Mental Health Commission finds one critical and twelve high risk ratings in three out of four mental health centres

6 January 2020: The Mental Health Commission (MHC) has today published four inspection reports from approved centres in Cork, Dublin, and Clare which identified one critical and twelve areas of high risk non-compliance in three of the four centres.

Commenting on the reports, Dr Susan Finnerty, Inspector of Mental Health Services, said: "Three of the inspection reports released today had high risk ratings for lack of individual care planning. The individual care plan is central to recovery for service users. An individual care plan allows service users to have an active role in decisions about their care, in conjunction with their multidisciplinary team. Under regulation, service users have a right to be involved in their own individual care plan. This is one of the fundamental standards of mental health care and leads to better outcomes." It is encouraging, however, to see that three approved centres have significantly increased the number of compliances over a three year period.

Jonathan Swift Clinic St James Hospital, Dublin 8 is a 32-bed acute adult located within the St. James's Hospital campus. The unit consists of three wards, with a total bed capacity of 47: Connolly Norman, a 9-bedded acute admissions unit for the care of older persons; Beckett Ward, a 16-bedded step down, pre-discharge unit; and William Fownes Ward, with 22 acute admission beds. All three wards shared a small internal garden on the ground floor; however, only residents in Beckett Ward had unrestricted access to this garden.

Due to the cramped environment and lack of access to outside space, the approved centre was unsuitable as an inpatient mental health unit; however, the service had worked hard to improve the existing conditions offered to residents, insofar as the structure allowed. This is evidenced by the year on year increase in compliance with regulations: 52% compliance in 2017; 70% in 2018; and 75% compliance in 2019. Five compliances with regulations were rated as excellent.

There was one condition attached to the registration of this approved centre at the time of inspection related to premises. Although the approved centre provided a progress report on the programme of maintenance, it was non-compliant and in breach of this condition.

The Mental Health Commission have been made aware of the medium to long term plans to address the condition of registration and are updated on a three monthly basis of any progress in this area. The next premises condition update is due in January 2020. The approved centre has ordered new furnishings which will enhance the environment, maximise space and minimise clutter in dormitory rooms. The expected date of delivery is February 2020.

The approved centre had one critical risk rating for premises and four high risk non compliances for individual care planning, the administration of medicines and risk management.

The premises lacked outdoor space on Fownes Ward, which was located on the first floor. Residents requiring supervision when accessing the downstairs courtyard area were dependent on the availability of a nurse to accompany them. Both residents and staff stated that planned time outside of the unit was often cancelled if something urgent arose. Residents expressed their frustration to the inspection team concerning the resulting limitation in outdoor access. While measures had been implemented to facilitate access, this was not monitored, resulting in access that was limited and not guaranteed for certain residents. This presented a serious risk to a resident's quality of life and the therapeutic environment.

The approved centre was not kept in a good state of repair externally and internally and was not clean, hygienic and free from offensive odours. Two sinks were blocked, two showers had cigarette burns, the floors of the dining rooms were marked, a ceiling tile had become dislodged in a dormitory, the ceiling in one of the shower rooms was dirty and discoloured, cigarette ash was found on the windowsill of the family room, and there was a consistent pervasive smell of cigarette smoke on Fownes Ward through each day of the inspection. While there was a programme of general maintenance and cleaning, there was no programme of decorative maintenance.

The four bedded rooms on Fownes Ward and the six bedded dorm on Beckett Ward were cramped and did not allow for resident privacy. Noticeboards detailing resident information located in both Beckett and Connolly Norman Ward offices were visible from corridors through door observation panels. The noticeboard in Beckett Ward office was moved during the inspection.

The risk of fire due to cigarette smoking on the wards was not documented within the local risk register, however it was included as a risk assessment within the safety statement. Various control measures were outlined to minimise this risk, but the problem of smoking continued on some of the wards. There were 82 incident reports documenting smoking on the wards since the last inspection. Additionally interviews with residents, the continuous smell of cigarette smoke throughout the inspection, and the finding of ash in sinks and stub marks on windowsills highlighted the problem. This risk assessment was reviewed on an annual basis only and was therefore not being regularly reviewed or monitored by the local management team to a degree which the problem indicated.

The centre was high risk rated for individual care planning. Although each resident had an individual care plan, the plans did not identify the residents' assessed needs. Five of ten care plans inspected did not document appropriate goals. Four plans did not document care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Half of the care plans reviewed did not document the resources required to provide care and treatment.

As there was no designated dietitian in the centre, the needs of residents identified as having special nutritional requirements were not regularly reviewed. An evidence-based nutritional tool was not used.

Cappahard Lodge, Ennis Co Clare is located in an urban area on the outskirts of Ennis town. It was formerly a nursing home and had single bedroom accommodation for all the residents. Most of the residents lived in the approved centre for a number of years. The approved centre was registered for 32 beds but had 15 residents at the time of admission.

Cappahard Lodge accepted transfer of residents from the Acute Psychiatric Unit (APU) to provide sleeping accommodation, in order to alleviate bed shortages in the APU. Cappahard Lodge is not suitable to provide care for acutely mentally ill people.

The approved centre had demonstrated impressive improvement in compliance with regulations over the previous 3 years: 65% compliance in 2017; 90% in 2018 and 93% compliance in 2019. There were 15 compliances with regulations rated as excellent.

There was one condition attached to the registration related to staffing requiring the centre to implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The centre was both non-compliant and in breach of this condition.

Cappahard Lodge have submitted a plan to the Mental Health Commission to address training deficits by reviewing educational and training needs and providing monthly training sessions.

The approved centre was under the governance of the Mid West Mental Health Service Management team which encompassed counties Limerick, Clare and North Tipperary.

There was an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Safety Meeting held monthly for the wider service. However, the centre did not hold regular business meeting and documents evidenced that the rehabilitation team business meeting had not taken place in 2019.

There was no system of performance appraisal for staff in the approved centre. Instead, it was reported that performance issues were addressed through clinical supervision. Staffing shortages were acknowledged as an ongoing challenge; however, this was mitigated for nursing with the use of overtime and agency staff. There was no social worker or psychologist on the psychiatry for old age team.

St Vincents Hospital, Fairview, Dublin 3 is a public voluntary hospital. The main building, a former convent, dated from 1899 and various extensions had been added throughout the twentieth century. The approved centre had three units: St. Louise's ward, a 30-bed admission unit serving the north city area from Clontarf to Ballymun, a 6-bed psychiatry of old age admission unit, and St. Mary's ward, a 9-bed continuing care facility.

St. Vincent's Hospital has shown a steady increase in compliance over the past three years: 62% compliance in 2017; 76% compliance in 2018; and 80% compliance in 2019. Eleven compliances with regulations were rated excellent, compared with two in 2018.

At the time of the inspection the centre had two high risk non-compliances related to individual care planning and premises.

There was one condition attached to the registration related to the administration of medicines. The centre was not in breach of this condition, however it was non-compliant at the time of the inspection.

The centre was not kept in a good state of repair inside and out. The building was over 100 years old, and a number of non-clinical areas were in a poor state of repair. There was no programme of decorative maintenance, and any decorative work was reactionary to faults and issued raised. Two areas outside contained old equipment which was potentially hazardous. The centre addressed this issue at the time of the inspection by putting the equipment into a skip. There was a loose stone slab on the grass area outside. Rooms were not ventilated and two bathrooms were malodourous at the time of the inspection, one of which had a recently installed extractor fan. There were no dedicated therapy or examination rooms. Appropriate signage and sensory aids were not provided to support residents' orientation needs, with a number of rooms incorrectly signposted. The pharmacy dispensing room of St. Louise's ward was incorrectly signposted with the title 'Kitchenette'. The centre had a designated sluice room in the psychiatry of old age ward but not in St. Mary's ward or St. Louise's ward.

Numerous potential ligature points were observed throughout the approved centre. Continuous works were underway to minimise these; however, at the time of the inspection, ligature points had not been minimised.

The centre was not compliant with individual care planning. This was the third successive year that the centre had been non-compliant with this regulation. The individual care plans of ten residents were inspected. In three care plans inspected, there was no evidence that the individual care plans had been prepared and developed within seven days of admission. A specific key worker was not identified in all plans inspected to ensure continuity of implementation. One individual care plan did not contain specific, accurate, and appropriately defined goals. Two plans did not identify the interventions required to meet the goals identified. Two did not identify the resources required to provide the care and treatment identified and six were not consistently reviewed by the multi-disciplinary team in consultation with the resident on a weekly basis. Additionally resident involvement in their care plans was not consistently documented, and there was no associated explanation documented for those that were not involved.

Residents' general health needs were not monitored and assessed at least every six months in two out of five clinical files inspected. Residents' body mass index, weight and waist circumference were not checked and recorded in four cases. Family and personal history were not recorded in four cases. Smoking and nutritional status was not documented in one case.

Staff were not trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. Staff were not trained in dementia care, end of life care, resident rights, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults.

A significant organisational risk cited within the risk register was the lack of adherence to governance and reporting relationships in the hospital by some unidentified parties. This could occur when persons with no contractual accountability to St. Vincent's Hospital engaged outside of the agreed governance structure.

At the time of inspection, there was no social worker present on the team for six weeks. Funding for a locum social worker was approved; however, recruitment was unsuccessful (emergency cover from disciplines within the admitting community teams was also unavailable). Health and social care professionals within these community teams were under HSE management and were only permitted to attend the approved centre for the purposes of pre-discharge planning. Service managers acknowledged that short-term staff replacement was challenging for the service.

St Catherine's Ward, St. Finbarr's Hospital is located in Cork city. The buildings dates back to the mid 1800's and in recent years a significant refurbishment of St. Catherine's had been completed. The resident profile was described by staff as a mix between continuing care and rehabilitation although neither of these specialities were available to the residents. There were 18 residents in the centre for more than six months at the time of the inspection.

There has been no improvement in the rate of compliance with regulations from 2017 to 2019, remaining poor at 62%. There was continuing non-compliance over three years with individual care planning, general health, premises, staffing, and maintenance of records. Two compliances with regulations were rated as excellent. The inspection process identified six high risk non compliances in the areas of: food and nutrition, individual care planning, general health, privacy and maintenance of records.

There are three conditions attached to the registration: individual care planning, staffing to ensure all healthcare professionals were up-to-date in mandatory training areas and staffing to ensure that residents had access to suitably qualified speech and language therapist, and dietitian. The approved

centre was not in breach of these conditions. However, it remained non-compliant in individual care planning which was rated as high risk.

There were a significant number of deficits in the 10 individual care plans inspected. The individual care plan did not include a risk management plan in five of the 10 care plans reviewed. Eight care plans reviewed did not specify appropriate goals for the residents. Four were not a composite set of documentation. One did not specify the treatment and care required. Seven had not been regularly reviewed and updated by the resident's multi-disciplinary team, in consultation with each resident. For seven residents it was not evidenced that they had been offered a copy of their own care plan.

For residents with special dietary requirements, an evidence-based nutrition assessment tool had not been used. Nutritional and dietary needs had not all been assessed, where necessary, and had not all been addressed in residents' individual care plans. The needs of residents identified as having special dietary requirements had not been reviewed by a dietitian.

In terms of general health two of five clinical files inspected indicated that the resident had not received a physical examination within the previous six-month timeframe. The nutritional status had not been documented in any of the five clinical files inspected. One of five had not had an assessment of dental health. Adequate arrangements were not in place for residents to access general health services and for their referral to other health services, as required. The clinical files were not all maintained in good order as there were loose pages in a number of files reviewed. This had the potential to compromise patient confidentiality.

Residents' privacy and dignity was not respected. Single bedrooms, did not have locks on the inside of the door. The residents could not use their bedrooms, located downstairs, from early morning until approximately 10pm at night. If a resident preferred to sleep during this time they did so in an armchair.

The approved centre was not kept in a good state of repair throughout internally. Some of the bedrooms were in a poor state and there were holes on some of the walls in the day area.

All four approved centres introduced quality initiatives which were identified on inspection. In St Catherine's ward they provided a weekly psychology led and a social work therapeutic group. The Jonathan Swift Clinic redesigned and decorated the Connolly Norman Ward sitting room to ensure a user friendly and homely environment through collaboration between the Occupational Therapy department and The Dementia Services Information and Development Centre. In Cappahard Lodge, in Ennis they introduced a weekly GP clinic for non-emergency consultations and in St Vincent's Hospital, Fairview they introduced a new proforma booklet for the purposes of documenting individual seclusion episodes.

The Chief Executive of the Mental Health Commission, John Farrelly said "Governance was identified as an issue in two centres published today and risk management issues highlighted in another approved centre. This is unacceptable to the Mental Health Commission. Healthcare teams must be accountable for the quality, safety and satisfaction of patients in the care they deliver.

"The continued practice identified in one centre, of a transfer of residents from an acute psychiatric unit to provide sleeping accommodation in order to alleviate bed shortages, on a systemic basis, is an outdated and obsolete practice that is not acceptable in a modern service. This was permitted under the old 1945 Act but has long been rejected as a practice in providing care for acutely mentally ill people." said Chief Executive of the Mental Health Commission, John Farrelly.

Ends

1. **Jonathan Swift Clinic St James Hospital, Dublin 8**
   https://www.mhcirl.ie/File/2019IRs/JonathanSwiftClinic_IR2019.pdf

Jonathan Swift Clinic St James Hospital, Dublin 8 is a 32-bed acute adult located within the St. James's Hospital campus. The unit consists of three wards, with a total bed capacity of 47: Connolly Norman, a 9-bedded acute admissions unit for the care of older persons; Beckett Ward, a 16-bedded step down, pre-discharge unit; and William Fownes Ward, with 22 acute admission beds. All three wards shared a small internal garden on the ground floor; however, only residents in Beckett Ward had unrestricted access to this garden.

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

Condition 1: To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 5: Food and Nutrition	✓		✓		✗	Moderate
Regulation 15: Individual Care Plan	✗	Moderate	✓		✗	High
Regulation 21: Privacy	✗	Moderate	✗	Moderate	✗	High
Regulation 22: Premises	✗	Critical	✗	High	✗	Critical
Regulation 23: Ordering, Prescribing, Administration of Medicines	✗	High	✗	Moderate	✗	High
Regulation 26: Staffing	✗	Critical	✗	Moderate	✗	Moderate
Regulation 32: Risk Management Procedures	✗	High	✓		✗	High
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Moderate	✗	Low	✗	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.

Areas of compliance rated "excellent" on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions

Regulation 11: Visits
Regulation 13: Searches
Regulation 29: Operating Policies and Procedures

2. **Cappahard Lodge, Ennis Co Clare**
   https://www.mhcirl.ie/File/2019IRs/Cappahard_Lodge_IR2019.pdf

Cappahard Lodge, Ennis Co Clare is located in an urban area on the outskirts of Ennis town. It was formerly a nursing home and had single bedroom accommodation for all the residents. Most of the residents lived in the approved centre for a number of years. The approved centre was registered for 32 beds but had 15 residents at the time of admission.

Cappahard Lodge accepted transfer of residents from the Acute Psychiatric Unit (APU) to provide sleeping accommodation, in order to alleviate bed shortages in the APU. Cappahard Lodge is not suitable to provide care for acutely mentally ill people.

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

Condition 1: To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 22: Premises	✗	Moderate	✗	High	✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	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.

Areas of compliance rated “excellent” on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents’ Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 14: Care of the Dying
Regulation 18: Transfer of Residents

Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 31: Complaints Procedures

3. **St Vincents Hospital, Fairview, Dublin 3**
   https://www.mhcirl.ie/File/2019IRs/StVincentsHospital_Fairview_IR2019.pdf

St Vincents Hospital, Fairview, Dublin 3 is a public voluntary hospital. The main building, a former convent, dated from 1899 and various extensions had been added throughout the twentieth century. The approved centre had three units: St. Louise's ward, a 30-bed admission unit serving the north city area from Clontarf to Ballymun, a 6-bed psychiatry of old age admission unit, and St. Mary's ward, a 9-bed continuing care facility.

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

Condition 1: To ensure adherence to Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines, the approved centre shall audit their Medication Prescription and Administration Records (MPARs) on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 15: Individual Care Plan	✗	Moderate	✗	Moderate	✗	High
Regulation 19: General Health	✓		✓		✗	Moderate
Regulation 22: Premises	✗	Low	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High	✗	Moderate	✗	Low
Regulation 26: Staffing	✗	High	✗	High	✗	Moderate
Code of Practice on Admission of Children	✗	High		Not applicable	✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	High	✗	Low

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

Areas of compliance rated "excellent" on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition

Regulation 7: Clothing
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 20: Provision of Information to Residents
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals

4. **St Catherine's Ward, St. Finbarr's Hospital**
https://www.mhcirl.ie/File/2019IRs/StCatherinesWard_IR2019.pdf

St Catherine's Ward, St. Finbarr's Hospital is located in Cork city. The buildings dates back to the mid 1800's and in recent years a significant refurbishment of St. Catherine's had been completed. The resident profile was described by staff as a mix between continuing care and rehabilitation although neither of these specialities were available to the residents. There were 18 residents in the centre for more than six months at the time of the inspection.

Condition 1: To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

Condition 2: To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Condition 3: To ensure adherence to Regulation 26: Staffing, the approved centre shall ensure that residents of the approved centre have access a suitably qualified speech and language therapist, and dietitian, in accordance with their assessed needs as documented in their individual care plan, by no later than 31 August 2019.

Non-compliant areas on this inspection:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 5: Food and Nutrition	✓		✗	High	✗	High
Regulation 15: Individual Care Plan	✗	Moderate	✗	High	✗	High
Regulation 19: General Health	✗	High	✗	High	✗	High
Regulation 21: Privacy	✗	Moderate	✓		✗	High
Regulation 22: Premises	✗	Moderate	✗	High	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✗	Low
Regulation 26: Staffing	✗	High	✗	Moderate	✗	Moderate

Regulation 27: Maintenance of Records	✗	High	✗	High	✗	High
Regulation 32: Risk Management Procedures	✗	Moderate	✗	Critical	✗	High
Regulation 34: Certificate of Registration	✓		✓		✗	Low
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Moderate	✗	High	✗	Low

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

The following area was rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 31: Complaints Procedures

For the Editor

About the Mental Health Commission:

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

Approved Centres:

A 'centre' is “a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder” (Mental Health Act 2001)

To operate an in-patient mental health service in Ireland, the service must be registered as an ‘approved centre’ with the Mental Health Commission. Each centre must re-register for approval every 3 years.

Upon registration, the service must comply with regulations made under the Mental Health Act 2001. Failure to comply with regulations may result in enforcement action including: corrective and preventative action plans, an immediate action notice, a regulatory compliance meeting, registration conditions, removal from the register (closure) and prosecution.

MHC inspection process:

There are 39 areas in the inspection process of approved mental health centres. Each approved centre is assessed against a suite of regulations, rules, and codes of practice.

Inspectors, over a three day period, use a combination of documentation review, observation and interview to assess compliance. The Inspection team

- speak with residents to find out their experience of the service,

- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell them,
- review documents to see if appropriate records are kept, that they reflect practice, in line with the standards and are what people tell them.

Areas of inspection are deemed either compliant or non-compliant. Where areas are considered non-compliant, this is risk rated. Risk measurements are rated as low, moderate, high or critical.

Following the inspection, the Inspector prepares a report on the findings. A draft of the report is furnished to the registered proprietor of the approved centre, and includes provisional compliance ratings, risk ratings and quality assessments.

The registered proprietor is provided with an opportunity to review the draft and comment on any of the content or findings. The Inspector takes into account the comments by the registered proprietor and amends the report as appropriate.

Following this, the registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance addressing the specific non-compliances identified.

The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

Enforcement and monitoring processes
The Commission has a range of powers in relation to monitoring compliance of approved centres and where necessary, taking enforcement action.

The Commission will generally request a corrective and preventative action (CAPA) plan in the first instance and work with the service to address the concern. A CAPA plan must specifically address the non-compliance and put measures in place to prevent recurrence.

The Commission may issue an Immediate Action Notice where a concern needs to be addressed urgently.

The Commission can also direct services to attend a Regulatory Compliance Meeting at the Commission offices where they must provide evidence that they are implementing plans to address the concern. Where the Commission is not satisfied with plans provided, then the matter will be escalated.

The Commission may attach conditions to an approved centre's registration (similar to a penalty or endorsement on a driver licence). It is an offence to breach a condition of registration.
Where the Commission has ongoing and serious concerns about the care and treatment provided by an approved centre then it may remove the service from the register. This in effect means the closure of the approved centre.

Finally, there are a number of offences under the Act including offences relating to the failure or refusal to comply with the provision of the regulations. The Commission may decide to prosecute a service in relation to very serious and ongoing concerns.