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

Annual Inspection Report 2024

Promoting Quality, Safety and Human Rights in Mental Health

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

Cherry Orchard Hospital Campus, Ballyfermot Road, Dublin 10,

Date of Publication: 25th March 2025

ID Number: AC0182

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:
10 December 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Brady, Head of Mental Health CHO 7

Inspection Team:
Aoife Gallaher, Lead Inspector
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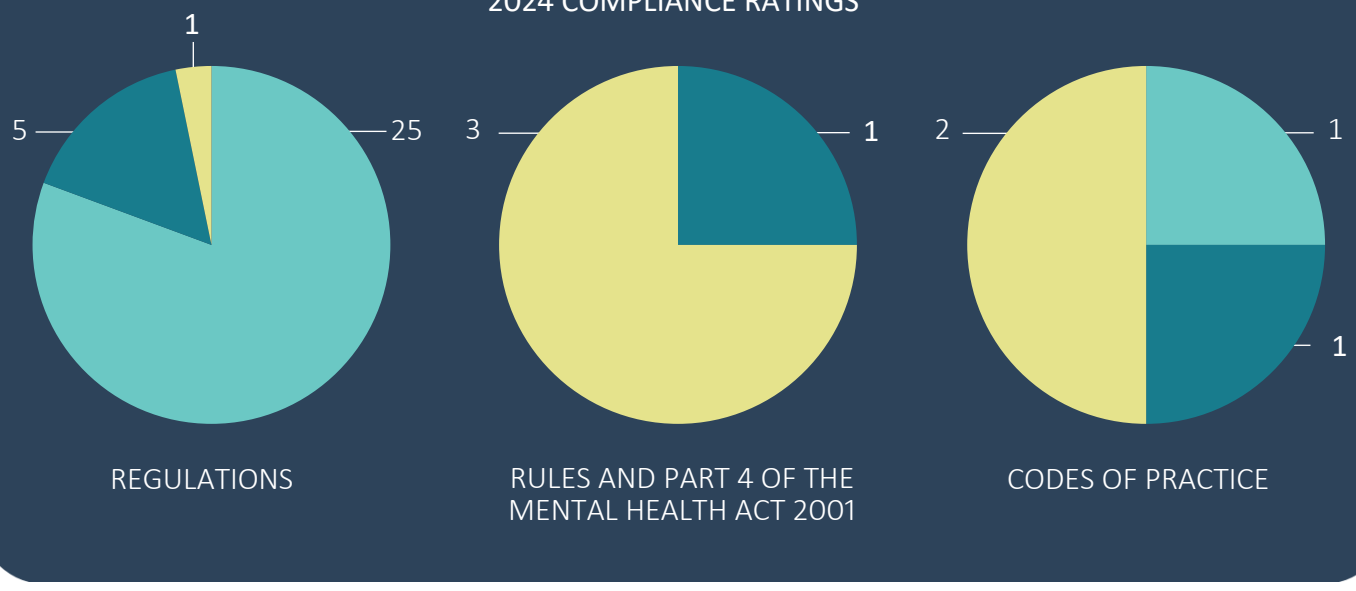
Inspection Date:
27 – 30 August 2024

Previous Inspection date:
29 August – 1 September 2023

Inspection Type:
Unannounced Annual Inspection

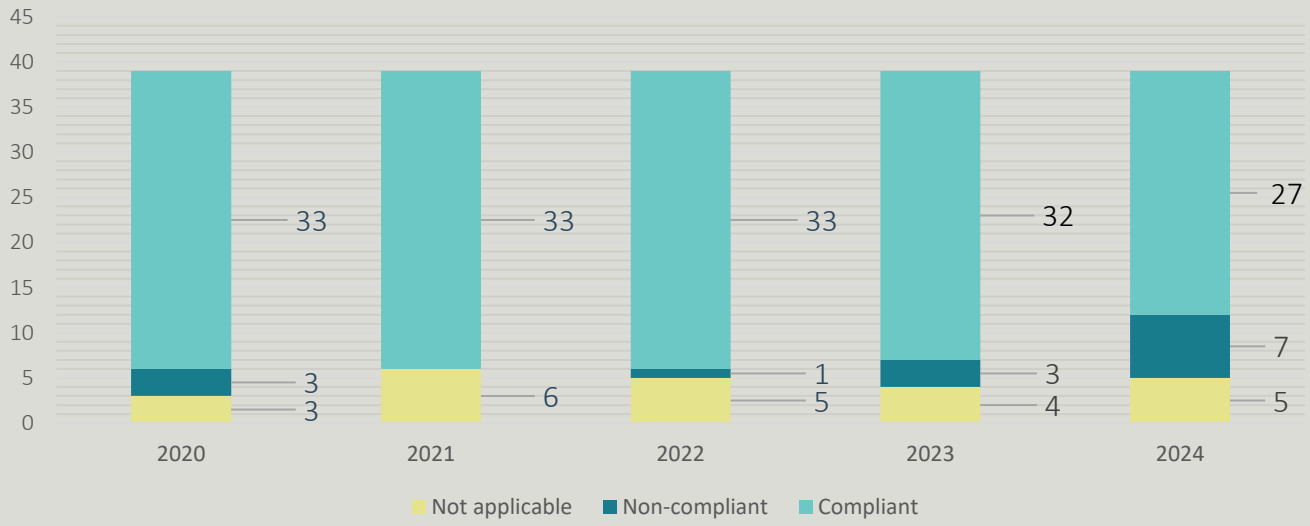
2024 COMPLIANCE RATINGS



RATINGS SUMMARY 2020 – 2024

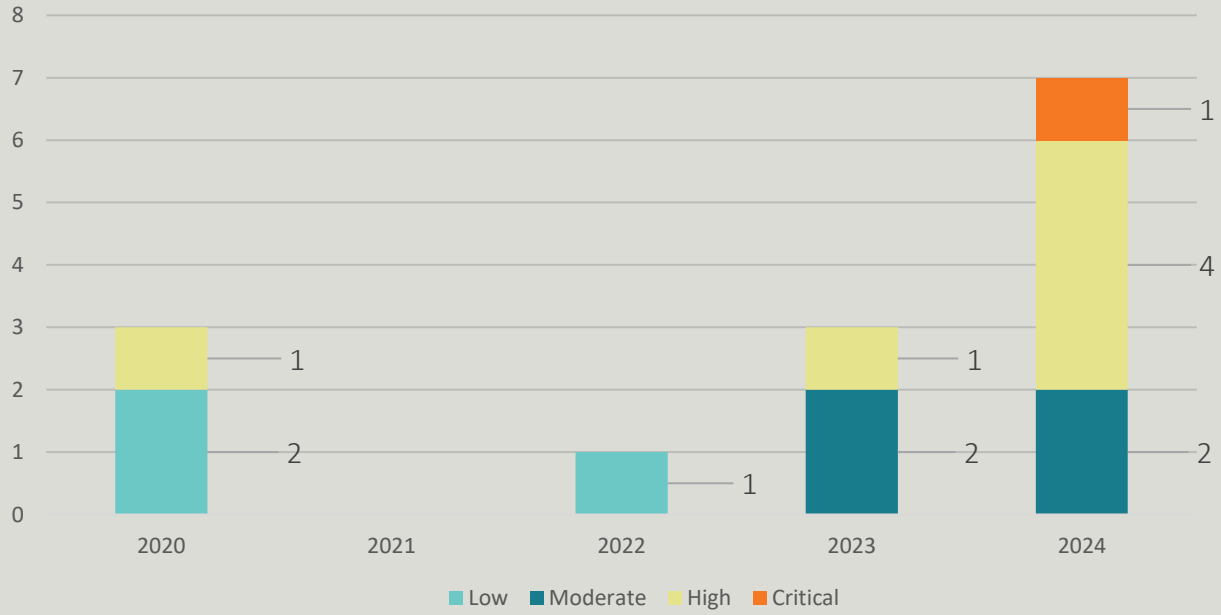
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Linn Dara Child and Adolescent Mental Health Services (CAMHS) is a 24 bedded purpose built unit comprising of three wards, Hazel and Rowan, each with 11 single en suite bedrooms, and Oak, a high dependency ward with two en suite bedrooms, located in the grounds of Cherry Orchard Hospital Campus in Ballyfermot, Dublin. At the time of inspection one ward was not in operation and therefore the bed capacity was reduced to 13. The inspection was unannounced and occurred over four days, from 27th to 30th August 2024. The inspection report reflects findings of the inspection over this period only.

The inspection team were concerned that residents in Oak ward did not have the ability to create privacy for themselves in their bedrooms. There were no curtains around their bed and no curtains or blinds that they could use independently on the observation window from the bedroom into the sitting room area. There was no privacy screening on the bedroom window overlooking the garden. An outdoor shutter, operated by staff created privacy from the garden. Closed circuit television (CCTV) operated in both bedrooms which further impacted concerns in relation to privacy and dignity.

In 2023, the service was non-compliant with three areas during the annual inspection. In 2024, there was an increase in the rate of non-compliance to seven with three reoccurring areas of non-compliance, featuring different reasons for non-compliance: Regulation 25 (CCTV),Code of Practice on the Use of Physical Restraint and Rules Governing the Use of Seclusion. Regulation 21 (Privacy) was rated as a critical non-compliance following this year's inspection.

Many aspects of service provision exceeded the minimum standards set out in mental health legislation. Regular audit schedules and committees demonstrated commitment to good practice and to quality improvement.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	92%	100%	97%	91%	79%

Conditions of registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice	*5 September 2024*	*The approved centre was deemed to be non-compliant with a risk rating of critical with Regulation 21: Privacy.*	*The approved centre did not provide adequate plans to address the critical risk and the MHC continues to engage with the approved centre.*

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Linn Dara provided a Multi-Family Therapy (MFT) programme for the young people and families attending the Eating Disorder Programme.
2. With the support of the Youth Advocacy Programme (YAP) team, the young people developed a young people specific information booklet for those being admitted to the approved centre, the aim of this information booklet was to offer support and reassurance regarding inpatient admission.
3. A Communication Passport was developed by the Speech and Language Therapist and Occupational Therapist for young people to complete on admission. This passport aimed to get to know the young person, and gave them an opportunity to inform staff how they communicate their distress, what helps when they're feeling distressed and what helps after they feel distressed. The objective was to help staff notice indicators, enabling early activation of a de-escalation response, resulting in the reduction in the use of restrictive interventions
4. The school team, along with the school's students, led a fundraising initiative "Race Across Ireland" This involved staff and students from the approved centre racing virtually across Ireland from The Forty Foot, Co. Dublin to Salthill in Co. Galway using the new NordicTrack equipment that the school purchased. This allowed participants to run or cycle anywhere in the world via the digital display screen. The fundraiser was also aimed at promoting and enhancing the students social and community awareness whilst admitted to the approved centre and raised funds for UNICEF Ireland.
5. The final phase of the school garden was completed in September with the installation of a peace pole with the inscription in English 'May Peace Prevail in our Homes and Communities', but also alongside Gaeilge and Ukrainian. The garden now had a fully landscaped planted area, with screening to provide privacy from the entrance to the hospital campus. The garden also had a raised bed and polytunnel to grow fruit and vegetables.
6. Speakers and an electronic tablet were provided, at the young people's request to develop their own playlists for the dining room to help support them during meal times.

In addition to the quality initiatives listed above, the inspection team also reviewed quality aspects in relation to the following specific regulation:

Regulation 26: Staffing:

- Two members of the nursing team undertook the Nurse Prescribing course with an additional nurse undertaking the course in 2024.
- In response to service demand two members of the nursing team commenced a Specialist Diploma in Eating Disorders.
- Education regulation and skills sessions for staff working with Trauma were facilitated and updated.
- Two Linn Dara School teachers completed their Graduate Diploma in Inclusive and Special Education at Dublin City University (DCU)

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Linn Dara Child and Adolescent Mental Health Services (CAMHS) was located on the Cherry Orchard Hospital Campus in Ballyfermot, Dublin. The approved centre was registered for 24 beds. This comprised of three wards, Hazel and Rowan, each with 11 single en suite bedrooms, and Oak, a high dependency ward with two en suite bedrooms. Hazel ward was closed due to a shortage of staff and therefore, the operational bed capacity at the time of inspection was 13. Admissions were accepted predominantly from Dublin, mid Leinster and Dublin North East. Admissions were also accepted from other areas depending on need.

The approved centre was bright and spacious. Rowan ward provided numerous seating areas; a family therapy room, kitchen and dining area overlooking a garden, team meeting rooms, visiting rooms, an arts and crafts room, a relaxation room, a quiet room, a games room, two television rooms, and a computer area. There was also a seclusion suite. There were two en suite bedrooms in Oak ward. Each had an adjoining sitting room area, and access to a garden and both were monitored by closed circuit television (CCTV). There was access to a seclusion suite. The approved centre also had a six-classroom school with access to a garden, an outdoor basketball court, a sports hall and gym, an occupational therapy suite, and a family accommodation suite.

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

Resident Profile	
Number of registered beds	***24***
Total number of residents	**12**
Number of detained patients	6
Number of wards of court	0
Number of children	12
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Community Healthcare Organisation Dublin South, Kildare and West Wicklow (CHODSKWW). The Executive Management Team (EMT) meeting convened monthly and provided oversight of corporate and clinical functions of CHODSKWW. This meeting was chaired by the registered proprietor nominee and was attended by heads of discipline, business manager and accounts manager.

agendas items including financial planning, compliance/regulation, human resources and operational processes. Approved centre risk registers were also part of the agenda.

The Linn Dara Governance group was an overarching group which reported to the management team and subsequently to the EMT. The Governance group, chaired by the clinical director met every two months. Agenda items included, quality improvement initiatives, monitoring of approved centre activity, staff training and development, and compliance with the Mental Health Act, including Corrective and Preventative Actions plans.

The management team held operational meetings monthly. Minutes documented agenda items including finance, quality, safety and service improvement (QSSI), risk register review, recruitment, facilities, estates, service activities and service planning, and the National Children's Hospital update. At local level, a number of committees convened including; the Quality, Safety and Service Improvement committee (QSSI), Policy review committee and Restrictive Practice Reduction committee.

QSSI committee membership had expanded to include Community CAMHS team senior managers, in addition to the senior management team within the approved centre. This committee met monthly and agenda items included; incident management, risk management, health & safety update, safeguarding, sexual safety & Children's First, complaints & compliments, quality initiatives, Mental Health Commission inspections & reports, audit review, infection prevention and control, staff Training, review of the risk register. Ward business meetings were also held monthly and reviewed ward activity, feedback from community meetings, feedback from advocacy service and updates in relation to regulatory practice, staff training and Linn Dara school.

The person with responsibility for risk was identified and known by all staff. The approved centre had access to the Quality Patient Safety advisor. The approved centre had a local risk register; however, not all health and safety risks were documented in the risk register as appropriate. This related to the risk associated with not conducting regular fire drills and evacuations. This risk was not identified, assessed, treated, reported or monitored and responsibilities regarding risk were not allocated at management level. Some ligature points were not identified as a ligature risk and therefore had not been removed or effectively mitigated. A six-monthly summary report of all incidents was provided to the Mental Health Commission.

An organisational chart identified the leadership and management structures as well as the lines of authority and accountability within the approved centre. All heads of discipline had defined strategic aims in relation to the approved centre. All heads of discipline met with staff regularly or utilised a line management structure for reporting and engaging with staff. All staff had completed mandatory training in: basic life support, the management of violence and aggression, fire safety, the protection and welfare of children, safeguarding and mental health legislation. Mandatory training in basic life support, the management of violence and aggression, fire safety remained outstanding for some nursing staff, however, a mandatory training plan, to deliver this training in the coming months, was provided to the inspection team.

At the time of inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. Health and Social care professionals, including occupational therapy, psychology, social work, dietetics, and speech and language therapy were accessible to all residents. Physiotherapy was via a referral process.There

was also access to a paediatrician. Similar to last year, the post of occupational therapy manager was vacant at the time of the inspection. This position had been advertised on a number of occasions since it became vacant in 2023, however, recruitment had been unsuccessful.

There was a commitment to good practice and quality improvement with a focus on development of numerous quality initiatives. A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a local policy group which provided a multi-disciplinary approach to policy development and review, and all policies were up to date at the time of inspection. However, the approved centre's written policy on Close Circuit Television (CCTV) which stated that CCTV was prohibited inside the Approved Centre with the exception of Seclusion room was not adhered to; as CCTV was operational in an area within the approved centre .

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2020 and 2024 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2020		2021		2022		2023		2024	
Regulation 8: Residents' Personal Property and Possessions	✓		✓		✓		✓		✗	High
Regulation 21: Privacy	✓		✓		✗	Low	✓		✗	Critical
Regulation 22: Premises	✓		✓		✓		✓		✗	High
Regulation 25: Use of Closed Circuit Television	✓		✓		✓		✗	Moderate	✗	High
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	High
Rules Governing the Use of Seclusion	✗	Low	✓		✓		✓	Moderate	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✓		✓		✗	High	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 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 Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, 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 mental health 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 Youth Advocacy Programme (YAP) representative was contacted to obtain residents' feedback about the approved centre.

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

Residents were invited to meet the inspection team but declined, however seven completed experience questionnaires were received by the inspection team. Residents documented that they knew who their key worker was. In four of the questionnaires it was documented that they could sometimes give feedback and make complaints, one said they could never give feedback or make complaints. Comments included " If you have a complaint we are told not to because this is a hospital not a home", "complaints are ignored as " just your illness"" and one comment was that "I am often disregarded when it's a valid complaint, little effort is made to rectify the situation." Three other respondents said they could always make a complaint, with one commenting that this can be done in the community meeting and with youth advocacy programme.

Three questionnaires documented that residents were happy with staff, four said they were not, with comments such as: "depends on staff member, some are great but some can be quite condescending and rude, but only two or three are like that", another said "I find a few staff come across as rude." Four respondents said their privacy and dignity were respected. However, one comment was that staff walked in when resident was changing even when door was locked, staff did not knock and therefore they only sometimes felt safe because of this. Two questionnaires documented an information booklet was not received on admission. The most positive aspects of their experience included "Getting better; that staff were very fair with their patients; being around people with similar problems was very helpful; and that certain nurses were so kind and patient and always willing to talk"

The residents were asked to rate their overall experience of the care and treatment in the approved centre On a scale of 1 to 10, 1 being poor and 10 being excellent. Two young people rated this as 2, one as 6, three as 7 and one as 8.

5.2 Advocacy

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

The inspection team spoke with a representative of YAP who informed the inspection team that there was a period of time young people had commented about the routine being delayed, due to commencement of newer staff, and found this frustrating. The peer advocate also advised that they had not received any complaints nor supported a young person to make a formal complaint but were available to do so if necessary. Other feedback included that the young people had requested outings to local cinemas or amenities and that this request was ongoing. Feedback from the peer advocate in relation to staff was very positive.

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:

- Executive Clinical Director
- Registered Proprietor Nominee
- Clinical Director
- Area Director of Nursing
- Director of Nursing
- Consultant Psychiatrist x 2
- Principal Psychologist
- Dietitian Manager
- Speech and Language Therapy Manager
- Quality and Patient safety advisor
- School Principal
- Assistant Director of Nursing
- Clinical Nurse Manager III
- Operations Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers that were appropriate to the resident group profile and individual residents' needs when administering medication, undertaking medical investigations and providing other healthcare services.

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

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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

Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate to the resident and considered the residents' preferences, dignity, bodily integrity and religious and cultural practices.

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

Residents were supported to manage and maintain their own laundry through the provision of internal or external laundry services.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2024.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each resident, listing their personal property and possessions. The checklist was updated on an ongoing basis and in line with the approved centre's policy, was kept separate to the resident's individual care plan and was available to the resident.

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

The access to and use of resident monies was not appropriately overseen by either two staff members or the resident and two staff members. Envelopes that contained resident monies, which was in the care of the approved centre, were not signed by two staff members, which was a breach of the approved centre's policy.

The process to record, secure and manage the personal property and possessions of the resident, including money, was not adequate and was in breach of the approved centre's policy. Envelopes

containing resident monies, in the approved centre's care, as well as entries in the valuables log, lacked appropriate identifiers.

The approved centre was non-compliant with this regulation because a record of each resident's personal property and possessions was not maintained in accordance with the approved centre's written policy, 8(3).

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities were available both on weekdays and during the weekend. Spaces for recreation were provided such as a quiet reading room with books, a relaxation room and an art room with art material, and other recreational activities included table tennis, foosball, keyboards, boardgames, videogames and television with streaming services. Outdoor areas with games were provided.

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

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to visits. The policy was last reviewed in April 2024.

Visiting times were appropriate and reasonable. A separate visitors room was provided where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Justifications for visiting restrictions implemented for a resident were documented in the clinical file.

The visiting room was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures on communication. The policy was last reviewed in June 2024.

Residents had access to mobile phones, ward computers and mail for the purposes of sending or receiving messages or goods, except where the resident was otherwise risk assessed with due regard to their wellbeing, safety and health.

The clinical director, or a senior member of staff designated by the clinical director, only examined incoming and outgoing resident communication where there was reasonable cause to believe that the communication would result in harm to the resident or to others based on the 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 written operational policies and procedures on:

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

The policy was last reviewed in April 2024.

The clinical files of three residents who were searched were inspected. Risk was assessed prior to a search of a resident, their property or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches. The request for consent and the reply was documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. Where consent was not received, the process relating to searches without consent was implemented.

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

The resident's dignity, privacy and gender were respected during searches and at least one of the staff members conducting the search was the same gender as the resident being searched. Residents were given the opportunity to give feedback regarding their experience of the search in relation to their dignity and privacy.

A written record of every search of a resident and every property search was available, and included the reason for the search, the names of both staff members who undertook the search and details of who was in attendance for the search. A written record was kept of all environmental searches.

Policy requirements were implemented when illicit substances were found during a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and protocols for care of residents who are dying. The policy was last reviewed in April 2024.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Five ICPs were inspected. The ICPs were a composite set of documents which addressed the resident's goals, mental health care and treatment needs based on a multi-disciplinary team (MDT) assessment of the person and where practicable, in consultation with them. The documents within the ICPs were identifiable and uninterrupted, and were not amalgamated with progress notes.

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

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

The ICPs were reviewed by the MDT in consultation with the resident [weekly in an acute setting and at least every six months for residents in a continuing care facility]. Following this review, the ICPs were updated contemporaneously to reflect any changes to the goals, treatment, care, best practice and required resources. The ICP of a child resident included their educational requirements.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided therapeutic services and programmes that were appropriate and met the assessed needs documented in residents' individual care plans. The approved centre had a dedicated occupational therapist, social worker, psychologist, speech and language therapist, dietitian and a paediatrician available to residents.

The recovery-oriented therapeutic programme was planned, delivered and co-ordinated by the multi-disciplinary team. Therapeutic groups offered included pet therapy, art therapy, sensory wellbeing workshops, decider skills groups, mindfulness groups, self-care groups, building self-esteem groups, cognitive skills groups, assertiveness skills and problem-solving groups, team building skills groups, yoga and cognitive remediation and emotion skills (CREST) training groups. The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning.

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

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the transfer of residents. The policy was last reviewed in February 2024.

The clinical file of one resident who had been transferred in emergency circumstances from the approved centre to another facility was inspected. Communications between the approved centre and the receiving facility were documented and followed up with a written referral. Information on the resident was transferred with them, and included a letter of referral, a list of current medications and a resident transfer form. This information was sent to a named individual.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for responding to medical emergencies. The policy was last reviewed in June 2024.

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

Residents were provided with general health services, and received appropriate health care interventions in line with their individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs. As no resident had been admitted for over six months at the time of inspection, there were no six-monthly general health assessments to inspect.

Arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents had access to national screening programmes according to age and gender.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures for the provision of information to residents. The policy was last reviewed in April 2024.

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

Residents were provided with the details of their multi-disciplinary team. Residents were provided with written and verbal information regarding their diagnosis, except where the resident's psychiatrist deemed the provision of such information as prejudicial to the resident's physical health, mental health, well-being or emotional condition. Where information was restricted regarding a resident's diagnosis, the justification for the restriction was documented in their clinical file.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating CRITICAL

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

INSPECTION FINDINGS

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

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

CCTV cameras were in use in Oak ward bedrooms. Residents in those rooms did not have access to bed screening or the means to manage their privacy. Observation panels in Oak ward bedrooms did not have blinds, curtains or opaque glass. There was no privacy screening on the main windows of the bedrooms. These windows overlooked a garden area but did not have opaque glass. The CCTV monitor in Oak ward was visible to non-clinicians.

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

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

a) **The lack of bed screening in Oak Ward meant that residents' privacy was compromised.**
b) **Not all observation panels on bedrooms in Oak Ward were fitted with blinds, curtains, or opaque glass.**
c) **Bedrooms in Oak Ward were overlooked from the garden area and the bedroom windows did not have opaque glass.**
d) **CCTV cameras were in use in resident bedrooms and the monitor was visible to non-clinicians.**

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 personal space and all resident rooms were adequately sized. Communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were sized and furnished to remove excessive noise. Lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs. Residents had space to move about, including outdoor spaces.

However, a hazard was not minimised in the approved centre. Sharp edges were observed in the seclusion suite in Rowan Unit. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair; however, a fire door in Rowan Unit was not fitted closely to the frame and stuck to the floor, impeding its closing. Another fire door was wedged open when the inspection team arrived and swung shut in a way that could cause injury when the wedge was removed. The heavy fire door closing control did not engage like other fire doors on the unit.

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

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

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 specific needs of residents and patients and the safety and wellbeing of residents as ligature risks were not identified, assessed, treated and minimised to the lowest practicable level, 22(3).**
b) **The approved centre was not kept in a good state of repair internally as two fire doors were not operating correctly, 22(3).**
c) **The condition of the physical structure and the overall approved centre environment was not developed with due regard to the safety and wellbeing of residents as a hazard such as a hard and sharp edge was present in the seclusion suite in Rowan Unit, 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 appropriate and suitable practices and written operational policies relating to:

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

The policy was last reviewed in June 2024.

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

When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file.

Medication was appropriately stored. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication was stored securely. Schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products 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 operational policy and procedures relating to the health and safety of residents, staff and visitors. The policy was last reviewed in April 2024.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had clear written policy and protocols in relation to the use of CCTV for observing residents. The policy was last reviewed in August 2024.

The policy prohibited the use of CCTV inside the approved centre, with the exception of seclusion room. However, CCTV was installed, and in use, in two bedrooms in Oak ward.

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

The use of CCTV, or other monitoring systems, had been disclosed to the Mental Health Commission or the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe residents were incapable of recording or storing a resident’s image on a tape, disc, hard drive or in any other form.

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

CCTV cameras or other monitoring systems transmitted images to a monitor that was viewable by other persons besides the health professional responsible for the resident. The CCTV monitor in Oak ward was in the nursing station and was operating during the time of inspection. This monitor was visible to any person who might enter the unit through the nursing station, including non-clinicians.

The approved centre was non-compliant with this regulation because CCTV cameras used to observe a resident transmitted images to a monitor that was not solely viewable by the health professional responsible for the resident, 25 (1)(a).

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Not all nursing staff had completed mandatory training in basic life support, fire safety and management of violence and aggression; however, a mandatory training plan to address this in the coming months was provided to the inspection team.

Staff Training Record

Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (26)	24	92%	21	88%	24	92%	26	100%	26	100%	26	100%
Medical (8)	8	100%	8	100%	8	100%	8	100%	8	100%	8	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 (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

Speech and Language Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written policies and procedures relating to the:

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

The policy was last reviewed in June 2024.

All residents' records were secure, up to date and in good order, and were constructed, maintained and used in accordance with national guidelines and legislative requirements. Resident records were physically stored together, where possible, and reflected the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and good order. There were no loose pages. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Documentation of food safety, health and safety and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the:

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

The policy was last reviewed in July 2024.

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

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

Minor complaints were documented. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, and subsequent investigations and outcomes,

were fully recorded and kept distinct from the resident's individual care plan. Complainants were informed promptly of the outcome of the complaint investigation, details of the appeals process were made available to them and this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

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 February 2024, and outlined the roles and responsibilities for risk management, including:

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

The policy also included:

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

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

The person with responsibility for risk was identified and known by all staff but responsibilities were not properly allocated at management level and throughout the approved centre to ensure their effective implementation. Responsibilities had not been allocated to ensure daily fire checks and regular fire drills and evacuations were conducted.

Identified health and safety risks were reduced to the lowest practicable level of risk. However, the risk associated with not conducting regular fire drills and evacuations was not identified, assessed, treated, reported and monitored by the approved centre. Clinical risks and corporate risks had been identified, assessed, treated, reported, monitored and documented in the risk register as appropriate. Ligature points observed by the inspection team were not identified in the approved centre's ligature audit and therefore were not removed or mitigated. The approved centre's ligature audit did not effectively mitigate ligature points as it was not updated to reflect the risk of low height ligature points.

Individual risk assessments were completed prior to and during resident seclusion and physical restraint. Individual risk assessments were also completed at admission, transfer and discharge, and in conjunction with medication requirements.

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

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT and a record was maintained of this review and recommended actions.

The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission.

An emergency plan was in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

a) **Responsibilities were not allocated at management level and throughout the approved centre to ensure regular fire drills and evacuations were conducted, 32(1).**
b) **The risk associated with not conducting regular fire drills and evacuations was not identified, assessed, treated, reported and monitored, 32(1).**
c) **Structural risks, including ligature points, were not removed or effectively mitigated, 32(1).**
d) **The registered proprietor did not ensure structural risks, including ligature points, were effectively mitigated as the ligature audit was not updated to reflect the risk of low height ligature points, 32(1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration displayed in a prominent location. Changes to the approved centre's operational bed capacity as detailed in the certificate of registration had been communicated to the Mental Health Communication.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated February 2024. The policy addressed the following:

- Who may initiate, and who may carry out, seclusion.
- The provision of information to the person being secluded, which included information about their rights, presented in accessible language and format.
- The safety, safeguarding and risk management arrangements that were to be followed during any episode of seclusion.

The approved centre had a written policy on the reduction of the use of restrictive practices. It was last reviewed in June 2023 and addressed:

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

Policy and procedures for training all staff involved in seclusion addressed:

- Who would receive training based on the identified needs of persons who are secluded and staff.
- The areas to be addressed within the training programme, including training in:
    - Alternatives to seclusion.
    - Trauma-informed care.
    - Cultural competence.
    - Human rights including the legal principles of restrictive intervention.

    - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional, or somatic causes or triggers of the person's behaviours.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in seclusion.

Training and Education: A written record indicated that staff involved in seclusion have read and understood the policy. All staff who participated, or may participate, in the use of seclusion received the appropriate training in its use and in the related policies and procedures.

A record of attendance at training was maintained.

Monitoring: An annual report on the use of seclusion was published on the registered proprietor's website. A multi-disciplinary review and oversight committee accountable to the registered proprietor nominee analysed in detail every episode of seclusion. The committee met at least quarterly and produced a report following each meeting. This report was made available to staff to promote on-going learning and awareness and to the Mental Health Commission upon request.

Evidence of Implementation: Seclusion facilities were furnished and cleaned in such a way that ensured the person's inherent right to personal dignity and ensured that the person's privacy was respected. However, seclusion facilities were not maintained adequately as ventilation in the seclusion room en suite in Oak Unit was out of order.

The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There were no ligature points or electrical fixtures.

The main door to each seclusion room on Rowan and Oak unit had an anti-barricade door, however, the en suite bathroom door in Rowan Unit's seclusion room was not an anti-barricade door.

Not all fittings in Rowan Unit seclusion room were of such a design and quality as not to endanger the safety of the person in seclusion. The en suite in Rowan Unit's seclusion room had a wooden window frame with sharp edges.

As far as possible, the seclusion room was in an area away from communal sitting rooms and sleeping accommodation, but not isolated. Seclusion facilities were not used as bedrooms and bedrooms were not used as seclusion facilities.

The clinical files of three persons who had been secluded were inspected. Orders for seclusion were appropriately initiated, carried out, renewed and ended. The person being secluded was assessed and monitored, and their dignity and safety were respected. The person's representative was informed of the seclusion in accordance with the person's wishes. The Mental Health Commission was informed of the start time and date, and the end time and date of each episode of seclusion.

An in-person debrief followed every episode of seclusion. This debrief was person-centred and gave the person the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved in their care and treatment. Where it was the person's wish not to engage in this debrief, that wish was respected.

Appropriate emotional support was provided to the person in the direct aftermath of the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion. Each episode of seclusion was appropriately recorded and all relevant information was placed in the person's clinical file.

Upon admission of a child, a registered medical practitioner or registered nurse carried out a documented risk assessment to determine if seclusion could be safely used or not. The reasons for, likely duration of, and the circumstances which led to the discontinuation of seclusion were explained in a way that the child could understand and in a format that was age-appropriate. The child's parent or guardian was informed as soon as possible of the child's seclusion, and the circumstances which led to seclusion. The child's parent or guardian was informed when the seclusion ended.

Child protection policies and procedures in line with relevant legislation and regulations were in place. Policy and procedure were in place addressing appropriate training for staff in relation to child protection.

Seclusion was not used to ameliorate operational difficulties including where there are staff shortages, as a punitive action, where mechanical restraint was also in use, solely to protect property or as a substitute for less restrictive interventions.

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

The registered proprietor appointed a named senior manager who was responsible for the approved centre's reduction of seclusion.

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

a) **Seclusion facilities were not maintained adequately as ventilation in the seclusion room en suite in Oak Unit was out of order, 8.1.**
b) **The en suite bathroom door in Rowan Unit's seclusion room was not an anti-barricade door, 8.1(iii).**
c) **All fittings in the seclusion room in Rowan Unit were not of such a design and quality as not to endanger the safety of the person in seclusion. The en suite in the seclusion room had a wooden window frame with sharp edges, 8.3.**

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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 January 2024. It addressed the following:

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

The approved centre had a policy on the reduction of the use of physical restraint. It was last reviewed in June 2023 and addressed the following:

- How the approved centre aimed to reduce, or where possible eliminate, the use of physical restraint within the approved centre.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.
- How the approved centre would provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint.

Policies and procedures regarding staff training included:

- Who would 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.
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.
    - The monitoring of the safety of the person during and after the physical restraint.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in physical restraint.

Training and Education: There was a written record that all staff involved in physical restraint had read and understood the policy. All staff who participated, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures and this training was in accordance with the policy outlined above.

A record of attendance at training was maintained.

Monitoring: An annual report was published on the registered proprietor's website.

A multi-disciplinary review and oversight committee met at least quarterly and produced a report following each meeting of the review and oversight committee which was available to the Mental Health Commission on request.

Evidence of Implementation: Three episodes of physical restraint 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. The order confirmed that there were no other less restrictive ways available to manage the person's presentation.

The order for physical restraint lasted for a maximum of 10 minutes. In one episode, the physical restraint was extended by a renewal order for a further period not exceeding 10 minutes.

The relevant section of the clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint as soon as was practicable and no later than three hours after the conclusion of the episode of physical restraint. The CPF was signed by the consultant psychiatrist (CP) or the duty CP within 24 hours.

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 and timeframe specified by the Mental Health Commission.

Staff involved in the use of physical restraint took into account any relevant entries in the person's individual care plan (ICP) pertaining to the person's specific requirements or needs in relation to the use of physical restraint. Where the person who was restrained had a past history of trauma or abuse, there was documented evidence that the principles of trauma-informed care were used during the episode of physical restraint when restraining the person.

The dignity and safety of the person being restrained was respected. The person was continuously assessed throughout the use of the restraint to ensure their safety. The person who led the physical restraint ended the restraint. The time, date and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended.

An in-person debrief with the person who was restrained followed every episode of physical restraint. This debrief was person-centred and gave the person the opportunity to discuss the physical restraint with

members of the multi-disciplinary team involved in their care and treatment. Where the person declined to participate in a debrief, this decision was respected, and a record of this was made in their clinical file.

However, the individual care plans of two persons who had been physically restrained were not appropriately updated following this debrief. In particular, the young persons' preferences in relation to restrictive interventions going forward was not updated.

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

The episodes of physical restraint were recorded in the clinical file and in the clinical practice form (CPF). A copy of the CPF was in the clinical file and available to the Mental Health Commission on request.

The episodes of physical restraint were reviewed by members of the multi-disciplinary team (MDT) within five working days from the date of the restraint. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

A named senior manager was responsible for the approved centre's reduction of physical restraint.

For child residents, an RMP or RN carried out a risk assessment to determine whether physical restraint could be safely used or not. The reasons for, and the circumstances which would lead to the discontinuation of restraint, were explained to the child in a way that they could understand and in a format that was appropriate to their age. A record was made of this communication that clearly outlined how the child's individual communication needs were met.

The child's parent or guardian was informed as soon as possible of the child's physical restraint and the circumstances which led to the child being physically restrained. The child's parent or guardian was informed when the episode of physical restraint ended.

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

The approved centre was non-compliant with this code of practice because the individual care plans of two young people who had been physically restrained were not updated to reflect the outcome of the in-person debrief that followed the episodes of restraint; in particular, the young persons' preferences in relation to restrictive interventions going forward was not updated, 5.5.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in January 2024, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in February 2024, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2024, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

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

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

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

The discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge and outstanding health or social issues. It provided follow-up arrangements, names and contact details of key people for follow-up and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate.

A timely follow-up appointment was arranged.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 08 Residents' Personal Property and Possessions					
Reason ID : 10005899		A record of each resident's personal property and possessions was not maintained in accordance with the approved centre's written policy, 8(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Following the MHC inspection, updated forms are in place to reflect the policy, please see supporting documentation.	The storage of personal items in the young persons safe are stored correctly as per the policy. This is part of the discharge process. Please see supporting documentation.	All staff are made aware of the policy with regards to resident's personal property and the discharge process, as per policy.	31/08/2024	Aine McCreevy ADoN & Sonia Griffith CNM3
Preventative Action	Updated forms are now in place.	The storage of personal items in the young persons' safe are stored correctly as per the policy this is part of the discharge process. Please see supporting documentation.	All staff are made aware of the policy with regards to resident's personal property and the discharge process, as per policy.	31/08/2024	Aine McCreevy ADoN & Sonia Griffith CNM3

Regulation 21: Privacy					
Reason ID : 10005900		**The lack of bed screening in Oak Ward meant that residents' privacy was compromised.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A meeting took place with operations and plans to: 2 x windows to be removed along with frames, 2 x windows replaced along with electrical work to be completed within the roof, External shutter to be removed and 2x new shutters installed with further electrical roof work required. unlimited access to Oak of approx. 1 week will be required in order to progress these works. These works will be commencing week of the 20th January 2025	Works will be commencing the week of the 20th January 2025 and will be completed by 27th January 2025.	Oak ward cannot accept admissions for a period of one week due to works be completed from Monday 20th - 27th January 2025	31/01/2025	Prof Brendan Doody - Clinical Director
Preventative Action	By installing the privacy screen, this will create privacy for the young person while in their bedroom in Oak.	Works will be commencing the week of the 20th January 2025 and will be completed by 27th January 2025.	Oak ward cannot accept admissions for a period of one week due to works be completed from Monday 20th - 27th January 2025	31/01/2025	Prof Brendan Doody Clinical Director

Reason ID : 10005901		Not all observation panels on bedrooms in Oak Ward were fitted with blinds, curtains, or opaque glass.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Works due to be commenced on the observation panels, week of the 20th January 2025 in both bedrooms and will be fitted with internal blinds allowing privacy for the young person.	As part of regulation 21 Privacy, this will create more privacy for the young person residing in Oak.	No admissions to oak ward during renovations from 20th January-27th January 2025	31/01/2025	Prof Brendan Doody - Clinical Director
Preventative Action	By fitting internal blinds in both bedrooms will allow privacy for the young person's residing in Oak ward and that the least intrusive level of observation that is appropriate to the young person's clinical need, should always be adopted so that due sensitivity is given to the young person's dignity and privacy whilst maintaining safety for the individual and those around them.	These works will be completed by the 27th January 2025	No admissions to oak ward during renovations from 20th January-27th January 2025	31/01/2025	Prof Brendan Doody - Clinical Director
Reason ID : 10005902		**Bedrooms in Oak Ward were overlooked from the garden area and the bedroom windows did not have opaque glass.**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Following on for the MHC inspection both Bedrooms and living areas' external windows have now been fitted with privacy film	As part of regulation 21 Privacy, this will create more privacy for the young person residing in Oak.	Privacy film have been fitted in both external windows in Oak ward	30/08/2024	Prof Brendan Doody - Clinical Director
Preventative Action	As part of regulation 21 Privacy, this will create more privacy for the young person residing in Oak.	Privacy film have been fitted in both external windows in Oak ward	Privacy film have been fitted in both external windows in Oak ward	30/08/2024	Prof Brendan Doody Clinical Director
Reason ID : 10005903		**CCTV cameras were in use in resident bedrooms and the monitor was visible to non-clinicians.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CCTV in oak ward, shall only be used solely for the purposes of observing a young person who has been identified as a high risk, this will be prescribed by the consultant psychiatrist or the person in charge. Please see supporting documents. A smaller CCTV screen is due to be installed which will be lowered to desk level.	All Staff to be aware of the use of CCTV as per policy.	All staff to be made aware of the use of CCTV cameras in Oak ward as per policy on CCTV. see supporting document	28/02/2025	Prof Brendan Doody Clinical Director

Preventative Action	CCTV in oak ward, shall only be used solely for the purposes of observing a young person who has been identified as a high risk, this will be prescribed by the consultant psychiatrist or the person in charge. Please see supporting documents. A smaller CCTV screen is due to be installed which will be lowered to desk level.	All Staff to be aware of the use of CCTV as per policy	All staff to be made aware of the use of CCTV cameras in Oak ward as per policy on CCTV see supporting document	28/02/2025	Prof Brendan Doody Clinical Director

Regulation 22: Premises					
Reason ID : 10005904		**The condition of the physical structure and the overall approved centre environment was not developed and maintained with due regard to the specific needs of residents and patients and the safety and wellbeing of residents as ligature risks were not identified, assessed, treated and minimised to the lowest practicable level, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	On the day there was an issue with the sensor lights outside bedrooms to alert the entering into the en-suite bathroom re ligature risk this has since been repaired.	Annual ligature audit to be completed by 28th February 2025 and will identify, assess and minimise ligature points to its lowest level.	All risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	14/03/2025	Prof Brendan Doody - Clinical Director
Preventative Action	Sensor lights outside bedrooms to alert the entering into the en-suite bathroom re ligature risk this has since been repaired.	Annual ligature audit to be completed by 28th February 2025 and will identify, assess and minimise ligature points to its lowest level.	All risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	14/03/2025	Prof Brendan Doody - Clinical Director
Reason ID : 10005905		**The approved centre was not kept in a good state of repair internally as two fire doors were not operating correctly, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Both Fire Doors have been given new floor closures and are in full working order.	Fire register for the approved center is completed on a weekly basis. All risk management procedures are identified, reported, monitored and there is a clear process in	Management is responsible for ensuring maintenance arrangements are in place to ensure the Approved Centre is kept in a good state of repair externally and internally	31/01/2025	Prof Brendan Doody - Clinical Director

		place to ensure compliance.			
Preventative Action	Both Fire Doors have been given new floor closures and are in full working order.	Fire register for the approved centre is completed on a weekly basis . All risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	Management is responsible for ensuring maintenance arrangements are is in place to ensure the Approved Centre is kept in a good state of repair externally and internally.	31/01/2025	Prof Brendan Doody-Clinical Director
Reason ID : 10005906		**The condition of the physical structure and the overall approved centre environment was not developed with due regard to the safety and wellbeing of residents as a hazard such as a hard and sharp edge was present in the seclusion suite in Rowan Unit, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following consultation with maintenance a new window frame to be installed in the seclusion en suite of rowan ward.	On completion of works this will ensure the safety of the young person in seclusion en suite bathroom	Minimal barriers identified once window frame has been installed.	28/02/2025	Prof Brendan Doody-Clinical Director
Preventative Action	Following consultation with maintenance a new window frame to be installed in the seclusion en - suite of rowan ward.	On completion of works this will ensure the safety of the young person in seclusion en-suite bathroom	Minimal barriers identified once window frame has been installed.	28/02/2025	Prof Brendan Doody - Clinical Director

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10005907		**CCTV cameras used to observe a resident transmitted images to a monitor that was not solely viewable by the health professional responsible for the resident, 25 (1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A smaller CCTV screen is due to be installed which will be lowered to desk level.	CCTV will not be in use if a young person starts to act in a way which compromises a his/her dignity as per policy No. 25 CCTV see supporting document	All staff to be made aware on the use of CCTV camera in Oak ward as per policy. See supporting document	28/02/2025	Prof Brendan Doody - Clinical Director
Preventative Action	A smaller CCTV screen is due to be installed which will be lowered to desk level.	CCTV will not be in use if a young person starts to act in a way which compromises a his/her dignity as per policy No. 25 CCTV see supporting document	All staff to be made aware on the use of CCTV camera in Oak ward as per policy. See supporting document	28/02/2025	Prof Brendan Doody - Clinical Director

Regulation 32: Risk Management Procedures					
Reason ID : 10005912		**Responsibilities were not allocated at management level and throughout the approved centre to ensure regular fire drills and evacuations were conducted, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Since the MHC inspection a staff member has been allocated the responsibility of carrying out fire drills and evacuations maintaining records for same. Management ensure all risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	Fire register will be completed on a weekly basis. All staff to attend fire drills and evacuations as per training.	All risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	28/02/2025	Prof Brendan Doody - Clinical Director
Preventative Action	Since the MHC inspection a staff member has been allocated the responsibility of carrying out fire drills and maintaining records for same. Management ensure all risk management procedures are identified, reported,	Fire register will be completed on a weekly basis. All staff to attend fire drills and evacuations as per training.	All risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	28/02/2025	Prof Brendan Doody - Clinical Director

	monitored and there is a clear process in place to ensure compliance.				
Reason ID : 10005913		**The risk associated with not conducting regular fire drills and evacuations was not identified, assessed, treated, reported and monitored, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire register completed on a weekly basis. All staff to attend fire drills and evacuations as per training.	By conducting regular fire drills and evacuations this will ensure compliance with regulation 32.	All risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	28/02/2025	Prof Brendan Doody - Clinical Director
Preventative Action	Fire register completed on a weekly basis. All staff to attend fire drills and evacuations as per training.	By conducting regular fire drills and evacuations this will ensure compliance with regulation 32.	All risk management procedures are identified, reported, monitored and there is a clear process in place to ensure compliance.	28/02/2025	Prof Brendan Doody - Clinical Director
Reason ID : 10005914		**Structural risks, including ligature points, were not removed or effectively mitigated, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following consultation with maintenance a new window frame to be installed in Rowan's en suite bathroom	Annual Ligature audit to be completed by 28th February 2025 and will identify, assess and minimise ligature points to its lowest level.	On completion of the ligature audit, points or structural risks will be identified and effectively mitigated	28/02/2025	Prof Brendan Doody - Clinical Director
Preventative Action	Following consultation with maintenance a new window frame to be	Annual Ligature audit to be completed by 28th February 2025 and will identify, assess	On completion of the ligature audit, points or structural risks will be identified and effectively mitigated	28/02/2025	Prof Brendan Doody- Clinical Director

	installed in Rowan's en suite bathroom	and minimise ligature points to its lowest level.			
Reason ID : 10005915		**The registered proprietor did not ensure structural risks, including ligature points, were effectively mitigated as the ligature audit was not updated to reflect the risk of low height ligature points, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	On the day of the inspection there was an issue with the sensor lights outside bedrooms to alert the entering into the en-suite bathroom re ligature risk this has since been repaired.	Annual Ligature audit to be completed by 28th February 2025 and will identify, assess and minimise ligature points to its lowest level.	On completion of the ligature audit, points or structural risks will be identified and effectively mitigated	28/02/2025	Prof Brendan Doody- Clinical Director
Preventative Action	On the day of the inspection there was an issue with the sensor lights outside bedrooms to alert the entering into the en-suite bathroom re ligature risk this has since been repaired.	Annual Ligature audit to be completed by 28th February 2025 and will identify, assess and minimise ligature points to its lowest level.	On completion of the ligature audit, points or structural risks will be identified and effectively mitigated	28/02/2025	Prof Brendan Doody - Clinical Director

Rules Governing the Use of Seclusion					
Reason ID : 10005909		**Seclusion facilities were not maintained adequately as ventilation in the seclusion room en suite in Oak Unit was out of order, 8.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The ventilation in Oak Seclusion Room en suite is currently not operating, following consultation with maintenance a fault has been identified and due to be repaired.	Environmental checklist to be completed on a daily basis and any areas identified will be reported and managed appropriately. See supporting document	Currently awaiting repair of oak seclusion en- suite	28/02/2025	Prof Brendan Doody - Clinical Director
Preventative Action	The ventilation in Oak Seclusion Room ensuite is currently not operating, following consultation with maintenance a fault has been identified and due to be repaired	Environmental checklist to be completed and any areas identified will be reported and managed appropriately. See supporting document.	Currently awaiting repair of oak seclusion en- suite	28/02/2025	Prof Brendan Doody - Clinical Director
Reason ID : 10005910		**The en suite bathroom door in Rowan Unit's seclusion room was not an anti-barricade door, 8.1(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Currently in the process of engaging with HSE estates to look at the possibility of installing an anti-barricade door.	Following consultation with HSE estates we endeavor to ensure the safety of young people by installing an anti barricade door in	Funding to be sourced, impact of structural changes to the unit and the contracting to the works.	25/07/2025	Prof Brendan Doody - Clinical Director

		Rowan's en suite seclusion			
Preventative Action	Currently in the process of engaging with HSE estates to look at possibility of installing an anti-barricade door.	Following consultation with HSE estates we endeavor to ensure the safety of young people by installing an anti barricade door in Rowan's en suite seclusion	Funding to be sourced, impact of structural changes to the unit and the contracting to the works	25/07/2025	Prof Brendan Doody - Clinical Director
Reason ID : 10005911		**All fittings in the Rowan seclusion room were not of such a design and quality as not to endanger the safety of the person in seclusion. The en suite in the seclusion room had a wooden window frame with sharp edges, 8.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following consultation with maintenance a new window frame to be installed.	On completion of works this will ensure the safety of the young person in seclusion.	Minimal barriers identified once window frame has been installed.	28/03/2025	Prof Brendan Doody - Clinical Director
Preventative Action	Following consultation with maintenance a new window frame to be installed.	On completion of works this will ensure the safety of the young person in seclusion.	Minimal barriers identified once window frame has been installed.	28/03/2025	Prof Brendan Doody - Clinical Director

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10005908		**The individual care plans of two young people who had been physically restrained were not updated to reflect the outcome of the in-person debrief that followed the episodes of restraint; in particular, the young persons' preferences in relation to restrictive interventions going forward was not updated, 5.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following the MHC inspection verbal feedback on these particular findings, staff were supported to attend a CPD session in Care planning and the Role of the Key Worker and Associate Key Worker which identified this area. Each restrictive intervention continues to be discussed and reviewed at the Reduction in Restrictive Interventions meeting every month, and the processes are also discussed to ensure compliance.	The monthly audit process remains in place to review each episode of physical restraint. The follow through to ensure that the care plan is updated to reflect the outcome of the review has been identified to all Clinicians responsible for the care of the young people.	All staff to be made aware and adhere to the policy on restriction reduction see supporting document.	28/02/2025	Prof Brendan Doody - Clinical Director
Preventative Action	Following the MHC inspection verbal	The monthly audit process remains in	All staff to be made aware and adhere to the policy on	28/02/2025	Prof Brendan Doody - Clinical Director

	feedback on these particular findings, staff were supported to attend a CPD session in Care planning and the Role of the Key Worker and Associate Key Worker which identified this area. Each restrictive intervention continues to be discussed and reviewed at the Reduction in Restrictive Interventions meeting every month, and the processes are also discussed to ensure compliance.	place to review each episode of physical restraint. The follow through to ensure that the care plan is updated to reflect the outcome of the review has been identified to all Clinicians responsible for the care of the young people.	restriction reduction see supporting document.		

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.

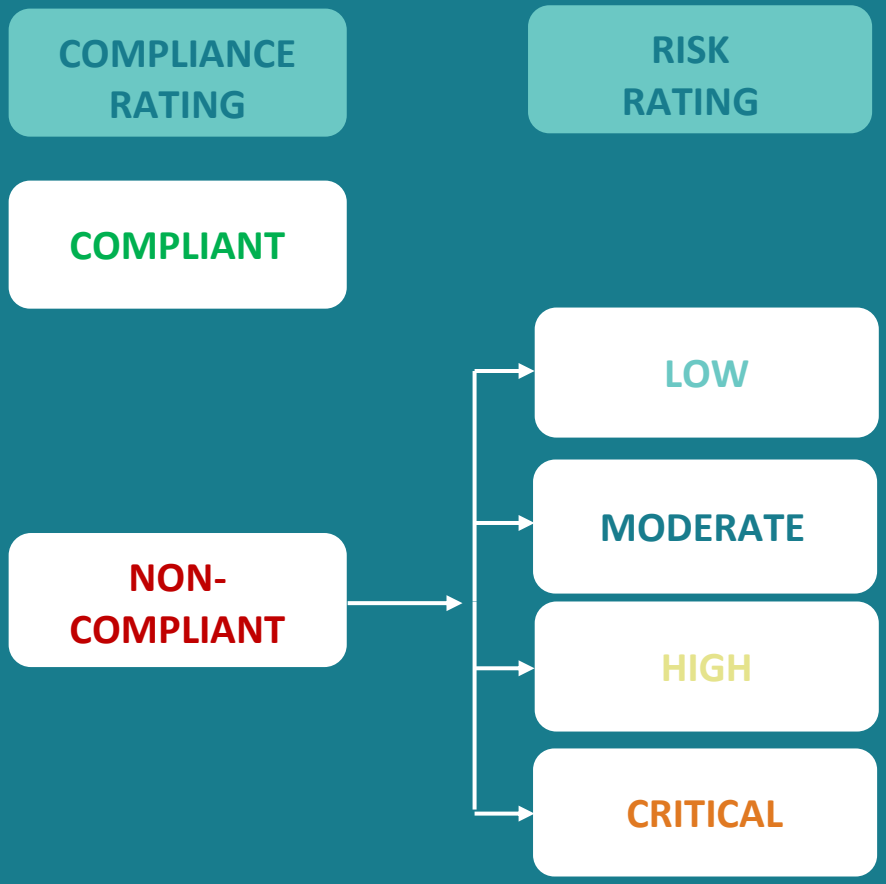
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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