtime and agency nursing staff. A senior social work post was vacant at the time of inspection, and limited cover was provided by the principal social worker in Eist Linn. As a result of vacant posts within the approved centre, there was a significant impact on service provision resulting in the needs of residents being unmet. Each head of discipline identified clear strategic goals in relation to the approved centre along with monitoring arrangements relating to each goal. Supervision and performance management processes were in place.

Resident involvement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, regular resident community meetings, suggestion boxes and engagement with the complaints process were used to support service improvement. The approved centre had a complaints policy and an appointed complaints officer. Details of the process to be followed to make a complaint were displayed in the centre and contact information for the nominated complaints officer was provided. A designated advocate from the Youth Advocacy Programme attended on a weekly basis and spoke directly with residents, and advocacy contact details were displayed within the approved centre.

The area lead for mental health engagement post was vacant at the time of inspection.

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

# 4.0 Compliance

## 4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 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 6: Food Safety | ✓ | | ✓ | | ✓ | | ✓ | | ✗ | Low |
| Regulation 16: Therapeutic Services and Programmes | ✓ | | ✓ | | ✓ | | ✓ | | ✗ | High |
| Regulation 19: General Health | ✓ | | ✓ | | ✓ | | ✓ | | ✗ | Moderate |
| Regulation 21: Privacy | ✗ | Moderate | ✗ | High | ✗ | High | ✗ | High | ✗ | High |
| Regulation 22: Premises | ✗ | Moderate | ✓ | | ✗ | Critical | ✗ | High | ✗ | High |
| Regulation 26: Staffing | ✓ | | ✗ | High | ✗ | Low | ✗ | Moderate | ✗ | High |
| Regulation 28: Register of Residents | ✓ | | ✓ | | ✓ | | ✓ | | ✗ | Moderate |
| Regulation 32: Risk Management Procedures | ✓ | | ✗ | High | ✗ | Critical | ✓ | | ✗ | High |
| Code Of Practice Physical Restraint | ✓ | | ✗ | High | ✓ | | ✓ | | ✗ | High |
| Code Of Practice Admission, Transfer and Discharge | ✓ | | ✓ | | ✓ | | ✗ | High | ✗ | High |

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

## 4.2 Areas that were not applicable on this inspection

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

| | |
|---|---|
| | Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As the approved centre was a child and adolescent facility this code of practice was not applicable. |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients | As the approved centre did not provide an ECT service, this code of practice was not applicable. |

# 5.0 Service-user Experience

## 5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. 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 representative was contacted to obtain residents' feedback about the approved centre.

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

The inspectors spoke with two young people and no completed service user experience questionnaires were returned to the inspectors. Comments made by young people were that food was good and there were good activities and therapies, but young people would like more groups and access to a dietitian. There were outings every week, young people were involved in care planning and staff responded to concerns.

## 5.2 Advocacy

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

The inspectors received a report from the YAP representative. The report identified that young people self-referred to the Youth Advocacy Programme to access individual consultations with the youth advocate. These consultations focused on gaining a better understanding of care plans and educational plans, school attendance and access and visits. The YAP representative also attended Eist Linn for group consultations with young people which focused on understanding policies and procedures within the unit, such as outings, staffing and restrictions.

# 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 Nominee
- Executive Clinical Director/Acting Clinical Director
- Area Administrator
- Area Director of Nursing
- Occupational Therapy Manager
- Principal Psychologist
- Principal Social Worker
- Consultant Psychiatrist
- Clinical Nurse Manager 2
- Clinical Nurse Manager 3
- Clinical Nurse Specialist
- Project and Compliance Officer

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

# 7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

## Regulation 4: Identification of Residents

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers, including name, date of birth and medical record number which was appropriate to the resident group profile and individual residents' needs. 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

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

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

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

## Regulation 6: Food Safety

**NON-COMPLIANT**

**Risk Rating** LOW

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

### INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs. Hygiene was maintained to support food safety requirements.

The occupational therapy (OT) kitchen fridge temperatures were not recorded in line with food safety recommendations, and a log sheet was not maintained and monitored with clearly identified actions if the temperature breached cold chain parameters. Therefore, there were not proper facilities for the refrigeration of food.

**The approved centre was non-compliant with this regulation because proper facilities for the refrigeration of food were not provided in the occupational therapy kitchen, 6(1)(b).**

## 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 July 2022.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities, including a safe, 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 separate 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. Self-directed activities included books, music, TV, movies, computer use, pool, jigsaws, board games and bikes. There was also a basketball court in the school building which included a table-tennis set and a boxing bag. A separate exercise room included a treadmill, exercise bike and cross trainer. The approved centre also had bikes available for residents' use. Group activities included the following: morning 'meet and greet' with staff, breakfast club, cooking, yoga, walks with nursing staff and outings with staff.

**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.

**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 February 2023. Visiting times were flexible, appropriate, 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 September 2022.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. After being risk assessed, residents had access to a ward phone to make and take phone-calls.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others based on risk assessment.

Where restrictions had been applied to a resident's means of communication, this was supported by an individual risk assessment.

**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 February 2022, 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.

The clinical files of three residents who were searched were inspected. 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 March 2022. As no resident had died in the approved centre since the last inspection, the regulation was inspected against policy requirements only.

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

## Regulation 15: Individual Care Plan

**COMPLIANT**

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

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

### INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and addressed the resident's goals, mental health care and treatment needs based on a multi-disciplinary team assessment of the person and where practicable, in consultation with them. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes.

The 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. All ICPs inspected identified appropriate goals for the resident, the care and treatment required to meet goals, and the resources required to provide the identified care and treatment. The ICPs inspected were reviewed by the multi-disciplinary team (MDT) in consultation with the resident weekly, and were updated to reflect the resident's changing goals, treatment, care, best practices and resources. Following this review, the individual care plan was updated contemporaneously to reflect any changes to the goals, treatment, care, best practice and the required resources.

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

## Regulation 16: Therapeutic Services and Programmes

**NON-COMPLIANT**

**Risk Rating** HIGH

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

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

### INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of the residents, as detailed in their individual care plans (ICPs). While there was a summer timetable of therapeutic groups, at the time of the inspection there was no therapeutic group scheduled for the Tuesday, Wednesday and Thursday of the inspection. Therapeutic groups timetabled for the Monday did not occur as staff were on leave and there was no cover available.

The approved centre's therapeutic services and programmes were not directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. There were vacant posts in the dietetics and social work departments and while some cover was provided by the dietetics manager and the principal social worker, this was insufficient to meet resident needs, particularly in relation to family support. The dietetics manager was not based in the approved centre and provided consultation to the clinical nurse specialist (CNS) by phone for residents receiving treatment for eating disorders. There was no dietetics provision for other residents of the approved centre, and new admissions for young people presenting with eating disorders could not be facilitated at the time of inspection due to the vacant dietetics' posts. Psychology and occupational therapy services were provided to residents of the approved centre based on identified need.

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

a) **Residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their individual care plan, 16(1).**
b) **The programmes and services provided were not directed to restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).**

## Regulation 17: Children's Education

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

## Regulation 18: Transfer of Residents

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in July 2022. As no resident transfers had taken place since the last inspection the approved centre was assessed on the basis of policy alone.

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

## Regulation 19: General Health

**NON-COMPLIANT**

**Risk Rating** MODERATE

(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 October 2022. 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. General health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

There were two residents in the approved centre for over six months at the time of the inspection and their clinical files were inspected. The six-monthly health assessments documented a physical examination, family and personal history, weight, blood pressure, smoking status, dental health, nutritional status, a medication review and weight.

For residents on anti-psychotic medication, the six-monthly form documented that there had been an annual assessment of their glucose regulation, blood lipids, prolactin levels and an electrocardiogram (ECG).

Adequate arrangements were not in place for residents to access general health services and for referral to other health services as required. There was no dietician on the clinical team in Eist Linn and limited cover was provided by the dietetics manager at the time of inspection. The dietetics manager was not based in the approved centre and provided consultation to the clinical nurse specialist (CNS) by phone for residents receiving treatment for eating disorders. There was no dietetics provision for other residents of the approved centre. Speech and language therapy, and physiotherapy were available to residents via community referral.

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that adequate arrangements were in place for access by residents to general health services and for their referral to other health services as required, as not all residents had access to a dietician, 19(1)(a).**

## 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 February 2023.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support 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

**NON-COMPLIANT**

**Risk Rating** HIGH

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

### INSPECTION FINDINGS

Staff displayed professional, engaging and compassionate attributes in their interactions with residents. Residents were called by their preferred name based on their self-identification. Staff appearance and dress was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls. All residents wore clothes that respected their privacy and dignity.

Where en suite bathroom doors had been replaced with anti-ligature swing doors, this did not provide privacy for residents using those en suite bathrooms as single bedrooms did not have locks on the inside of the doors.

**The approved centre was non-compliant with this regulation because all single bedrooms did not have a lock on the inside of the bedroom door, which did not ensure that the dignity of the resident was appropriately respected at all times.**

## Regulation 22: Premises

**NON-COMPLIANT**

**Risk Rating** HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and bedrooms. Rooms were ventilated. 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. Hazards were minimised in the approved centre. However, ligature points were not minimised to the lowest practicable level, based on risk assessment.

While the approved centre was kept in a good state of repair externally, the internal physical environment required improvement. Handbasins in two bedrooms did not have hot water and in two en suite bedrooms the showers did not work. Not all areas of the approved centre were clean as two resident bathrooms were observed to require cleaning at the time of inspection. The approved centre provided enough toilets and showers for residents, with at least one assisted toilet per floor. The centre provided assistive devices and equipment to address resident needs. Furnishings in the approved centre were inadequate as window curtains or blinds were missing from the Suaimhneas suite bedroom.

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

a) **The condition of the physical structure and the overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff and visitors, as not all ligature points were minimised to the lowest practicable level based on risk assessment, 22(3).**
b) **Not all areas of the premises were clean, as two resident bathrooms were dirty and required cleaning, 22(1)(a).**
c) **The approved centre did not have adequate furnishings as window curtains or blinds were missing in the Suaimhneas suite bedroom, 22(2).**
d) **The approved centre was not kept in a good state of repair internally, as two bedrooms had no hot water coming to the hand basins and two bedroom showers did not work, 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 2023 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 January 2022.

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

## Regulation 25: Use of Closed Circuit Television

**COMPLIANT**

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

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in March 2023.

There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. The approved centre's use of CCTV and any other monitoring system was disclosed to residents, residents' representatives, and the Mental Health Commission. Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed solely by the health professional with responsibility for the resident. CCTV was not used to monitor a resident in the event of their dignity being compromised, and all monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc or hard drive.

The registered proprietor ensured that the existence and usage of closed circuit television or other monitoring device was disclosed to the resident and their representative.

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

## Regulation 26: Staffing

**NON-COMPLIANT**

**Risk Rating** HIGH

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy in place in relation to staffing which included procedures for the recruitment, selection and vetting requirements for staff in the approved centre. The policy was last reviewed in September 2022.

The numbers of staff and the skill mix of staff were not appropriate to the assessed needs of residents. At the time of inspection, there were several vacant posts within the approved centre. In the nursing department there was one vacant assistant director of nursing (ADON) post and nine nursing vacancies. While agency nursing staff and overtime work covered some nursing needs of residents, there were not enough nursing staff to cover day shifts on a number of occasions on the staff rotas. A dietetics post was vacant at the time of inspection. The dietitian manager based outside of the approved centre provided limited cover for current residents of Eist Linn who were receiving treatment for eating disorders, but this was not sufficient to meet resident's needs. Admissions to Eist Linn requiring specialist dietary input for eating disorders could not be facilitated due to the deficit in dietetics service provision at the time of inspection. A social worker post was also vacant at the time of the inspection. While the principal social worker based in Eist Linn provided limited cover, unmet needs of residents were identified in relation to individual work, family work and group work.

All healthcare staff were trained in the Mental Health Act 2001, Children First and safeguarding. A small number of staff were due to complete fire safety, basic life support and management of aggression and violence on the next available training dates.

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

**Staff Training Record**

| Profession | Basic Life Support | | Fire Safety | | Management of Violence and Aggression | | Mental Health Act 2001 | | Children First (mandated persons) | | Safeguarding | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Nursing (25)** | 25 | 100% | 25 | 100% | 25 | 100% | 25 | 100% | 25 | 100% | 25 | 100% |
| **Medical (5)** | 5 | 100% | 4 | 80% | 4 | 80% | 5 | 100% | 5 | 100% | 5 | 100% |
| **Occupational Therapist (1)** | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| **Social Worker (1)** | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| **Psychologist (3)** | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| **SLT (2)** | 1 | 50% | 1 | 50% | 1 | 50% | 2 | 100% | 2 | 100% | 2 | 100% |
| **Mult Task Attendants (3)** | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| | # | % | # | % | # | % | # | % | # | % | # | % |

**The approved centre was non-compliant with this regulation because the numbers of staff and the skill mix of staff, in relation to nursing, dietetics and social work were not appropriate to the assessed needs of residents, 26(2).**

## 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 2023. 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

**NON-COMPLIANT**

**Risk Rating** MODERATE

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

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

### INSPECTION FINDINGS

The approved centre had a documented register of residents. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not contain the diagnosis on admission for two residents.

**The approved centre was non-compliant with this regulation because the register did not contain the diagnosis on admission for two residents, 28(1).**

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

## Regulation 31: Complaints Procedures

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in February 2023 and included the process for managing complaints, 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 based in the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. 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 and major complaints were documented.

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

## Regulation 32: Risk Management Procedures

**NON-COMPLIANT**

**Risk Rating** HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in November 2023, and included the following:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff.

The risk management procedures did not actively reduce identified risks to the lowest practicable level as not all ligature risks were identified and assessed by the approved centre. Structural risks posed by ligature points were not removed or effectively mitigated in all instances.

Not all clinical risks were assessed, monitored and documented in the risk register as appropriate., as the risk relating to unmet needs of residents due to the vacant social work post within Eist Linn was not documented on the risk register. While individual risk assessments were completed at admission to identify individual risk factors for each resident, such as general health risks, risk of absconding and risk of

self-harm, there was no documented risk assessment on admission to determine if physical restraint could be safely used or not, as required by the Mental Health Commission's Code of Practice on the Use of Physical Restraint.

Health and safety and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate.

Individual risk assessments were completed in conjunction with medication requirements or administration, and prior to and during each episode of physical restraint, resident transfer and resident discharge. Multi-disciplinary teams were involved in the development, implementation and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

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

a. **The registered proprietor did not ensure the identification and assessment of risks throughout the approved centre, as not all ligature risks were identified and assessed; there was no risk assessment completed for young people on admission to determine if physical restraint could be safely used or not; and the risk related to unmet needs of residents due to a vacant social work post within Eist Linn was not assessed and documented on the risk register, 32(2)(a).**
b. **Precautions were not in place to control the risks identified, as risks posed by ligature points were not removed or effectively mitigated in all instances, 32(2)(b).**

## 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)

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

# 9.0 Inspection Findings – Mental Health Act 2001

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

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

# 10.0 Inspection Findings – Codes of Practice

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

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

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

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

## Use of Physical Restraint

**NON-COMPLIANT**

**Risk Rating** HIGH

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated March 2024. It addressed:

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

Policies and procedures regarding staff training included:

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

The approved centre had a restrictive practice reduction policy which included all stipulated components.

**Training and Education:** There was a written record to indicate that all staff involved in the use of physical restraint had read and understood the policy. All staff members involved in the use of physical restraint had undertaken appropriate training in accordance with the policy. A record of attendance at training was maintained.

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

- Determined if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed.

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

**Evidence of Implementation:** The clinical files of three child residents who were physically restrained were inspected.

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

The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the CP within 24 hours. The residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint except where the information was prejudicial to the residents' mental health, well-being or emotional condition.

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

A staff member of the same gender as the individual being restrained was present at all times during the episodes of physical restraint. In each episode of physical restraint, the person was continuously assessed throughout the use of restraint to ensure the person's safety, and this was documented. In each episode of physical restraint, the person's head and neck were supported where necessary. In each episode of physical restraint, the person's airway and breathing were not compromised. Observations were conducted, including vital clinical indicators such as the monitoring of pulse, respiration and complexion, with special attention to pallor or discolouration. These observations were documented. The physical restraint in each instance was ended by the person who had led it.

The reason for ending the physical restraint was recorded in the clinical files of each resident.

**In-person debrief:** An in-person debrief with the person who was restrained followed the episode of physical restraint in two episodes of physical restraint. In the third episode, the resident declined the debrief.

The in-person debrief included a discussion regarding the person's preferences in the event that a restrictive intervention would be needed in the future. The debrief gave the person the option of having their representative or nominated support person attend the debrief with them.

In two episodes of physical restraint where the de-brief took place, the person's individual care plan was not updated to reflect the outcome of the debrief, which meant the person's preferences in relation to restrictive interventions going forward was not documented.

Appropriate emotional support was provided to the individuals following the episode of physical restraint. Support was offered to other people who may have witnessed the restraint of the person.

**Risk assessment:** In the three episodes of physical restraint of child residents, there was no evidence of a documented risk assessment undertaken pertaining to physical restraint upon admission by the RPM or RN. As the risk assessment was not undertaken this meant there was no determination whether physical restraint could be used safely or not.

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

a) **In two episodes of physical restraint where the de-brief took place, the person's individual care plan was not updated to reflect the outcome of the debrief, which meant the person's preferences in relation to restrictive interventions going forward was not documented, 5.5.**
b) **In the three episodes of physical restraint of child residents, there was no evidence of a documented risk assessment being undertaken pertaining to physical restraint on admission by the registered medical practitioner or registered nurse. As the risk assessment was not undertaken this meant there was no determination whether physical restraint could be used safely or not, 9.1.**

## Admission, Transfer and Discharge

**NON-COMPLIANT**

**Risk Rating** HIGH

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a series of separate written policies in relation to admission, transfer and discharge. The transfer policy was last reviewed in July 2022, and the admission and discharge policies were last reviewed in February 2023.

**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 transfer, admission 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 keyworker. A discharge meeting was held and attended by the resident and their key worker, and relevant members of the multi-disciplinary team (MDT). A pre-discharge assessment was completed which addressed the resident's psychiatric and psychological needs, a comprehensive risk assessment and risk management plan, and social and housing needs of the resident. The discharge assessment did not include a current mental state examination and details of the informational needs of the resident.

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; medication; 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 discharge summary did not include details of the following: prognosis; mental state at discharge; or outstanding health or social issues.

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

a) **The discharge assessment did not include current mental state examination, 35.1.**
b) **The discharge assessment did not include informational needs, 35.1.**
c) **A comprehensive discharge summary was not issued within 14 days, 38.3(b).**
d) **The discharge summary did not include prognosis, mental state at discharge or outstanding health or social issues, 38.4.**

## Appendix 1: Corrective and Preventative Action Plan

| Regulation 06 Food Safety | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10006043** | | **Proper facilities for the storage of food were not provided in the occupational therapy kitchen, 6(1)(b).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | A digital refrigerator thermometer was purchased and installed. | A daily temperature log is maintained. | Achieved. | 01/09/2024 | CNM3 |
| **Preventative Action** | Monthly Maintenance Walkthroughs take place every month. Identified issues are logged on the Maintenance tracker and are tracked until completion. | A daily temperature log is maintained. | Achievable. | 31/12/2025 | CNM3 |

| Regulation 16: Therapeutic Services and Programmes | | | | | |
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| **Reason ID : 10006044** | | **Residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their individual care plan, 16(1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | 1. A Therapeutic Services Committee is being stood up. The inaugural meeting of this committee will take place on 05.03.2025 and the Terms of Reference will be finalised at this meeting. 2. The Committee will include the co-ordination of group programmes, and identify and advocate for any gaps in therapeutic services. 3. The weekly therapeutic programme is reviewed each Monday at the MDT team meeting. | Eist Linn Therapeutic Services Committee operational. | Achievable. | 07/03/2025 | Representatives from the MDT Team. |
| **Preventative Action** | Monthly review of therapies calendar will be overseen by the Therapeutic Services Committee and audited as part of the ICP audit. | Monitored as part of the audit program and the ICP Lead presents audit results to the Eist Linn Audit Committee on a quarterly basis. | Achievable | 31/12/2025 | Representatives from the MDT Team. |
| **Reason ID : 10006045** | | **The programmes and services provided were not directed to restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).** | | | |

| | Specific | Measurable | Achievable/Realistic | Time-bound | Post-Holder(s) |
|---|---|---|---|---|---|
| **Corrective Action** | 1. A Therapeutic Services Committee is being stood up. The inaugural meeting of this committee will take place on 05.03.2025 and the Terms of Reference will be finalised at this meeting. 2. The Committee will include the co-ordination of group programmes, and identify and advocate for any gaps in therapeutic services. 3. The weekly therapeutic programme is reviewed each Monday at the MDT team meeting. | Eist Linn Therapeutic Services Committee operational. | Achievable | 07/03/2025 | Representatives from the MDT Team. |
| **Preventative Action** | The provision of cross-cover when a member of the MDT team is on leave is tabled for discussion at the next CAMHS Governance group meeting on 11.03.2025. The aim of this discussion is to get agreement with the HOD's for a cross cover implementation | Eist Linn Therapeutic Services Committee operational. | Achievable | 11/04/2025 | Representatives from the MDT Team. |

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| | plan for Eist Linn with immediate effect. | | | | |

| Regulation 19 General Health | | | | | |
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| **Reason ID : 10006046** | | **The registered proprietor did not ensure that adequate arrangements were in place for access by residents to general health services and for their referral to other health services as required, as not all residents had access to a dietician, 19(1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | A clinical specialist dietician post for CAMHS has been approved in the post prioritisation process and is progressing through recruitment channels. The Eist Linn dietician currently on leave is scheduled to return in May 2025. | Clinical specialist dietician in post. | Achievable. | 31/07/2025 | Head of Service and Head of HR. |
| **Preventative Action** | A clinical specialist dietician post for CAMHS has been approved in the post prioritisation process and is progressing through recruitment channels. The Eist Linn dietician currently on leave is scheduled to return in May 2025. In the interim a referral pathway for private dietetics is in place. | Clinical specialist dietician in post. | Achievable. | 31/07/2025 | Head of Service and Head of HR. |

| Regulation 21: Privacy | | | | | |
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| **Reason ID : 10006047** | | **All single bedrooms did not have a lock on the inside of the bedroom door, which did not ensure that the dignity of the resident was appropriately respected at all times.** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | 16 anti-ligature thumb turn down door locks for the bedroom doors were procured and installed. | Anti-ligature locks in place. | Achieved. | 10/01/2025 | General Manager, Area Administrator and HSE Estates. |
| **Preventative Action** | Monthly Maintenance Walkthroughs take place every month. Identified issues are logged on the Maintenance tracker and are tracked until completion. | All doors and associated locks to be fully functioning. | Achievable | 31/12/2025 | General Manager, Area Administrator and representatives from the MDT Team and HSE Estates. |

| Regulation 22: Premises | | | | | |
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| **Reason ID : 10006048** | | **The condition of the physical structure and the overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff and visitors, as not all ligature points were minimised to the lowest practicable level based on risk assessment, 22(3).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Updated Ligature audit complete and risk mitigation reviewed. This Ligature Audit is reviewed on a monthly basis at the Eist Linn Management Meeting. The 2025 Ligature audit for Eist Linn is scheduled for completion by the end of Q1 in line with the HSE National Guideline on the Implementation and use of the National Ligature risk reduction audit tool for Approved Centres | Ligature audit action plan reviewed monthly. | Achievable | 31/12/2025 | General Manager, Area Administrator and representatives from the MDT Team and HSE Estates. CD and HOD's. |
| **Preventative Action** | Monthly Maintenance Walkthroughs take place every month. Identified issues are logged on the Maintenance tracker and are tracked until completion | Ligature risks are minimised as low as possible. | Achievable | 31/12/2025 | General Manager, Area Administrator and representatives from the MDT Team and HSE Estates. CD and HOD's. |
| **Reason ID : 10006049** | | **Not all areas of the premises were clean, as two resident bathrooms were dirty and required cleaning, 22(1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |

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| **Corrective Action** | Cleaning schedule for the contractor cleaners was reviewed and amended to ensure that more cleaners are on the unit simultaneously. | Clean and tidy Centre. | Achievable | 31/12/2025 | Area Administrator and external cleaning contractor. |
| **Preventative Action** | During the monthly maintenance walkthroughs of the Unit, standard of cleanliness is assessed and any issues identified escalated to the Cleaning Supervisor. Monthly cleaning audits are completed by staff in Eist Linn and a plan put in place to address any identified issues. In addition, supervisors from the contract cleaning company completes quarterly cleaning audits which are shared and followed up on by Nursing Staff. | Clean and tidy Centre. | Achievable | 31/12/2025 | General Manager, Area Administrator and representatives from the MDT Team and HSE Estates. |
| **Reason ID : 10006050** | | **The approved centre did not have adequate furnishings as window curtains or blinds were missing in the Suaimhneas suite bedroom, 22(2).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | An external provider has been identified to make alterations to existing curtains and rehang and provide an | Effective blinds and curtains. | Achievable | 31/12/2025 | General Manager, Area Administrator and external curtain provider. |

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| | anti-ligature blind for the Suaimhneas suite bedroom. This company were on site w/c 03/02/2025 to measure up and is due to submit quotation w/c 24th February, 2025. | | | | |
| **Preventative Action** | An external provider has been identified to make alterations to existing curtains and rehang and provide an anti-ligature blind for the Suaimhneas suite bedroom. This company were on site w/c 03/02/2025 to measure up and is due to submit quotation w/c 24th February, 2025. | Effective blinds and curtains. | Achievable | 31/12/2025 | General Manager, Area Administrator and external curtain provider. |
| **Reason ID : 10006051** | | **The approved centre was not kept in a good state of repair internally, as two bedrooms had no hot water coming to the hand basins and two bedroom showers did not work, 22(3).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The hot water issue and the two-bedroom showers that did not work were addressed during the week of the inspection. | Functioning taps with hot water and fully functioning showers. | Achievable | 15/08/2024 | CNM3 and HSE Maintenance. |
| **Preventative Action** | During the monthly maintenance walkthroughs of the Unit, bathrooms are assessed and any | Functioning bathrooms with adequate provision of hot water. | Achievable | 31/12/2025 | General Manager, Area Administrator and external curtain provider. |

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| | issues identified and logged Maintenance tracker and tracked until completion. | | | | |

| Regulation 26: Staffing | | | | | |
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| **Reason ID : 10006052** | | **The numbers of staff and the skill mix of staff, in relation to nursing, dietetics and social work were not appropriate to the assessed needs of residents, 26(2).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | 1. Nurse staffing levels have increased with an addition of 5 new nursing staff. Conversion of 8 agency nursing staff on-going. 2. The post of Clinical specialist for dietetics has been approved and is with recruitment for the next stage of the process. The Eist Linn dietician that is currently on leave is scheduled to return in May 2025. In the interim, there is a referral pathway for private dietetic assessment. 3. The General Manager and HOS continue to advocate for the CAMHS Social Work post to be prioritized. | Adequate staffing levels. | Achievable | 31/12/2025 | General Manager, Area Director of Nursing, Mental Health Services HR Lead. |
| **Preventative Action** | 1. Nurse staffing levels have increased with an addition of 5 new nursing staff. Conversion of 8 agency nursing staff | Adequate staffing levels. | Achievable | 31/12/2025 | General Manager, Area Director of Nursing, Mental Health Services HR Lead. |

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| | on-going. 2. The post of Clinical specialist for dietetics has been approved and is with recruitment for the next stage of the process. The Eist Linn dietician that is currently on leave is scheduled to return in May 2025. In the interim, there is a referral pathway for private dietetic assessment. 3. The General Manager and HOS continue to advocate for the CAMHS Social Work post to be prioritized. | | | | |

| Regulation 28: Register of Residents | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10006053** | | **The register did not contain the diagnosis on admission for two residents, 28(1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The Register of Residents was updated during the inspection. The admission pack is updated and will be fully implemented by 1st March, 2025. | Updated admission pack. | Achievable | 01/03/2025 | Medical and Nursing Staff. |
| **Preventative Action** | NCHD induction informs new doctors of the process for updating Register of Residents and compliance with same is audited via Regulatory audits. | Audit results and subsequent action plan on any non-compliances. | Achievable | 31/12/2025 | Medical and Nursing Staff. |

| Regulation 32: Risk Management Procedures | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10006056** | | **The registered proprietor did not ensure the identification and assessment of risks throughout the approved centre, as not all ligature risks were identified and assessed; there was no risk assessment completed for young people on admission to determine if physical restraint could be safely used or not; and the risk related to unmet needs of residents due to a vacant social work post within Eist Linn was not assessed and documented on the risk register, 32(2)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | 1. The admission pack has been updated and will be fully implemented by 1st March, 2025. 2. Vacant social work posts were put on the Eist Linn Risk Register on 26/08/2024 and reviewed on a monthly basis. | 1. Admission pack to be updated. 2. Management of vacant social work post via the Eist Linn Risk Register. | 1. Achievable. 2. Achievable. | 31/12/2025 | 1. Medical and Nursing Staff 2. Eist Linn Management Team |
| **Preventative Action** | 1. The admission pack has been updated and will be fully implemented by 1st March, 2025. 2. Vacant social work post not on the Eist Linn Risk Register and reviewed on a monthly basis. 3. The General Manager and HOS continue to make representations to the Regional Executive Officer for the CAMHS Social Work post to be prioritized via the post prioritization process | 1. Admission pack to be updated. 2. Management of vacant social work post via the Eist Linn Risk Register. | 1. Achievable. 2. Achievable. | 31/12/2025 | 1. MDT Team 2. Eist Linn Management Team |

| Reason ID : 10006057 | | Precautions were not in place to control the risks identified, as risks posed by ligature points were not removed or effectively mitigated in all instances, 32(2)(b). | | | |
|---|---|---|---|---|---|
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Eist Linn Risk register updated to include windows in the bedrooms and a ligature action plan in place. | Ligature risks to b effectively mitigated. | Achievable | 31/12/2025 | MDT and Management Team. |
| **Preventative Action** | Monthly Maintenance Walkthroughs take place every month. Identified ligature issues are logged on the Maintenance Tracker and are tracked until completion. The ligature audit tool is reviewed on a monthly basis at the Eist Linn Management Team. | Ligature risks to be effectively mitigated. | Achievable. | 31/12/2025 | General Manager, Area Administrator, representatives from the MDT and HSE Estates. |

| Code of Practice on the Use of Physical Restraint in Approved Centres | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10006054** | | **In two episodes of physical restraint where the de-brief took place, the person's individual care plan was not updated to reflect the outcome of the debrief, which meant the person's preferences in relation to restrictive interventions going forward was not documented, 5.5.** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The Individual Care plan has been updated to reflect the outcome of the debrief documenting the person's preference going forward. | Updated Individual Care Plan. | Achieved. | 30/11/2024 | MDT Team. |
| **Preventative Action** | All ICP's reviewed to ensure accuracy and completeness and audited on a fortnightly basis. | The ICP lead presents the audit results to the Eist Linn audit committee on a quarterly basis. | Achievable | 31/12/2025 | MDT Team. |
| **Reason ID : 10006055** | | **In the three episodes of physical restraint of child residents, there was no evidence of a documented risk assessment being undertaken pertaining to physical restraint on admission by the registered medical practitioner or registered nurse. As the risk assessment was not undertaken this meant there was no determination whether physical restraint could be used safely or not, 9.1.** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Admission process updated to include Risk Assessment and all relevant staff informed of same. | Adherence to the COP on the use of physical restraint in the Approved Centre. | Achievable | 01/10/2025 | CNM2 |
| **Preventative Action** | All patient files reviewed to ensure that risk assessments are completed and on file via the audit process. | Audit results and subsequent action plan on any non-compliances. | Achievable | 31/12/2025 | NCHD's and Nursing. |

| Code of Practice on Admission, Transfer and Discharge to and from an approved centre | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10006038** | | **The discharge assessment did not include current mental state examination, 35.1. The discharge assessment did not include informational needs, 35.1. The discharge summary did not include prognosis, mental state at discharge or outstanding health or social issues, 38.4.** | | | |
| The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly. | | | | | |
| **Reason ID : 10006040** | | **A comprehensive discharge summary was not issued within 14 days, 38.3(b).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | NCHD induction informs new doctors of the process for adherence to the Code of Practice on Admission, Transfer and Discharge to and from an approved centre and compliance with same is audited via Regulatory audits. | Audit results and subsequent action plan on any non-compliances. | Achievable | 31/12/2025 | Medical and Nursing Staff |
| **Preventative Action** | NCHD induction informs new doctors of the process for adherence to the Code of Practice on Admission, Transfer and Discharge to and from an approved centre and compliance with same is audited via Regulatory audits. | Audit results and subsequent action plan on any non-compliances. | Achievable | 31/12/2025 | Medical and Nursing Staff |

## 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.

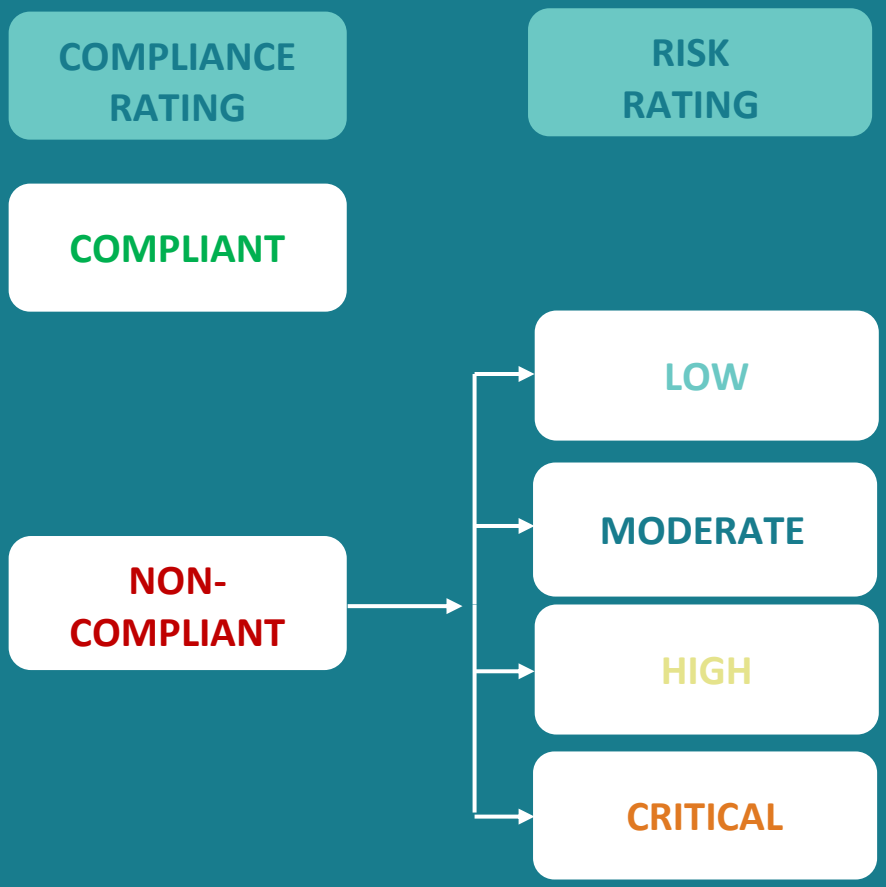
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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