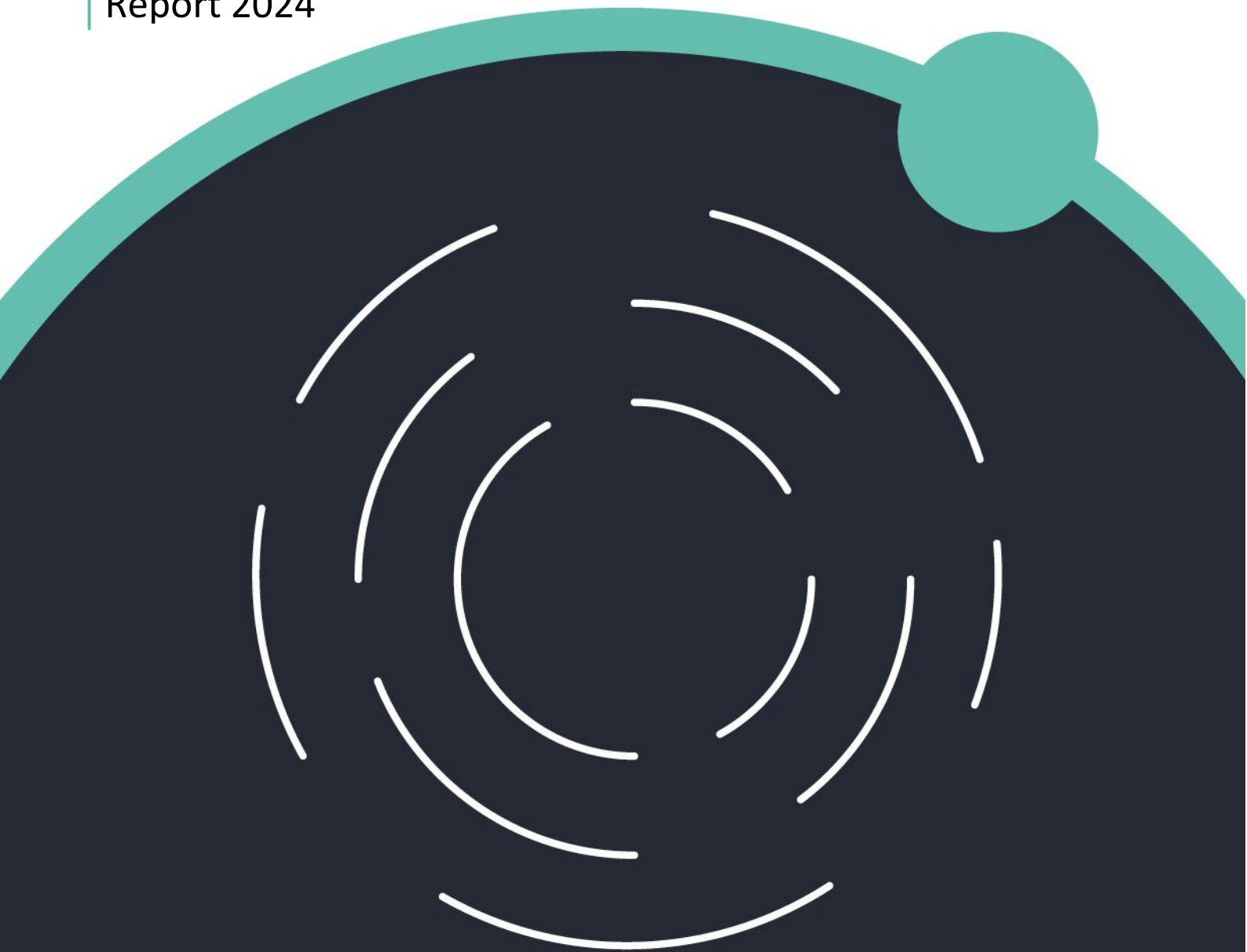
Child and Adolescent Mental Health In-Patient Unit, Merlin Park University Hospital

mhc
coimisiún meabhair - shláinte
mental health commission

Annual Inspection Report 2024



Promoting Quality, Safety and Human Rights in Mental Health

CHILD AND ADOLESCENT MENTAL HEALTH IN-PATIENT UNIT, MERLIN PARK UNIVERSITY HOSPITAL

Merlin Park, Galway

Date of Publication: 29th August 2024

ID Number: AC0180

2024 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and adolescent mental health care

Conditions Attached:
Yes

Most Recent Registration Date:
9 December 2022

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager
Mental Health Services

Inspection Team:
Damien Lanigan, Lead Inspector
Barbara McGeough
Barbara Murphy

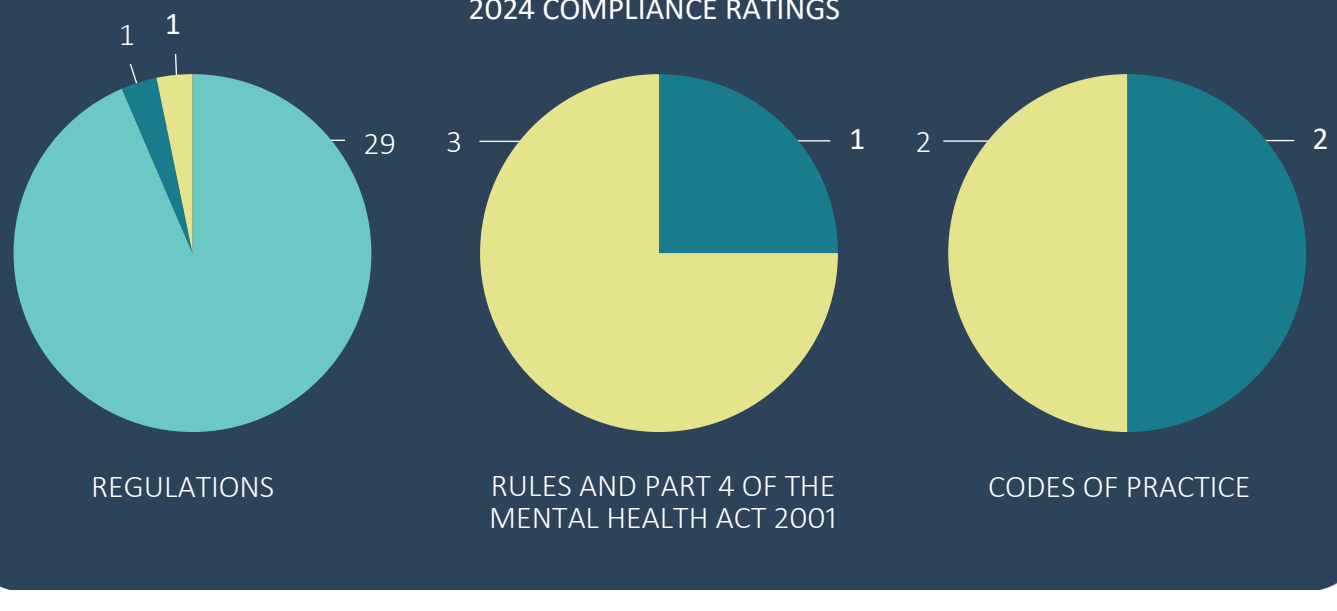
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
20 – 23 February 2024

Previous Inspection date:
25 – 28 April 2023

Inspection Type:
Unannounced Annual Inspection

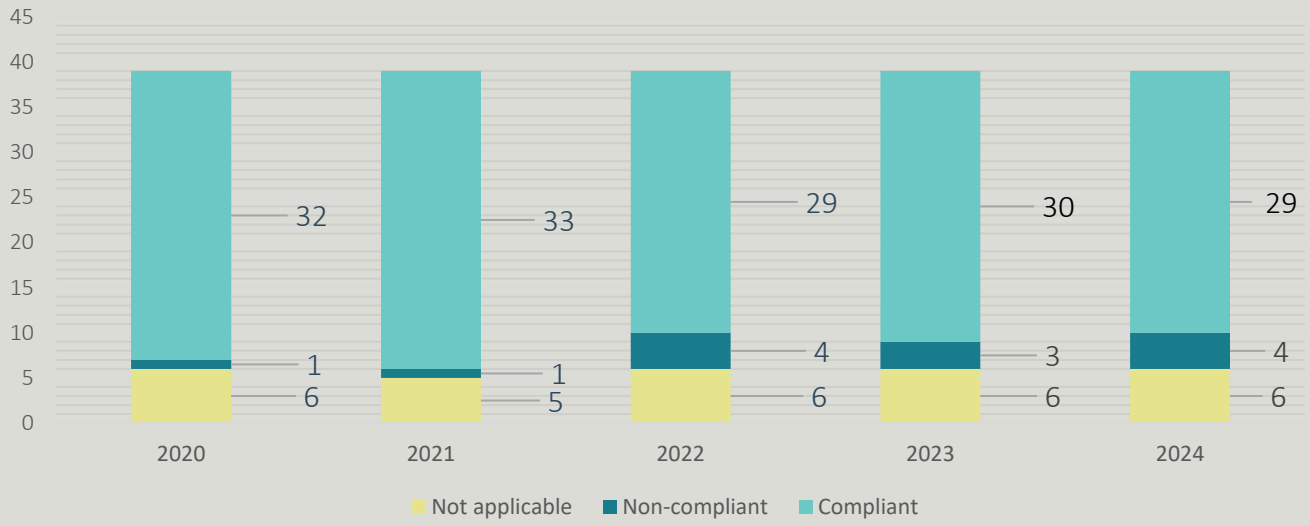
2024 COMPLIANCE RATINGS



RATINGS SUMMARY 2020 – 2024

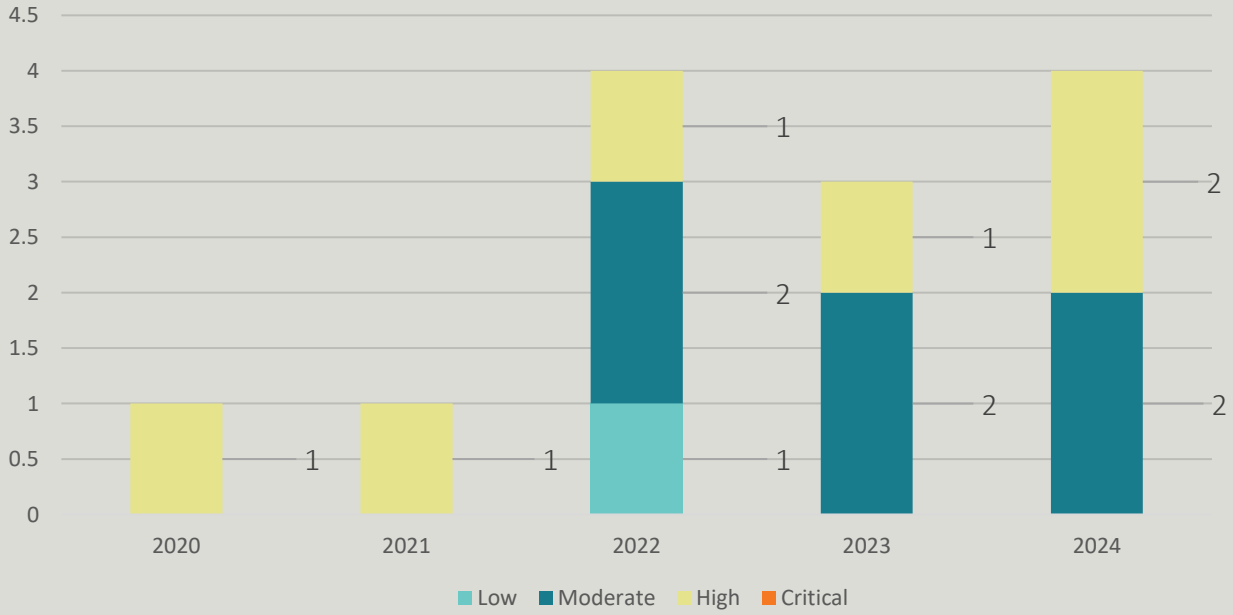
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

Inspector of Mental Health Services Summary

The inpatient Child and Adolescent Mental Health Service (CAMHS) facility is located within the campus of Merlin Park University Hospital in Galway. It is a purpose-built inpatient facility with two individual units: Woodsend and The Willows. The approved centre is a national referral centre for CAMHS.

The operational bed capacity in the approved centre was reduced from 20 to 12 beds at the time of inspection due to ongoing building works to facilitate the construction of a new seclusion suite, step-down area and other ancillary works. The approved centre had one condition attached to its registration related to the ongoing non-compliance with the rules governing the use of seclusion. These works were aimed at addressing the approved centre's condition requirements and had a provisional completion date set for April 2024.

The annual inspection was unannounced and occurred over four days, from the 20th to the 23rd of February 2024. The inspection report reflects findings of the inspection over this period only. In 2023, the service was non-compliant with three regulatory areas during the annual inspection. In 2024, there was an increase in the rate of non-compliance with four regulatory areas found to be non-compliant on this inspection. The inspection team findings were generally very positive. The inspection process was very well co-ordinated and prepared for by the staff and management in the approved centre.

The inspection team were concerned about the impact of the approved centre's non-compliance with the code of practice on the use of physical restraint, on the individual care plans of the young people. Staff were not sufficiently aware of the policies and procedures at the approved centre. Not all staff had completed the mandatory training in the required areas; however, a mandatory training plan for the coming months was provided to the inspection team.

The inspection team found that there was a strong culture of clinical auditing of compliance with regulations, codes and rules evident in the approved centre. Across the various disciplines it was also clear that there was a fostering of research with the singular aim of quality improvement in the provision of care and treatment to the residents. There was a strong emphasis on staff education and training that was directed towards enabling the delivery of safe, effective, recovery-focused care that the young people received. The service had recently won two National Healthcare Awards for the research and provision of care at the approved centre.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	97%	97%	88%	91%	88%

Conditions of registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *The Health Service Executive must implement the costed, funded and timebound plan for the new seclusion room submitted to the Mental Health Commission on 3 November 2022. The approved centre shall provide a progress update on the costed, funded and timebound plan to the Mental Health Commission in a form and frequency prescribed by the Mental Health Commission.*	The approved centre was not in breach of Condition 1.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- A Sensory Room was opened in October 2023 in the Woodsend unit. Its aim was to provide a variety of sensory modalities that were personalised to the individual needs of the young people. It was a therapeutic space for young people to use as part of their overall mental health recovery journey. This allowed for therapeutic input across all areas of severe mental health illness including psychosis, catatonia, eating disorder and self-harm. It also contributed to the Trauma Informed Care programme. Training for all staff in the use of the sensory room took place so the room was available for young people to use.

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

- Regulation 11: Visits
    - There were comfortable and well-decorated visiting spaces in the approved centre and information available for visitors in information leaflets. Parents accommodation was available to families in order to support visiting from long distances which was a valuable resource given the size of the catchment area of the approved centre.

- Regulation 19: General Health
    - The "Vigorous Physical Activity Initiative" from January 2024 promoted positive physical health and wellbeing during treatment of mental illness. The National Guidelines on Physical Activity for Ireland (Department of Health) recommended that all children and young people be active at a moderate to vigorous level for at least 60 minutes every day. However, the compounding effect of mental illness, the effects of specific medication along with the limited area within an approved centre could mean this recommendation may not be achieved. This initiative was led by the dietitians and supported by multi-disciplinary team. A small group of young people being treated with antipsychotic medication were brought outside of the grounds of the approved centre with a focus on jogging and running weekly. Encouragement and coaching was provided to promote exertion according to individual ability. The importance of vigorous physical activity is well established. The gymnasium facilities in the approved centre enabled the initiative to continue indoors when weather was poor.
    - A "weight management and antipsychotic medication in adolescence" booklet was produced in May 2023 for residents and was also used in online nutrition education sessions with parents for outreach support.
    - In 2023 the approved centre won an Irish Healthcare Centre Award for best project in the category of Healthcare Initiative - Mental Health Care in a Hospital / Inpatient Setting. The research and project, "Nutritional Rehabilitation in Anorexia Nervosa – The Patient's Choice: One, Two, Or Three Sandwiches", was a first of its kind approach that reduced to very low levels any need for nasogastric tube intervention for Anorexia Nervosa in this unit. This

initiative had been in place over a number of years and in September 2023 a child and parent evaluation of this initiative was conducted.

- Regulation 20: Provision of Information to Residents
    - There was a weekly advocacy service provided to the residents advising on rights and supports for young people in hospital.
    - General Information for young people in the unit was provided in a number of formats: printed booklets, displays and information boards. Colours and graphics were used in displayed information.
    - The approved centre had "You said - We did" boards. These were information boards where feedback was provided to resident's on the actions taken by the service arising from suggestions from residents and community meetings.

- Regulation 26: Staffing
  There was evidence of additional training that was provided for staff at the approved centre that included:
    - Hazard Analysis and Critical Control Point (HACCP) training was provided for nursing staff involved in food preparation.
    - Decider skills training was provided which enabled staff to teach the young people the skills to recognise their own thoughts, feelings and behaviours, enabling them to monitor and manage their own emotions and mental health.
    - Trauma-informed practice workshops and working with trauma in young people with moderate to serious mental illness workshops. This training would form part of mandatory training at the centre.
    - Safe wards training. Safewards is a program that encourages staff and clients including carers, family, and support people to work together and make wards more positive places.

- Regulation 29: Operating Policies and Procedures
    - The approved centre had a policy committee in place that met quarterly to review policies.
    - The approved centre incorporated feedback from residents and families into policies, procedures or protocols and education programmes.

- Regulation 31: Complaints Procedures
    - The approved centre had a complaints process that was visible and easily accessible to residents and families. Posters with details of the complaints process and complaints officer were displayed in the units and the inpatient unit information booklet for young people and their families.
    - The approved centre had a process of gathering information from residents; this was done via the resident community meetings and comments box.
    - An annual audit was completed, and findings and outcomes were shared with staff.
    - Complaints management training was scheduled for senior nurse managers as part of the 2024 training plan.

- Regulation 32: Risk Management Procedures
    - There was evidence of a strong culture of clinical auditing of compliance with regulations, codes and rules evident in the approved centre.
    - There was evidence of learnings from incident reviews and how this was incorporated into the improvement of clinical practice.
    - Research conducted by the staff in the approved centre was driving changes in clinical practice and care given to young people.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre is located within the campus of Merlin Park University Hospital in Galway. It is a purpose-built inpatient facility for the Child and Adolescent Mental Health Service (CAMHS). An administration block includes the reception area, the main dining facilities, therapy and activity rooms, a large gymnasium, office and visiting rooms. Accommodation comprises two individual units: Woodsend and the Willows. All the buildings are located around well-maintained outdoor areas. There is access to the school onsite and a parent accommodation flat from this garden area.

The approved centre was registered for 20 beds. However, due to ongoing building at the time of inspection, works for a new seclusion suite, a step down area, a link corridor between the units and the restructuring of the layout of the units, the operational bed capacity was reduced to 12 beds. The Woodsend unit had four single ensuite bedrooms in operation and the Willows unit accommodated up to eight young people within six single bedrooms of which two were ensuite and two double bedrooms ensuite (with single occupancy in each). Residents within Woodsend unit and the Willows unit had access to internal courtyards and a large well-kept garden. The Willows incorporated a high dependency suite with three bedrooms and a seclusion facility.

The approved centre had two inhouse multi-disciplinary teams (MDTs). It served the catchment area of Clare, Limerick, North Tipperary, Galway, Roscommon, Mayo, Sligo, Leitrim, and Donegal and was also a national referral centre for CAMHS.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**10**
Number of detained patients	1
Number of wards of court	0
Number of children	10
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 West, Galway Roscommon Mental Health Service. The Galway Roscommon Mental Health Service governance structure encompassed two core monthly meetings: an Area Management Team meeting and a Quality and Safety Committee (QSC) meeting. The Area Management Team comprised of representatives from senior management and clinical management and convened monthly as did the Quality and Patient Safety meeting. The approved centre was represented at the area management team meeting, and minutes evidenced agenda items such as health and safety, finance, quality and safety, human resources, risk management, mental health engagement and recovery and policies and procedures. There was also an overarching Clinical Governance Group meeting which was held monthly that governed subgroups in health and safety, drugs and therapeutics, audit and quality improvement and policies and procedures.

Within the approved centre, governance was further enhanced by local business meetings. The minutes of these meetings evidenced agenda items that included policy and procedures, health and safety, drugs and therapeutics, restrictive practices, training, bed management, service user feedback and auditing. Issues discussed at the meeting were escalated to the area management meeting as appropriate. An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.

The approved centre had a standardised process for the management of risks and incidents. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. Risks were identified, assessed, treated, reported and monitored. Identified risks were documented in the risk register.

The Child and Adolescent Mental Health Service (CAMHS) inpatient service comprised of two multi-disciplinary teams. Each team included a consultant psychiatrist, non-consultant hospital doctor, social worker, psychologist, dietitian and nursing staff. Both teams utilised one occupational therapist. The speech and language therapy (SLT) post was vacant at the time of inspection, but the interim SLT manager provided a consultative service until such point as the post would be filled. There were eight vacancies in the nursing staffing numbers at the time of inspection. This was managed in part through use of overtime and agency staffing and due to the fact that the approved centre was operating at a reduced bed capacity of 12 beds due to ongoing building works.

Governance questionnaires were returned to the inspection team by the registered proprietor nominee, executive clinical director, principal social worker, psychology director, area director of nursing, director of nursing, interim speech and language therapy manager in primary care and the manager of dietetics. There was no occupational therapy manager in post at the time of inspection, but this post was being managed by the general manager for administrative purposes. Clinical supervision was provided to the occupational therapist by an independent senior occupational therapist on a contractual basis. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. However, as there was no dedicated head of discipline in CAMHS SLT, the temporary primary care manager for SLT was responsible for clinical line management and supervision only. The approved centre's policies were developed by the Policies, Procedures, Protocols and Guidelines (PPPG) committee. The approved centre had an established program of audit towards continuous quality improvement.

The approved centre had one condition attached to its registration with the Mental Health Commission, which pertained to the use of the seclusion facility. The Rules Governing the Use of Seclusion was a reoccurring non-compliance since 2018. The Mental Health Commission had received the approved centre's

costed, funded and time-bound plan to replace the current seclusion facility. This plan had commenced in 2023 with a provisional completion date of April 2024. Building works were ongoing at the approved centre and bed capacity was reduced to 12 beds as a result at the time of inspection.

Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement. The approved centre's complaints process was displayed and accessible to residents and their representatives. No formal complaints had been submitted since the last inspection. The Youth Advocate Programme (YAP) provided an advocacy service within the approved centre. The YAP advocate visited the young people in the approved centre weekly and provided feedback to the inspection team.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2019 and 2023 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2020		2021		2022		2023		2024	
Regulation 15: Individual Care Plans	✓		✓		✓		✓		✗	Moderate
Rule on the Use of Seclusion	✗	High	✗	High	✗	High	✗	High	✗	High
Code Of Practice on the Use of Physical Restraint	✓		✓		✗	Low	✓		✗	High
Code of Practice on Admission, Transfer and Discharge to and from an approved centre	✓		✓		✓		✓		✗	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.
Part 3 and Part 4 of the Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent facility, this code of practise 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 engaged with residents in a number of different ways:

- 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.
- Residents could engage with the inspection team on any matter relating to their care whilst in the approved centre.
- The Youth Advocate in Mental Health representative was contacted to obtain residents' feedback about the approved centre.

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

Five young people availed of the opportunity to meet with the inspection team and six completed questionnaires were also received from the young people during the inspection.
Comments made by the young people included that the staff were very nice, approachable, respectful and gave them time and listened to the young people. They described being aware of and meeting their treating multi-disciplinary teams (MDTs) frequently. They commented that they were involved in their care planning. The young people expressed a desire to have more activities, as they enjoyed them, and they also wanted to have access to a computer in the units. Overall, the young people described the service as good, that they felt able to ask questions of the staff and that they felt safe in the approved centre.

Of the six completed questionnaires, all six indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood. Four respondents indicated that they 'always' received information on their diagnosis, care and treatment in a way that they understood, one respondent indicated 'sometimes', and one indicated 'never' to this question. Three respondents indicated that they found the information 'useful', one indicated 'partially', and one indicated 'no' to this question.

Five respondents indicated that they understood what their care plan was, and one did not. Three indicated that they were 'always' involved in setting goals for their individual care plans while two indicated 'sometimes' to this question and one did not want information on their careplan. Five of the respondents indicated that they knew their multi-disciplinary team members and one did not, with three indicating that they knew their keyworkers and three indicating they did not.

Five respondents indicated that they were always able to discuss worries or concerns with a member of staff with one respondent indicating, not being able to do so.

Five respondents felt there were enough leisure activities in the approved centre while one did not. Five respondents felt there were enough group activities during the day while one did not. Five respondents felt there were enough talking therapies if they needed them while one did not.
Four of the six respondents indicated that they were happy with how staff spoke with them, felt their privacy and dignity was respected and indicated that they could communicate freely with family, friends and the advocate.

Five of the six respondents indicated that they always felt safe in the approved centre.
Four respondents indicated that they were always able to give feedback to staff, and to make a complaint when they were not satisfied with any part of their stay. One said 'no' to this question and one did not know how to make a complaint to the staff.

General comments on the questionnaires included that the access to the exercise facilities and activities were good, that staff were lovely, that getting therapeutic leave and getting better were the most positive aspects of their experience at the approved centre.

General comments on the questionnaires also included suggestions such as providing access to a computer for the young people and always having things to do during the day as ways to improve the service provided. On a scale of 1–10, with 1 being poor and 10 being excellent for their overall experience of care and treatment at the approved centre, three residents rated it 7 out of 10, one resident rated it 8 out of 10 and two residents rated it 9 out of 10.

5.2 Advocacy

The approved centre had access to an independent advocacy service from Youth Advocate Programmes Ireland. The advocate attended the approved centre once a week in person and hosted an advocacy group with the young people. The group gave the young people an opportunity to raise any issues they had on the unit anonymously, to use the group as an opportunity to work on their own self-advocacy skills and to build confidence when communicating with staff.

The advocate also met with young people on a one-to-one basis as needed. This would usually be if the young person had any issues or questions that directly related to their own care. The young people could also contact the advocate by phone during the week for further support. This service was funded by the approved centre through the HSE.

A report from the advocate was received by the inspection team. It included information on advocate activities at the approved centre and how that is fed back into the service. Examples of this included how relationships could be built with staff through the medium of activities and how young people found this helpful especially when building up trust and confidence. The report outlined that staff were great at encouraging the young people to attend their weekly care plan review meetings and advising them how to

raise questions about their care plans, discharge dates or home leave for example. Staff at the approved centre informed the young people that they could have an advocate attend alongside them at their multi-disciplinary team (MDT) meeting.

The advocate accompanied some of the young people every week throughout their time in the approved centre whereas others got support initially until they started to feel confident to attend their MDT meeting on their own. The advocate reported that every young person they had worked with in this way had left the meeting with their questions answered.

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:

- Acting Registered Proprietor Nominee
- Area Director of Nursing
- Principal Psychologist
- Principal Social Worker
- Head of Pharmacy
- Executive Clinical Director / Clinical Director
- Director of Nursing
- Clinical Nurse Manager 3
- Senior Occupational Therapist
- Consultant Psychiatrist (2)
- Senior Dietitian Manager
- Clinical Nurse Manager 2 (2)
- Business Manager
- Administration Officer
- Quality Patient Safety Advisor

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

There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations and providing other health care services. The approved centre used medical record number, date of birth, photograph and names as identifiers. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. Dietetics developed meal plans which were informed by residents' needs, preference and choice. The approved centre used a three week menu cycle. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre.

Nutritional and dietary needs were assessed where necessary, with the use of an evidence based nutrition assessment tool and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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.

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 a supply of emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices where needed. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans. The residents were supported to manage and maintain their own laundry through the provision of internal laundry services.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2021.

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

A resident's personal property, possessions and monies were safeguarded when the approved centre assumed responsibility for them. Secure facilities including property presses and safes were provided for the safekeeping of the resident's monies and valuables, as necessary. Residents were supported to manage their own property, as appropriate.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. There was a full time activities coordinator on site. The timetable of activities included art, self-care, gym, social outings, couch to 5k, life skills, quiz, therapy dog visit and soccer. There were board games and art and craft supplies available to residents also. Residents provided input into the activities schedule.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. A multi-faith room was available to residents in the approved centre for their spiritual and religious needs. Ministers were arranged by request.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in September 2023.

Visiting times were appropriate and reasonable. There was a visitors room available where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting rooms were suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in September 2023.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents did not have access to their personal mobile phones, but a landline phone was available in the nurses' office and quiet room, and a mobile phone was provided for resident use for those who were on bed rest. There was no restriction on communication for any resident at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in September 2023, and included all requirements related to:

- The management and application of searches of a resident, their belongings and the environment in which they are accommodated.
- The consent requirements of a resident regarding searches.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property or the environment, as appropriate to the type of search being undertaken. As per the approved centre's search policy, routine searches were conducted on all residents when they returned from leave and from visits. The approved centre's search policy was based on the requirement to maintain a safe and therapeutic environment for all residents, but this process did not include an assessment of individual risk. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident’s dignity, privacy and gender. At least one of the staff members conducting the

search was the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both staff members who undertook the search and details of who was in attendance for the search. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances are found as a result of a search. Residents were given the opportunity to give feedback regarding their experience of the search in relation to their dignity and privacy.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in October 2022. As no resident had died in the approved centre since the last inspection, the regulation was inspected against policy requirements only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

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

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The ICPs were discussed, agreed where practicable and drawn up with the participation of the resident and their representative, family and next of kin, as appropriate. All ICPs inspected identified appropriate goals for the resident, the care and treatment required to meet goals, and the resources required to provide the identified care and treatment. The ICPs inspected were reviewed by the multi-disciplinary team (MDT) in consultation with the resident weekly.

However, in three individual care plans inspected following episodes of physical restraint, the care plans were not updated to reflect the resident's changing needs, condition and circumstances and in particular, the person's preferences in relation to restrictive interventions going forward.

The approved centre was non-compliant with this regulation because three individual care plans were not updated after being reviewed by their multi-disciplinary team. This meant that the individual care plans did not reflect the resident's changing needs, condition and circumstances.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). Residents had access to occupational therapy (OT), social work, psychology and dietetics on an individual basis as required.

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

The therapeutic services and activity programme included group and individual work which was planned, delivered and co-ordinated by the multi-disciplinary team (MDT). It included group and individual work with residents and family work with parents and siblings. The multi-disciplinary therapeutic programme was reviewed on a continuous basis with staff and residents through written and verbal feedback.

The therapeutic activity programme included: pet therapy, life skills, wellness recovery action planning (WRAP), decider skills, a self-esteem group, relaxation, dietary education, art therapy, newsletter group, self-care group and a social club for residents with an eating disorder. Individual work with residents included compassion focused therapy, meal support learning, emotion regulation, dialectical behaviour therapy (DBT) skills with eating disorders. Parent support groups on eating disorder and psychosis were also facilitated by the MDT.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

Child residents were assessed by a multi-disciplinary team (MDT) in relation to their educational requirements and with consideration of their individual needs and age on admission. Education appropriate to the needs and age of the child was provided by the approved centre and reflected the required educational curriculum.

Sufficient personnel resources were available for the provision of education. The approved centre had four teachers and four special-needs assistants and occupational therapy, social work and psychology attended the school. The young people's progress and evaluations were maintained in the school and a progress report on each student was written weekly and recorded in their Individual Care Plan.

Appropriate facilities were available for the provision of education, the approved centre had four classrooms available for the provision of education. There was also a sensory room, a practical room, a relaxation room and a newly renovated room which was used as a relaxation space, and it was decorated by an artist in conjunction with the students. There was a sensory garden. Residents had access to books, laptops, interactive screens and required materials.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in October 2022.

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

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a care of resident's general health policy which was last reviewed in September 2023. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

Residents received appropriate general health care interventions in line with their individual care plan. Residents' general health needs were monitored and assessed as indicated by their specific needs.
There were no residents in the approved centre for six months at the time of the inspection. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Access to the national screening programmes, could be facilitated for a resident where applicable to their needs.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Staff displayed professional, engaging and compassionate attributes in their interactions with residents. Residents were called by their preferred name based on their self-identification. Staff appearance and dress was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately 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 adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards were minimised. Ligature points were minimised to the lowest practicable level, based on risk assessment. The approved centre was kept in a good state of repair externally and internally. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic and free from offensive odours.

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

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in January 2024, and included the following requirements:

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

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

All entries in the MPARs were legible and included the signature of the medical practitioner or nurse prescriber for each entry. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in January 2024.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in January 2024.

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staffing were sufficient to meet resident needs at the current operational capacity.

The inpatient service comprised two multi-disciplinary teams. Each team included a consultant psychiatrist, non-consultant hospital doctor, social worker, psychologist, dietitian and nursing staff. Both teams utilised one occupational therapist. The speech and language therapy (SLT) post was vacant at the time of inspection; however, the interim SLT manager provided a consultative service until such point as the post will be filled. There were eight vacancies in the nursing staffing numbers at the time of inspection. This was managed in part through use of overtime and agency staffing and due to the fact that the approved centre was operating at a reduced bed capacity of 12 beds due to ongoing building works.

Not all healthcare staff had completed mandatory training in basic life support, safeguarding, fire safety, and the management of violence and aggression. Not all healthcare staff were trained in the Mental Health Act 2001. Not all mandated individuals were trained in Children First. However, the approved centre had a staff training co-ordinator and a mandatory training plan for the coming months that was provided to the inspection team and would, when implemented, ensure full compliance with mandatory training requirements. The approved centre also had a number of on-site trainers for the areas of mandatory training.

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

The following is a table of staff showing the numbers and percentages of staff trained in the mandatory training topics at the time of inspection:

Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (31)	30	100%	27	87%	26	86%	29	94%	30	97%	12	39%
Medical (6)	4	67%	4	67%	3	50%	5	83%	6	100%	2	33%
Occupational Therapist (1)	0	0%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	2	100%	2	100%	1	50%	2	100%	2	100%	0	0%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	1	50%
Dietitian (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in March 2023.

Resident records were kept in good order and were up to date with no loose pages present. All records were maintained in a manner to ensure security, completeness, accuracy and ease of retrieval. Residents' records were developed and maintained in a logical sequence. Throughout the approved centre, records were appropriately secured from loss, destruction, tampering or unauthorised access. Documentation of food safety, health and safety and fire inspections were maintained in the approved centre.

The approved centre was non-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 all residents admitted to the approved centre. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in September 2023 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in January 2024. The risk management policy addressed all requirements including:

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

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate 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 with one condition to registration attached. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

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

The policy addressed:

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

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

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

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

Monitoring: There were no seclusion episodes since in the approved centre since the last inspection. There was a multi-disciplinary review and oversight committee established and available to analyse any future episode of seclusion.

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

The seclusion facilities were not furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's privacy was respected. The outside of the seclusion room window had no frosting or privacy film, which meant it was possible for individuals on the outside of the seclusion room window to see into the seclusion room.

The seclusion room did not have an anti-barricade door. The seclusion room did not have externally controlled heating and air conditioning, which did not enable those observing any person in seclusion to monitor the seclusion room temperature. The seclusion room did not have a clock that displayed the time, day and date visible to a person in seclusion, instead the clock in the seclusion room only displayed the time. The seclusion suite did not provide access to suitable sanitary facilities as there was no shower in the seclusion bathroom facilities, only a sink and toilet.

Order of Seclusion: No episodes of seclusion had taken place since the last inspection.

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

a) **The seclusion suite did not provide access to suitable sanitary facilities, 8.2.**
b) **The seclusion room did not have externally controlled heating and air conditioning to enable those observing the person to monitor the room temperature, 8.1(v).**
c) **The seclusion facilities were not furnished in such a way that ensured the person's inherent right to personal dignity and the seclusion room did not ensure that the person's privacy was respected as the window in the seclusion room to the outside area did not prevent observation of a patient in seclusion from the outside, 8.1.**
d) **The seclusion room did not have a clock that displayed the time, day and date visible to a person in seclusion, 8.1(viii).**
e) **The seclusion room did not have an anti-barricade door, 8.1(iii).**

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated September 2023. It addressed:

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

Policies and procedures regarding staff training included:

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

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

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

Training and Education: There was not a written record to indicate that all staff involved in the use of physical restraint had read and understood the policy. All staff members involved in the use of physical restraint had not undertaken appropriate training in accordance with the policy.

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

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

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

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

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

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

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

The physical restraint in each instance was ended by the person who had lead it. The child's parent or guardian was informed as soon as possible of the PR and the circumstances which led to it. The parent or guardian was informed when the episode of PR ended. The approved centre had child protection policies and procedures in place that were in line with relevant legislation and regulations. The approved centre had a policy and procedures in place addressing appropriate training for staff in relation to child protection.

The following were found on inspection of the recording and implementation of the use physical restraints in the approved centre:

- The reason for ending the physical restraint was not recorded in the clinical file of one resident.
- An in-person debrief with the person who was restrained did not follow the episode of physical restraint for two residents.
- In the one episode of physical restraint where a debrief had taken place, the in-person debrief did not include a discussion regarding the person's preferences in the event where a restrictive intervention would be needed in the future, the debrief did not give the person the option of having their representative or nominated support person attend the debrief with them and the individual care plan was not updated to reflect the outcome of the debrief.

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

a) **The reason for ending the physical restraint was not recorded in the clinical file of one resident, 5.2.**
b) **An in-person debrief with the person who was restrained did not follow the episode of physical restraint for two residents, 5.3.**
c) **In the one episode of physical restraint where a debrief had taken place, the in-person debrief did not include a discussion regarding the person's preferences in the event where a restrictive intervention would be needed in the future, 5.3(v).**
d) **In the one episode of physical restraint where a debrief had taken place, the debrief did not give the person the option of having their representative or nominated support person attend the debrief with them, 5.3(vi).**
e) **In the one episode of physical restraint where a debrief had taken place, the individual care plan was not updated to reflect the outcome of the debrief, 5.5.**
f) **There was not a documented written record to indicate that all staff involved in the use of physical restraint had read and understood the policy, 7.2(b).**
g) **All staff members involved in the use of physical restraint had not undertaken appropriate training in accordance with the policy, 8.2.**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

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

Transfer: The transfer policy, which was last reviewed in October 2022, included all the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2023, included all the policy-related criteria for this code of practice.

Training and Education: There was not a written record to indicate that all 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 resident had been admitted on the basis of a mental illness or mental disorder. An admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, a risk assessment, work situation, dietary requirements and education. A key worker system was in place, and a full physical examination was carried out. A family member or carer was involved in the admission process with the resident's consent.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a reference to early warning signs of relapse and other risks and documented communications with the relevant general practitioner, and the community Child and Adolescent Mental Health Team (CAMHS). A discharge meeting with the

treating multi-disciplinary team took place. The discharge assessment was coordinated by a key worker and addressed the resident's psychiatric and psychological needs. It contained a comprehensive risk assessment and risk management plan.

A preliminary discharge summary was sent to the general practitioner and the community Child and Adolescent Mental Health Team (CAMHS) within three days. A comprehensive discharge summary was issued within 14 days. The comprehensive discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues and risk issues such as signs of relapse. A family member was involved in the discharge process.

The approved centre was non-compliant with this code of practice because there was not documentary evidence to indicate that relevant staff had read and understood the admission, transfer and discharge policies, 9.1.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10005422		**Three individual care plans were not updated after being reviewed by their multi-disciplinary team. This meant that the individual care plans did not reflect the resident's changing needs, condition and circumstances.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All 3 ICP's had not been updated post restraint to highlight the residents changing needs. Since the inspection a Restraint care pathway has been put in place, this includes a prompt to ensure that the ICP has been updated to reflect the residents changing needs. There has also been a new ICP document put in place, as previously there were 2 ICP's between 2 teams, this allowed for non transparency to utilize the documents, and potential for mistakes. The new document is being	Through the Use of Audit	This is a realistic and achievable measure, no barriers identified	31/12/2024	Both Consultants and CNM's

	used by all clinical staff, it has been stream lined and easier to input any updates such as Post restraint ICP updates.				
Preventative Action	All 3 ICP's had not been updated post restraint to highlight the residents changing needs. Since the inspection a Restraint care pathway has been put in place, this includes a prompt to ensure that the ICP has been updated to reflect the residents changing needs. There has also been a new ICP document put in place, as previously there were 2 ICP's between 2 teams, this allowed for non transparency to utilize the documents, and potential for mistakes. The new document is being used by all clinical staff, it has been	Through the Use of Audit	This is a realistic and achievable measure , no barriers identified	31/12/2024	Both Consultants and CNM's

	stream lined and easier to input any updates such as Post restraint ICP updates.				

Rules Governing the Use of Seclusion					
Reason ID : 10005430		**The seclusion suite did not provide access to suitable sanitary facilities, 8.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is current a new seclusion room build in progress. Due for completion and handover in October 2024	Rachel O' Shaughnessy CNM3 link person for the service to oversee requirements are being met.	Achievable	31/10/2024	Building contractors - Hollyfort
Preventative Action	There is a toilet beside the current seclusion room which is the current practice. The Patient is not deprived of their right to utilize the facilities. Based on a risk assessment, the patient in seclusion can be offered a shower in one of our shower facilities. There is current a new seclusion room build in progress which includes suitable facilities within the seclusion room. Due for completion and handover in October 2024	Rachel O' Shaughnessy CNM3 link person for the service to oversee requirements are being met.	Achievable	31/10/2024	Building contractors - Hollyfort

Reason ID : 10005431		The seclusion room did not have externally controlled heating and air conditioning to enable those observing the person to monitor the room temperature, 8.1(v).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is current a new seclusion room build in progress. Due for completion and handover in October 2024	Rachel O' Shaughnessy CNM3 , HSE link person to ensure requirements are being met.	Realistic and Achievable	31/10/2024	Building Contractors - Hollyfort
Preventative Action	There is current a new seclusion room build in progress. Due for completion and handover in October 2024	Rachel O' Shaughnessy CNM3 , HSE link person to ensure requirements are being met.	Achievable and realistic	30/10/2024	Building Contractors - Hollyfort
Reason ID : 10005432		**The seclusion facilities were not furnished in such a way that ensured the person's inherent right to personal dignity and the seclusion room did not ensure that the person's privacy was respected as the window in the seclusion room to the outside area did not prevent observation of a patient in seclusion from the outside, 8.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion room currently in the middle of a new build project. As a component of this privacy will be ensured, the furnishing will meet all the requirements of a seclusion room as outlined in the rules governing the use of seclusion 2022	Rachel O' Shaughnessy CNM3 , HSE link person to ensure requirements are being met.	Achievable	31/10/2024	Rachel O' Shaughnessy CNM3

Preventative Action	Seclusion room currently in the middle of a new build project. As a component of this privacy will be ensured, the furnishing will meet all the requirements of a seclusion room as outlined in the rules governing the use of seclusion 2022 In the interim we have applied privacy film to the current seclusion room to ensure that privacy and dignity is maintained whilst a patient is inside the seclusion room.	Rachel O' Shaughnessy CNM3 ,	Achievable	30/10/2024	Rachel O' Shaughnessy CNM3
Reason ID : 10005433		**The seclusion room did not have a clock that displayed the time, day and date visible to a person in seclusion, 8.1(viii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The new seclusion room on completion will have all the requirements as outlined in the rules governing the use of seclusion including a clock displaying the time , day and date.	the clock has been provided, no monitoring necessary.	Achieved	05/07/2024	Rachel O' Shaughnessy CNM3

	Additionally a clock containing the time day and date has been added to the existing seclusion room.				
Preventative Action	The new seclusion room on completion will have all the requirements as outlined in the rules governing the use of seclusion including a clock displaying the time , day and date. Additionally a clock containing the time day and date has been added to the existing seclusion room.	the clock has been provided, no monitoring necessary.	Achieved	05/07/2024	Rachel O' Shaughnessy CNM3
Reason ID : 10005434		**The seclusion room did not have an anti-barricade door, 8.1(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	This is on a point of correction, our current seclusion has an Antibarricade door and once the build is complete.The new seclusion room will have an anti barricade door	Rachel O Shaughnessy is the HSE link person , she will oversee that all requirements are met including the installation of an anti barricade door	Achievable	31/10/2024	Contractors - Hollyfort
Preventative Action	The current seclusion room does have an	Rachel O Shaughnessy is the	Avhievable	31/10/2024	Contractors - Hollyfort

	anti barricade door. The new seclusion room once completed in October will also have an anti barricade door	HSE link person , she will oversee that all requirements are met including the installation of an anti barricade door			

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10005423		**The reason for ending the physical restraint was not recorded in the clinical file of one resident, 5.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There has been a new Restraint care pathway implemented to prompt all required elements of documentation during and post restraint. this will eliminate any further failures to document the requirements as set out in the regulations. Staff will receive training on the required documentation from our training Co-ordinator	Through the use of audit	No barriers identified in achieving this goal. This is an achievable goal.	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe Training Co-ordinator
Preventative Action	There has been a new Restraint care pathway implemented to prompt all required elements of documentation during and post restraint. this will eliminate any further	Through the use of audit	No barriers identified in achieving this goal. This is an achievable goal.	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe Training Co-ordinator

	failures to document the requirements as set out in the regulations. Staff will receive training on the required documentation from our training Co-ordinator				
Reason ID : 10005424		**An in-person debrief with the person who was restrained did not follow the episode of physical restraint for two residents, 5.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The new Restraint care pathway has within it a tool for the debrief know as the Bevan Incident debrief tool- Post Physical Restraint debrief. Again this is a prompt for staff to conduct the debrief, and within it are the required headings for discussion within the debrief. Training on the restraint care pathway will be conducted by the training Co-ordinator with all current staff who complete the document, and all new staff who enter	Through the use of documentation audit	This is achievable and realistic. No barriers identified	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe - Training Co-ordinator

	the service who will be required to complete the document.				
Preventative Action	The new Restraint care pathway has within it a tool for the debrief know as the Bevan Incident debrief tool- Post Physical Restraint debrief. Again this is a prompt for staff to conduct the debrief, and within it are the required headings for discussion within the debrief. Training on the restraint care pathway will be conducted by the training Co-ordinator with all current staff who complete the document, and all new staff who enter the service who will be required to complete the document.	Through the use of documentation audit	This is achievable and realistic. No barriers identified	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe - Training Co-ordinator
Reason ID : 10005425		**In the one episode of physical restraint where a debrief had taken place, the in-person debrief did not include a discussion regarding the person's preferences in the event where a restrictive intervention would be needed in the future, 5.3(v).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The new Restraint care pathway has within it a tool for the debrief called the Bevan Incident debrief tool- Post Physical Restraint debrief. Again this is a prompt for staff to conduct the debrief, and within it are the required headings by the MHC for discussion ie negotiated forward plan: including patient preferences for restrictive interventions they would NOT like to be used in the future where the discussion within the debrief. Training on the restraint care pathway will be conducted by the training Co-ordinator with all current staff who complete the document, and all new staff who enter the service who will be required to	Through the use of documentation audit	This is an achievable measure. No barriers identified	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe CNM 2 Training Co-ordinator

	complete the document.				
Preventative Action	The new Restraint care pathway has within it a tool for the debrief called the Bevan Incident debrief tool- Post Physical Restraint debrief. Again this is a prompt for staff to conduct the debrief, and within it are the required headings by the MHC for discussion ie negotiated forward plan: including patient preferences for restrictive interventions they would NOT like to be used in the future where the discussion within the debrief. Training on the restraint care pathway will be conducted by the training Co-ordinator with all current staff who complete the document, and all new staff who enter	Through the use of documentation audit	This is an achievable measure. No barriers identified	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe CNM 2 Training Co-ordinator

	the service who will be required to complete the document.				
Reason ID : 10005426		**In the one episode of physical restraint where a debrief had taken place, the debrief did not give the person the option of having their representative or nominated support person attend the debrief with them, 5.3(vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The new Restraint care pathway has within it a tool for the debrief called the Bevan Incident debrief tool- Post Physical Restraint debrief. Again this is a prompt for staff to conduct the debrief, and within it are the required headings by the MHC for discussion ie patient present for debrief, and representative present for debrief. Training on the restraint care pathway will be conducted by the training Co-ordinator with all current staff who complete the document, and all new staff who enter	Through the use of documentation audit	This is an achievable measure. No identified barriers	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe CNM2 Training Co-ordinator

	the service who will be required to complete the document.				
Preventative Action	The new Restraint care pathway has within it a tool for the debrief called the Bevan Incident debrief tool- Post Physical Restraint debrief. Again this is a prompt for staff to conduct the debrief, and within it are the required headings by the MHC for discussion ie patient present for debrief, and representative present for debrief. Training on the restraint care pathway will be conducted by the training Co-ordinator with all current staff who complete the document, and all new staff who enter the service who will be required to complete the document.	Through the use of documentation audit	This is an achievable measure. No identified barriers	31/12/2024	Rachel O' Shaughnessy CNM3 Brendan Harlowe CNM2 Training Co-ordinator

Reason ID : 10005427		In the one episode of physical restraint where a debrief had taken place, the individual care plan was not updated to reflect the outcome of the debrief, 5.5.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Since the inspection a Restraint care pathway has been put in place, this includes a prompt to ensure that the ICP has been updated to a prompt the outcome of the debrief There has also been a new ICP document put in place, as previously there were 2 ICP's between 2 teams, this allowed for non transparency to utilize the documents, and potential for mistakes. The new document is being used by all clinical staff, it has been stream lined and easier to input any updates such as Post restraint ICP Debrief updates updates.	Through the use of documentation audit	This is a realistic measure . No barriers identified	31/12/2024	Both Consultants and CNM's
Preventative Action	Since the inspection a Restraint care	Through the use of documentation audit	This is a realistic measure . No barriers identified	31/12/2024	Both Consultants and CNM's

	pathway has been put in place, this includes a prompt to ensure that the ICP has been updated to a prompt the outcome of the debrief There has also been a new ICP document put in place, as previously there were 2 ICP's between 2 teams, this allowed for non transparency to utilize the documents, and potential for mistakes. The new document is being used by all clinical staff, it has been stream lined and easier to input any updates such as Post restraint ICP Debrief updates updates.				
Reason ID : 10005428		**There was not a documented written record to indicate that all staff involved in the use of physical restraint had read and understood the policy, 7.2 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	When Policies have been updated, all staff will be notified directly by email as is	Monthly checks of signature banks	This is achievable, however the barrier identified is staff on long term leave/sick leave might miss the reminders.	31/12/2024	Rachel O' Shaughnessy CNM3

	the current process, in addition to this staff will be advised at handovers and policy folders will made available at these times as well as documenting reminder in daily nursing diary. There will be prompter labels left on the front of policy folders also to remind staff which policies require reading and signing		They will however have an email prompt		
Preventative Action	When Policies have been updated, all staff will be notified directly by email as is the current process, in addition to this staff will be advised at handovers and policy folders will made available at these times as well as documenting reminder in daily nursing diary. There will be prompter labels left on the front of policy folders also to remind staff	Monthly checks of signature banks	This is achievable, however the barrier identified is staff on long term leave/sick leave might miss the reminders. They will however have an email prompt	31/12/2024	Rachel O' Shaughnessy CNM3

	which policies require reading and signing				
Reason ID : 10005429		**All staff members involved in the use of physical restraint had not undertaken appropriate training in accordance with the policy, 8.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Since the inspection , there has been an identified Training Co-ordinator whos role is solely to organize training and all it encompasses. He will be able to oversee the training register, identify the specific training needs and organize Therapeutic Management of Violence Training reflective of staff members who require the training Next Training of TMV on 08.08.24, outstanding staff have been invited onto this	Active Training Register- Training needs easily identified. Training plan can be created around this.	Realistic, however as always there are staff on long term leave/sick leave that may miss the training on the dates they are carried out. They will be invited onto the next available training.	31/12/2024	Brendan Harlowe CNM2 Training Co-ordinator.
Preventative Action	Since the inspection , there has been an identified Training Co-ordinator whos role is solely to organize training and	Active Training Register- Training needs easily identified. Training plan can be created around this	Realistic, however as always there are staff on long term leave/sick leave that may miss the training on the dates they are carried out.	31/12/2024	Brendan Harlowe CNM2 Training Co-ordinator.

	all it encompasses. He will be able to oversee the training register, identify the specific training needs and organize Therapeutic Management of Violence Training reflective of staff members who require the training Next Training of TMV on 08.08.24, outstanding staff have been invited onto this		They will be invited onto the next available training.		

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10005421		**There was not documentary evidence to indicate that relevant staff had read and understood the admission, transfer and discharge policies, 9.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	When Policies have been updated, all staff will be notified directly by email as is the current process, in addition to this staff will be advised at handovers and policy folders will made available at these times as well as documenting reminder in daily nursing diary. There will be prompter labels left on the front of policy folders also to remind staff which policies require reading and signing	Rachel O' Shaughnessy will oversee same, and conduct monthly checks to ensure policies have been signed.	Barriers to this implementation is where there are staff on annual leave, sick leave, long term leave. However, they will receive the email advising them of the updated policies. Otherwise it is acheievable.	31/12/2024	Rachel O' Shaughnessy CNM3
Preventative Action	When Policies have been updated, all staff will be notified directly by email as is the current process, in addition to this staff will be advised at handovers and policy folders will	Rachel O' Shaughnessy will oversee same, and conduct monthly checks to ensure policies have been signed.	Barriers to this implementation is where there are staff on annual leave, sick leave, long term leave. However, they will receive the email advising them of the updated policies. Otherwise it is acheievable.	31/12/2024	Rachel O' Shaughnessy CM3

	made available at these times as well as documenting reminder in daily nursing diary. There will be prompter labels left on the front of policy folders also to remind staff which policies require reading and signing				

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.

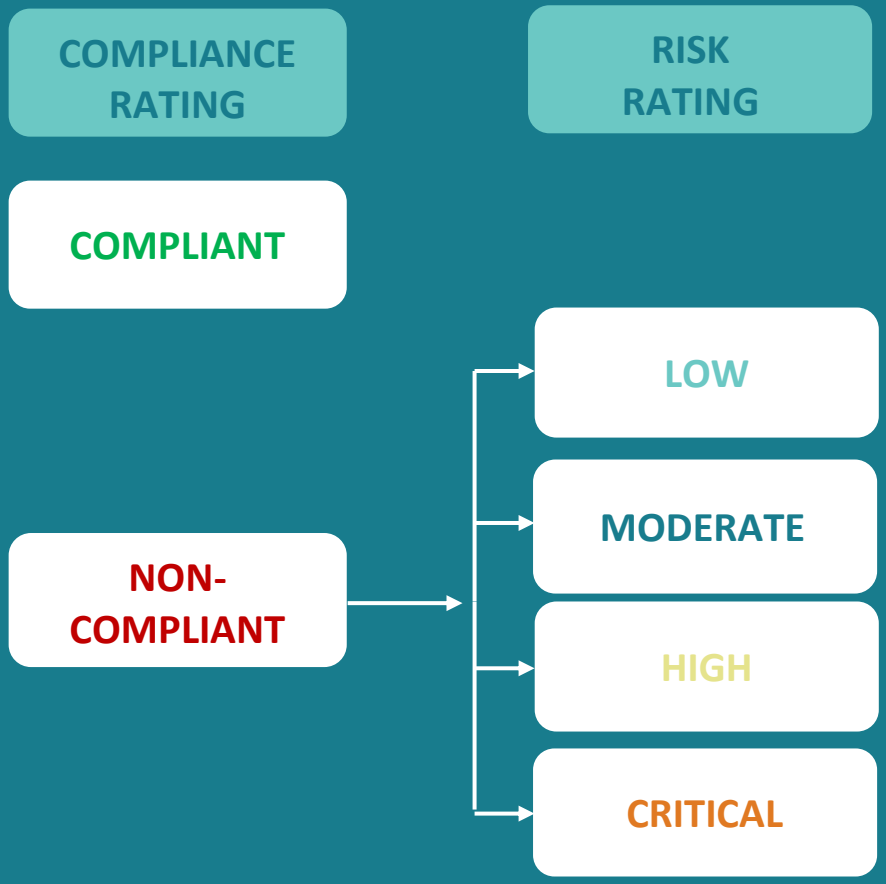
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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