Ginesa Suite

ID Number: AC0212

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Ginesa Suite
St. John of God Hospital
Stillorgan
Co. Dublin

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
17 May 2019

Conditions Attached:
None

Registered Proprietor:
St. John of God Hospital CLG

Registered Proprietor Nominee:
Ms Emma Balmaine, Chief Executive

Inspection Team:
Susan O'Neill, Lead Inspector
Raj Ramasawmy
Sarah Moynihan

Inspection Date:
2 – 5 December 2019

Inspection Type:
Unannounced Annual Inspection

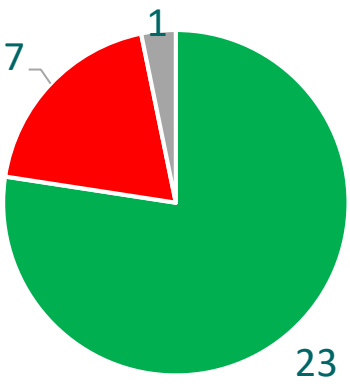
Previous Inspection Date:
N/A

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

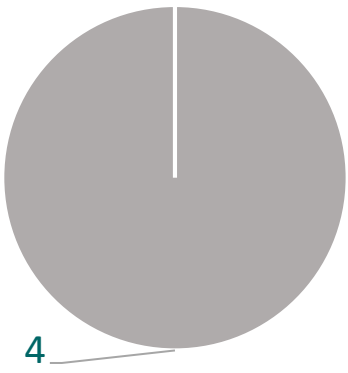
Date of Publication:
Monday August 04 2020

2019 COMPLIANCE RATINGS

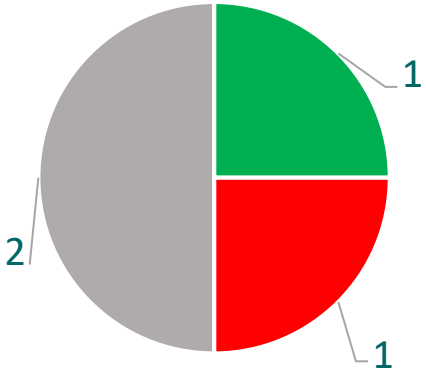
REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



CODES OF PRACTICE

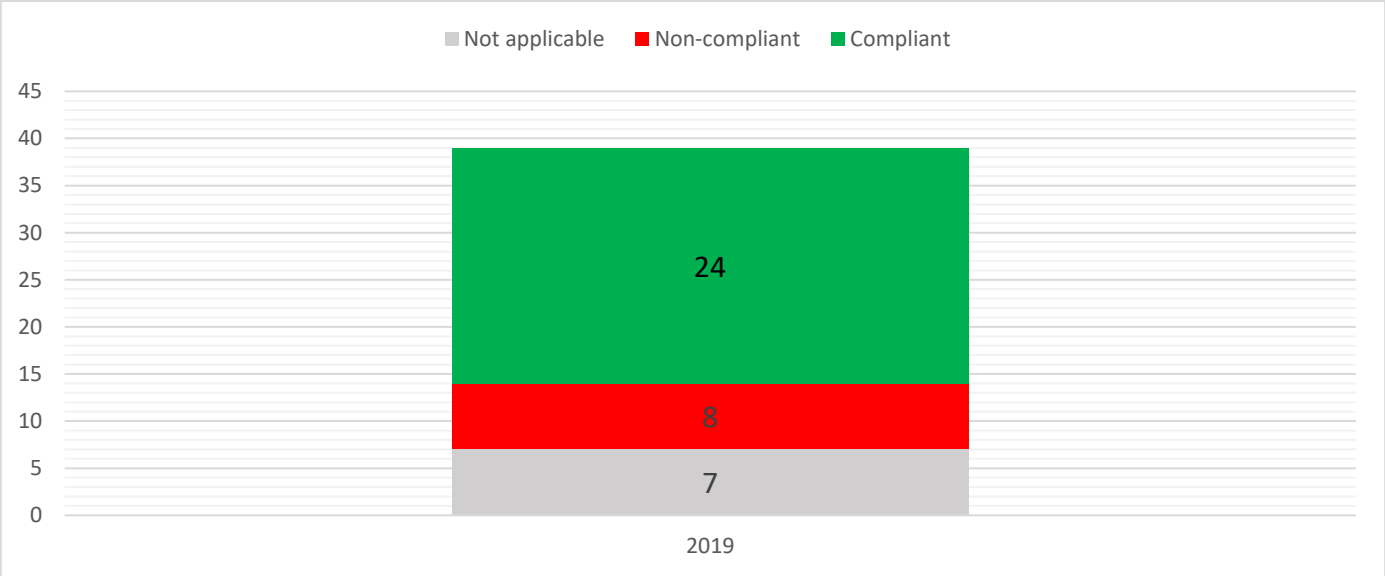


Compliant
Non-compliant
Not applicable

RATINGS SUMMARY 2019

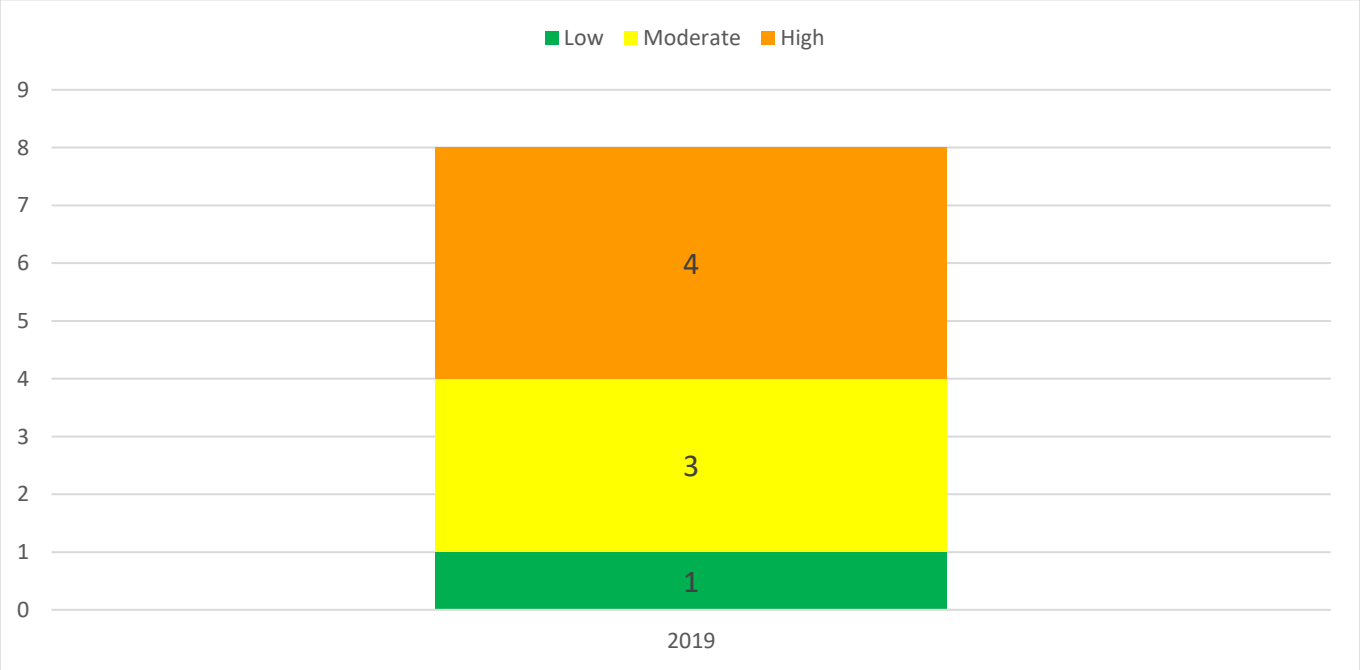
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Overall compliance ratings 2019



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 – Overall risk ratings 2019



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

Ginesa Suite was a 12-bed approved centre for child and adolescent mental health services, located in St John of God Hospital. It was registered as an individual approved centre on 17th June 2019. Previously, Ginesa Suite operated as a part of the St John of God Hospital approved centre. It provided treatment to young people aged from 14 to 17 from all over Ireland. All residents were under the care of a single multi-disciplinary team (MDT).

Compliance with regulations, rules and codes of practice was 75% and 12 compliances with regulations were rated as excellent.

Conditions to registration

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

Safety in the approved centre

- Medication was ordered and stored in a safe manner.
- Regular food safety audits were carried out and kitchen areas were clean.
- Most, but not all staff, were trained in the management of violence and aggression and basic life support.
- All staff were trained in the Mental Health Act 2001 and in fire safety.

However:

- Not all hazards were minimised within the approved centre. One section of the Ginesa garden area, was overgrown, and contained a broken plant pot with sharp edges and a protruding metal wire. While this area had fencing around, it was accessible via an open garden gate.
- There were numerous electrical cables exposed within the Ginesa Suite communal lounge area, accessible to all residents.

- Not all ligature points were minimised to the lowest practicable level. However, at the time of inspection, the service was in the process of implementing a ligature minimisation plan, which was due for completion in 2020.
- Out of ten medication prescription and administration records examined, eight did not contain a clear record of the discontinuation date for each medication and five did not record all of the medications administered to the resident.

Appropriate care and treatment of residents

- All residents had a care plan which was developed and reviewed by the multi-disciplinary team. Residents and their families were involved in the development and review of their ICPs. The ICPs reflected appropriate goals, interventions and resources required.
- Appropriate therapeutic interventions were provided by the multi-disciplinary team.
- All residents had access to necessary medical interventions and physical status was regularly reviewed.
- An evidence-based nutrition assessment tool was used for residents with special dietary requirements. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

However:

- In the case of one discharged resident, the discharge process was not carried out in compliance with the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.

Respect for residents' privacy, dignity and autonomy

- Bathrooms, showers, and toilets had locks on the doors. Bedrooms did not have locks due to identified risks to residents. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.
- Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.
- Residents had access to personal space and all resident bedroom and communal areas were appropriately sized to address residents' needs.
- Residents could meet their visitors in private.
- A cleaning schedule was implemented and the approved centre was clean, hygienic, and free from offensive odours.
- Physical restraint was carried out in compliance with the relevant code of practice.

However:

- In general, the approved centre was not kept in a good state of repair. Internally, multiple areas of wear and tear were noted including damage to the exterior of one of the bedroom doors and stained ceiling tiles in the toilets located in the activities room. Dirty windows, cracked floor tiles, and damaged paintwork in one of the main access corridors used by residents were also observed. Externally, a part of the Ginesa garden area was overgrown with thistles and nettles, and there was a broken plant pot in this area also.
- A room known as "The Bubble" was used for monitoring blood pressure, conducting blood tests, recording a resident's weight and height, and undertaking individual assessments and therapeutic interventions. This room was situated within the main communal area, and while the room had opaque glass windows fitted, one window remained fully transparent, and residents within the room could be viewed by staff and other residents while they were undergoing physical or therapeutic interventions. Residents reported to the inspectors that it was "embarrassing" when residents became upset within this room due to the visibility to other residents and staff. The use of this room in its current configuration did not respect the privacy and dignity of residents.
- Not all windows of the room used for therapeutic groups and activities had blinds fitted, despite the fact that it was overlooked by public areas.

Responsiveness to residents' needs

- There was a wide range of suitable recreational activities for residents.
- Written information was provided about the approved centre and residents' diagnoses and medication. The approved centre revised the information handbooks in collaboration with young people, staff and caregivers to improve formatting and content.
- There was a complaints procedure in place, which was displayed in the approved centre.
- There was a choice of food at mealtimes and meals were attractively presented.
- A school was included in the approved centre and provided curriculum based education.

Governance of the approved centre

- Ginesa Suite was registered as an approved centre in June 2019. The approved centre was part of the St John of God Hospital services and fell within the remit of overall service governance processes. The overall service was governed by a board of directors and there was an established organisational and clinical governance structure.
- The Clinical Governance Quality and Safety Executive Committee (CGQSE) met on a monthly basis and reported to a board sub-committee for clinical governance, quality and safety.
- The Ginesa Management Team meeting on a quarterly basis was specifically dedicated to issues relating to the adolescent unit.
- An induction programme was undertaken by all new staff commencing employment within the approved centre and there was a structured in-service training programme in operation.

- The approved centre had a local risk register which was reviewed on a quarterly basis by Ginesa Suite nursing management and the risk officer, and on an annual basis by members of the risk committee. Where appropriate, risks were escalated to the corporate risk register.
- There was a comprehensive auditing cycle which was undertaken by members of the multi-disciplinary team across St John of God Hospital services. The clinical audit committee convened on a monthly basis and this provided a forum for the dissemination of audit results and planning for future audits. A member of the Ginesa Suite multi-disciplinary team attended the clinical audit committee meetings. Indirect representation was also provided by the Nurse Practice Development Manager who attended the audit committee meetings.
- There were weekly resident community meetings and suggestion boxes. An advocate from the Youth Advocacy Programme (YAP) attended the approved centre on a weekly basis and met with residents on an individual or group basis. Regular feedback was provided by the advocate to Ginesa Suite nursing management and issues arising were discussed at the Ginesa Management meeting.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre introduced “Calm Down” methods help lower levels of agitation among residents as part of the ongoing implementation of the Safewards project. Safewards is a programme that encourages staff and residents to work together to make the inpatient unit safer for everyone.

2. The approved centre revised the information handbooks in collaboration with young people, staff and care givers to improve formatting and content.

3. A weekly parent group was facilitated by the social worker and clinical nurse specialist.

4. The approved centre acquired new membership of the IFI (Irish Film Institute) student film club which provided access to educational and recreational DVD resources.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Ginesa Suite was registered as an individual approved centre for child and adolescent mental health services on 17th June 2019. Previously, Ginesa Suite operated as a part of the St John of God Hospital approved centre. Ginesa Suite was located within the main St John of God Hospital building. It provided treatment to young people aged from 14 to 17 from all over Ireland. All residents were under the care of a single multi-disciplinary team (MDT).

The centre was registered for 12 beds and was fully operational at the time of this inspection. There were two single bedrooms and five double bedrooms with separate communal washing and toileting facilities. The unit had adequate therapeutic and communal areas and young people had access to a gym and outdoor recreational facilities located on the grounds of St John of God Hospital. A school facility was also available to young people in Ginesa Suite.

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

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

3.2 Governance

Ginesa Suite was registered as an approved centre in June 2019. The approved centre was part of the Saint John of God Hospital services and fell within the remit of overall service governance processes. The service was governed by a board of directors and there was an established organisational and clinical governance structure. The Clinical Governance Quality and Safety Executive Committee (CGQSE) convened on a monthly basis and reported to a board sub-committee for clinical governance, quality and safety. The CGQSE was, in turn, informed by multiple committees including risk, health and safety, clinical audit and the clinical effectiveness and quality improvement committees. There was variable direct representation from the Ginesa Suite multi-disciplinary team at the different committee meetings. The only committee specifically dedicated to issues relating to the adolescent unit was the Ginesa Management Team meeting which convened on a quarterly basis.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The numbers and skill mix of staffing were sufficient to meet resident needs. An induction programme was undertaken by all new staff commencing employment within the approved centre and there was a structured in-service training programme in operation. The service supported staff to pursue opportunities for further education and provided course funding and study leave where appropriate. The majority of staff were trained in the required areas of mandatory training, however not all staff were trained in the management of violence and aggression and basic life support.

The approved centre had a local risk register which was reviewed on a quarterly basis by Ginesa Suite nursing management and the risk officer, and on an annual basis by members of the risk committee. The clinical nurse manager of Ginesa Suite was a member of the risk committee which convened on a monthly basis. Where appropriate, risks were escalated to the corporate risk register. The inspected risk management procedures actively reduced identified risks to the lowest practicable level of risk. All incidents were recorded and risk-rated in a standardised format on the Datix system, the approved centre's electronic risk management system.

There was a comprehensive auditing cycle which was undertaken by members of the multi-disciplinary team across St John of God Hospital services. Each audit clearly documented the results specifically in relation to Ginesa Suite. An audit or other form of monitoring was not completed in all areas, however, as the approved centre was registered for less than six months, the auditing cycle was still underway at the time of inspection. Therefore, upon inspection of the monitoring pillar of the Judgement Support Framework, where no form of monitoring had yet occurred, this pillar was deemed non-applicable and a quality assessment was not awarded. The clinical audit committee convened on a monthly basis and this provided a forum for the dissemination of audit results and planning for future audits. A member of the Ginesa Suite multi-disciplinary team attended the clinical audit committee meetings. Indirect representation was also provided by the Nurse Practice Development Manager who attended the audit committee meetings.

Weekly resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer engagement. An advocate from the Youth Advocacy Programme (YAP) attended the approved centre on a weekly basis and met with residents on an individual or group basis. Regular feedback was provided by the advocate to Ginesa Suite nursing management and issues arising were discussed at the Ginesa Management meeting.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below.

Regulation/Rule/Act/Code	Compliance/Risk Rating 2019	
Regulation 18: Transfer of Residents	✗	Moderate
Regulation 21: Privacy	✗	High
Regulation 22: Premises	✗	High
Regulation 23: Ordering, Prescribing and Administration of Medicines	✗	High
Regulation 26: Staffing	✗	Low
Regulation 27: Maintenance of Records	✗	Moderate
Regulation 28: Register of Residents	✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an approved centre	✗	High

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

4.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 7: Clothing
Regulation 8: Resident's Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 17: Children's Education
Regulation 19: General Health
Regulation 29: Operating Policies and Procedures
Regulation 31: Complaints procedure

4.3 Areas that were not applicable on this inspection

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

5.0 Service-user Experience

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:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.

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

The inspection team met with six residents. Residents were complimentary of staff, the choice and quality of daily food menus, and the facilities on site. All were familiar with their care plan and key worker. Specific issues raised by the residents related to privacy. They reported that whilst staff always knock on the bedroom door, they do not always wait for a reply from the resident before immediately entering the room. Another issue raised was in relation to the embarrassment that residents can sometimes experience when being assessed or interviewed in the room known as the "Bubble". This room is located in the centre of Ginesa Suite and has one fully transparent glass window. Two of the young people reported that they became distressed and started to cry during an assessment or interview. They also felt very embarrassed and uncomfortable due to the either being observed or the risk of being observed by others on the ward at the time.

Six resident questionnaires were completed and returned to the inspection team. The majority of questionnaires indicated that a staff member explained what was happening when they arrived on the unit. Most respondents understood their individual care plan and knew the multi-disciplinary team members and their key worker. Five respondents indicated that they only received information from staff about diagnosis, care and treatment sometimes. Five questionnaires indicated that not all residents had enough space for privacy, and that privacy and dignity was not respected at all times. The majority of questionnaires indicated that they were always able to give feedback to staff and were aware of the complaints procedure.

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:

- Administrator
- Chief Executive Officer
- Clinical Director
- Clinical nurse manager 2
- Deputy Director of Nursing
- Head of Operations and Quality Department
- Head of Psychology
- Nurse Practice Development Manager
- Occupational Therapist
- Senior Social Worker

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

Quality Rating **Excellent**

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

Processes: The approved centre had a written policy in relation to the identification of residents, which was dated November 2019. The policy included all requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: There was a minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs. The identifiers were person-specific and appropriate to the residents' communication abilities. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. A resident identifier was used prior to the provision of therapeutic services and programmes. Alerts were used to inform staff of the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

(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

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in November 2019. The policy included all requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The approved centre menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents' needs and residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Hot meals were provided on a daily basis and residents had at least two choices for meals, including a meat and vegetarian option. Residents could also request other foods if they so wished. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition. Hot and cold drinks were offered to residents regularly; there were two water coolers in easily accessible locations within the approved centre, hot drinks could be obtained on request, and a snack trolley made a number of rounds to the residents during the day.

An evidence-based nutrition assessment tool was used for residents with special dietary requirements and weight charts were implemented, monitored, and acted upon for residents, where appropriate. Residents, their representatives, family, and next of kin were educated about residents' diets, where appropriate, specifically in relation to any contraindications with medication. Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans, and the needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(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

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in November 2019. The policy included all requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services and appropriate protective equipment, including Personal Protective Equipment (PPE), where required, was used during the catering process. There was suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements and catering areas and associated catering and food safety equipment were appropriately cleaned. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

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

Processes: The approved centre had a written policy in relation to residents' clothing, which was dated November 2019. The policy included all requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents changed out of nightclothes during daytime hours unless otherwise specified in their individual care plan (ICP). Residents had an adequate supply of individualised clothing and were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was dated November 2019. The policy included all requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: The resident was entitled to bring personal possessions with them, the extent of which was agreed at admission. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them and secure facilities were provided for their safe-keeping.

The property checklist was kept separately to the resident's ICP and was available to the resident. Where necessary, the access to and use of resident monies was overseen by two members of staff and the resident or their representative. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP and in accordance with the approved centre's policy.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in October 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake and attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and on weekends, including a gym, football pitch, basketball court, tennis court, pitch and put course, bicycles, board games, TV, movies, books, jigsaws, and a computer. Structured recreational groups included yoga, sports and exercise, and music. Information was provided to residents as a printed timetable on the approved centre's corridors and was in an accessible format, which was appropriate to their individual needs: the information included the types and frequency of appropriate recreational activities available within the approved centre.

Recreational activity programmes were developed, implemented, and maintained for residents, with resident involvement. Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. A resident's decision on whether or not to participate in activities was respected and documented. The recreational activities provided by the approved centre were appropriately resourced and opportunities were provided for both indoor and outdoor exercise and physical activity. Communal areas were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the resident's clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in December 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy to support residents' religious practices was reviewed to ensure that it reflected the identified needs of residents. This was documented.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable: residents could attend daily mass in the church of the main building of the St. John of God's approved centre, other than on Fridays. There were facilities provided within the approved centre for residents' religious practices, including the approved centre's family room. Residents had access to multi-faith chaplains and had access to local religious services; they were supported to attend if deemed appropriate following a risk assessment. Care and services that were provided within the approved centre were respectful of the residents' religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. The resident was facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in December 2019. The policy and procedures included all requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. This was the approved centre's first inspection under its own registration. At the time of inspection, as the approved centre was registered in June 2019, documented analysis to identify opportunities for improving visiting processes was not yet completed.

Evidence of Implementation: Visiting times were publicly displayed and were reasonable and appropriate. A separate visitors' room or visiting area was provided 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. Children visiting were accompanied at all times to ensure their safety and this was communicated publicly to all relevant individuals. The approved centre had a separate visitor room to facilitate visiting children. This room was suitable for children and contained toys and books.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy and procedures in relation to resident communication. The policy was last reviewed in October 2019. The policy and procedures included all requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: All residents were informed pre-admission that they could bring a phone that could make texts and calls, but that smart phones were not allowed. Residents had access to email on the ward. This was risk assessed and documented. Residents could also make calls by using the phones available on the ward. No residents had their communication restricted at the time of the inspection. The clinical director or a senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication might result in harm to the resident or to others.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in January 2019. The policy and procedures addressed all requirements of the *Judgement Support Framework*, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: The clinical file of one resident who had been searched was examined. Risk was assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches. The request for

consent and the received consent were documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. Where consent was not received, this was documented and the parents or guardian of the resident were contacted informing them of the search being carried out.

The resident search policy and procedure was communicated to all residents and residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender, and at least one of the staff members conducting the search was the same gender as the resident being searched.

A written record of every search of a resident and every 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. Policy requirements were implemented when illicit substances were found as a result of a search. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was dated November 2019. The policy and protocols included all requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

As there had been no death in the approved centre, this regulation was only assessed against the processes and training and education pillars.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in October 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Residents' ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Ten ICPs were examined during the inspection process. The approved centre used an electronic patient record system and all ICPs were a composite set of documents. Each ICP included allocated space for goals, treatment, care, resources required, and reviews. They were identifiable, uninterrupted, and were not amalgamated with progress notes.

Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address immediate needs of the resident. An ICP was developed by the MDT following a comprehensive assessment, within seven days of admission. The comprehensive assessment included medical, psychiatric, and psychosocial history, as well as a current physical health assessment, a detailed risk assessment, their communication abilities, and educational history. Evidence-based assessments were used where possible. Though residents did not attend their ICP review meetings, there was documented evidence that their needs were discussed with them prior to the meeting and reviewed following the meeting.

All of the ICPs examined identified the resident's assessed needs, appropriate goals, and the care, treatment and resources required to meet the goals identified. A key worker was also identified in the ICPs to ensure continuity in the implementation of a resident's ICP. The ICPs included an individual risk management plan and a preliminary discharge plan, where deemed appropriate. The ICP was reviewed

by the MDT in consultation with the resident on a weekly basis. The ICP was updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. Residents were offered a copy of their ICP. When a resident declined or refused a copy of their ICP, this was recorded, including the reason, if given. All residents had access to their ICP and were kept informed of any changes. The ICPs included the resident's educational requirements.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.

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

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in December 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: This was the approved centre's first inspection under its own registration. At the time of inspection, as the approved centre was registered in June 2019, monitoring of therapeutic services and analysis to identify opportunities to improve the processes for therapeutic services and programmes had not yet been completed. Therefore, this pillar was deemed not applicable.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. The therapeutic services and programmes provided by the approved centre were evidence-based and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A list of all therapeutic services and programmes provided in the approved centre was available to residents and where a resident requires 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.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. Therapeutic services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. A record was maintained of resident participation, engagement, and outcomes achieved in therapeutic services or programmes in residents' individual care plans or clinical files.

The approved centre was compliant with this regulation. As all requirements of the monitoring pillar were deemed not applicable, *Regulation 16: Therapeutic Services* was only assessed under the three pillars of processes, training and education, and evidence of implementation.

Regulation 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

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

Processes: The approved centre had a written policy in relation to the provision of education to child residents, which was dated February 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had been trained on the policy relating to children's education and its implementation throughout the approved centre. Individual providers of educational services on behalf of the approved centre were appropriately qualified in line with their roles and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs.

Monitoring: A record was maintained of the attendance of child residents at internal and external educational services.

Evidence of Implementation: Residents were assessed in relation to their educational requirements with consideration of their individual needs and age on admission. Where appropriate, the approved centre linked with educational authorities and local education providers to ensure that each child resident was appropriately assessed for education needs. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. The approved centre tailored educational content to each individual resident and liaised with local educational providers and schools in relation to the curriculum and work load. Residents were given their own tailored school timetable, which was based on their educational assessments and on discussion with the resident themselves at the start of each week.

Facilities were available for provision of education to child residents in the approved centre, including a school classroom, computers, books, online access to educational content, and iPads for individual ward work. There was sufficient personnel resources to provide education to child residents in the approved centre, including a teacher and special needs assistant. There was also sufficient personnel and resources to support child residents to access external education services.

The educational provisions available within the approved centre were effectively communicated to child residents and their representatives: the approved centre provided an information leaflet to residents and families regarding educational services and the role of the teacher. Attendance by child residents at the approved centre's educational services was documented, including reasons for non-attendance, as was attendance by the residents at external educational services.

The approved centre maintained comprehensive records of each resident's educational history, such as schools attended, reports obtained, certificates awarded, assessment reports received, and any remedial assistance provided. Where child residents were managing a transition, such as changing school or entering a higher level of education, they received additional support and appropriate assistance from the approved centre.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 18: Transfer of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was dated December 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was not maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The file of one resident who had been transferred from the approved centre was examined on inspection in relation to the transfer process. Communication records with the receiving facility prior to the resident transfer were not documented. Documented consent of the resident to the transfer was available. An assessment of the resident was completed prior to transfer however this did not include an individual risk assessment relating to the transfer and the resident's needs. Full and complete written information for the resident was not transferred when they moved from approved centre to another facility. While a transfer letter was issued to the receiving facility, it did not include a list of current medications, psychiatric history or a risk assessment.

A resident transfer form was not used and information on the required medication for the resident during the transfer process was not documented. No checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. Copies of completed records relevant to the resident transfer were retained in the resident's clinical file.

The approved centre was non-compliant with this regulation because it did not ensure that all relevant information was issued as part of the transfer documentation to the receiving hospital, 18(1).

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies, which were last reviewed in February 2018. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED). Weekly checks were completed on the resuscitation trolley and on the AED. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Information was provided to residents regarding the national screening programmes available through the approved centre and residents had access to smoking-cessation programmes. As there were no residents in the approved centre for more than six months at the time of the inspection no six-monthly health check had occurred and were therefore not inspected.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in February 2019. The policy and procedures included all requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

Monitoring: This was the approved centre's first inspection under its own registration. At the time of inspection, as the approved centre was registered in June 2019, monitoring of the provision of information and analysis to identify opportunities to improve the processes for providing information to residents had not yet been completed. Therefore, this pillar was deemed not applicable.

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed the care and services provided. The booklet was available in the required formats to support resident needs and information was clearly and simply written. It included details of the complaints procedure, visiting times and arrangements, residents' rights, and the housekeeping arrangements, as well as arrangements for personal property and mealtimes. Residents were provided with the details of their multi-disciplinary team and with written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information was prejudicial to the resident's physical or mental health, well-being, or emotional condition.

Information was provided to residents on the likely adverse effects of treatments, including the risks and other potential side-effects. Medication information sheets as well as verbal information were provided

in a format appropriate to resident needs and the content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. The information in the documents provided by or within the approved centre was evidence-based and was appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. As all requirements of the monitoring pillar were deemed not applicable, *Regulation 20: Provision of Information to Residents,* was only assessed under the three pillars of processes, training and education and evidence of implementation.

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in February 2018. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Residents were called by their preferred name and the general demeanour of staff and the manner in which they addressed residents was respectful. Staff were discreet when discussing a resident's condition or treatment needs and sought permission before entering a resident's room, as appropriate. All residents were wearing clothes that respected their privacy and dignity.

Bathrooms, showers, and toilets had locks on the doors. Bedrooms did not have locks due to identified risks to residents. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

Situated within the main communal area, a room known as "The Bubble" was used for monitoring blood pressure, conducting blood tests, recording a resident's weight and height, and undertaking individual assessments and therapeutic interventions. While the room had opaque glass windows fitted, one window remained fully transparent, and residents within the room could be viewed by staff and other residents. It was reported to inspectors in interviews with residents, that it was "embarrassing" when residents became upset within this room due to the visibility.

Not all windows of the room used for therapeutic groups and activities had blinds fitted, despite the fact that it was overlooked by public areas. Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

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

a) **The residents' privacy and dignity was not respected during therapeutic interactions within "The Bubble" as the residents could be viewed by staff and residents, 21.**
b) **The residents' privacy and dignity was not respected whilst in the therapeutic group and activities room; this room was overlooked by public areas but did not have all windows fitted with blinds, 21.**

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in January 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed a hygiene audit. The approved centre had completed a ligature audit however a validated audit tool was not used. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space and all resident bedroom and communal areas were appropriately sized to address residents' needs. There was suitable and sufficient heating within the approved centre, pipework and radiators were guarded, and rooms were centrally heated. The heating could not be controlled by the residents in their own rooms. Rooms were well ventilated and lit, and were suitably sized to remove excessive noise. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces. Not all hazards were minimised within the approved centre. One section of the Ginesa garden area was overgrown, and contained a broken plant pot with sharp edges and a protruding metal wire. While this area had fencing around, it was accessible via an open garden gate. This broken plant pot was removed during the inspection period. A second hazard noted was

the numerous electrical cables exposed within the Ginesa Suite communal lounge area, accessible to all residents. Not all ligature points were not minimised to the lowest practicable level. At the time of inspection, the service was in the process of implementing a ligature minimisation plan which was due for completion in 2020.

In general, the approved centre was not kept in a good state of repair. Internally, multiple areas of wear and tear were noted including damage to the exterior of one of the bedroom doors and stained ceiling tiles in the toilets located in the activities room (Elvira room). Dirty windows, cracked floor tiles, and damaged paintwork in one of the main access corridors used by residents were also observed. Externally, a part of the Ginesa garden area was overgrown with thistles and nettles, and there was a broken plant pot in this area also. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. A cleaning schedule was implemented and the approved centre was clean, hygienic, and free from offensive odours. Current national infection guidelines were followed and back-up power was available to the approved centre.

There was a sufficient number of toilets and showers in the approved centre and toilets were accessible, clearly marked, and close to day and dining areas, with at least one assisted toilet per floor. There was a dedicated sluice room, cleaning room, and laundry room. The approved centre had dedicated therapy and examination rooms. Suitable furnishing were provided to support resident independence and comfort. Assisted devices and equipment were also provided by the approved centre to address resident's needs. Remote or isolated areas of the approved centre were monitored.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and the safety and well-being of residents for the following reasons:

a) **Ligature points were not reduced to the lowest practicable level, 22(3).**
b) **There were exposed electrical flexes in the communal lounge area and a broken plant pot with exposed metal wiring within the Ginesa garden area, 22(3).**
c) **The registered proprietor did not ensure that the premises were maintained in good structural and decorative condition, 22 (1)(a).**

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in November 2019. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: All nursing and medical staff as well as pharmacy staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff as well as pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff as well as pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined during the inspection process. The MPARs detailed two appropriate resident identifiers, a record of any allergies or sensitivities to medications, the generic name of the medication and preparation, the administration route for the medication, and a record of any medications refused by the resident. The MPARs also had dedicated space for routine, once-off, and “as required” (PRN) medications and detailed the dose to be given and the frequency of administration, including the minimum dose interval for PRN medication.

Micrograms were not written in full within one of the MPARs. All the MPARs examined detailed a clear record of the date of initiation for each medication. Five MPARs did not contain a record of all medications administered or not administered to the resident and eight did not detail a clear record of the date of discontinuation for each medication. Each MPAR detailed the Medical Council Registration Number (MCRN) number of every medical practitioner that prescribed medication to the resident, as well as the signature of the medical practitioner for each entry.

All entries in the MPARs were legible and written in black, indelible ink. No prescription was altered where a changes was required. Instead, where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident's pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration and expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications.

When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file. Where the resident refused the medication, this was documented in the MPAR and clinical file and communicated to medical staff. Schedule 2 controlled drugs were checked by two staff members, one of which was a registered nurse, against the delivery form and details were entered in the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book, and, following administration, the details were entered in the controlled drug book and signed by both staff members. Residents could self-administer medications where risks had been assessed and their competence to self-administer was confirmed: any change to the initial risk assessment was recorded and arrangements for self-administering medicines were kept under review.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were clean and free from damp, mould, litter, dust, pests, and from spillage or breakage. Medication storage areas were incorporated in the cleaning and housekeeping schedules and food and drink was not stored in areas used for the storage of medication. Medications for self-administration were labelled individually by a pharmacist with the resident name, medical record number, and appropriate directions for use and was stored appropriately.

Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication trolley remained locked at all times and secured in a locked room. Scheduled 2 and 3 controlled drugs were locked in a cupboard separate from other medicinal products to ensure further security. A system of stock rotation was implemented, to avoid accumulation of old stock. An inventory of medications was conducted on a monthly basis, checking the name and dose of medication, the quantity of medication, and the expiry date of medications. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

a) **Eight MPARs did not contain a clear record of the discontinuation date for each medication, 23(2).**
b) **Five MPARs did not record all of the medications administered or not administered to the resident, 23(2).**

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

Processes: The approved centre had written operational policies and procedures in relation to the health and safety of residents, staff, and visitors, as well as for infection control. The safety management system policy was dated December 2019 and the approved centre's inflectional control procedures and precautions were dated November 2019. The policies included all requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

Monitoring: The health and safety policy was monitored pursuant to Regulation 29: Operational Policies and Procedures.

Evidence of Implementation: Regulation 24 was only assessed against the approved centre's written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

(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

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in December 2019. The policy addressed requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre. The policy did not include the disclosure of the existence and usage of CCTV or other monitoring devices 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.

Training and Education: All relevant staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the use of CCTV, as set out in the policy.

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras or other monitoring systems were located throughout the approved centre. A resident was monitored solely for the purposes of ensuring the health, safety, and welfare of that resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The use of CCTV or other monitoring systems had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services.

CCTV cameras within the Ginesa Suite ward area did not record or store the residents' image on a tape disc or hard drive. CCTV cameras used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. One CCTV camera located outside of the Ginesa Suite ward area was recording and storing the residents' image. This camera was located on the ground floor within St John of God Hospital. The purpose of the camera was for monitoring an entrance/exit door for security reasons. This door was located beside the door of dining room specifically used for residents of Ginesa Suite. However, the position and orientation of the camera meant that images of the resident's accessing the dining area were also captured. Footage from the camera was recorded and stored for a short period of time.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes pillar.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating LOW

(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

Processes: The approved centre had written policies and procedures in relation to its staffing requirements. The policies were last reviewed in October 2019. The policies and procedures addressed requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including the Garda vetting requirements.

The policies and procedures did not address the following:

- The staff rota details and the methods applied for their communication to staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre's staff. A

planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. The numbers and skill mix of staffing were sufficient to meet resident needs.

All staff were recruited, selected, and vetted in accordance with the approved centre's policies and procedures for recruitment, selection, and appointment, and information from referees was sought and documented. Staff had the appropriate qualifications to do their job and an appropriately qualified staff member was on duty and in charge at all times: this was documented. There was no written staffing plan for the approved centre. Where agency staff were used, there was a comprehensive contract between the approved centre and licensed staffing agency used that set out the agency's responsibilities in relation to the vetting of staff, confirmation of registration, identity, and staff training, as well as professional indemnity and arrangements for responding to complaints.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Both orientation and induction training was completed for staff. All health care professionals were trained in fire safety, Children First, and the Mental Health Act 2001. Not all health care professionals were trained in the management of violence and aggression and Basic Life Support.

Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan, including manual handling, infection control and prevention, care for residents with an intellectual disability, risk management, and the protection of children and vulnerable adults. However, staff had not been trained in resident rights or incident reporting. All staff training was documented and staff training logs were maintained.

Opportunities were made available to staff by the approved centre for further education: these opportunities were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was completed by appropriately trained and competent individuals and facilities and equipment were available for staff in-service education and training.

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (17)	17	100%	17	100%	16	94%	17	100%	17	100%
Consultant Psychiatrist (1)	0	0%	1	100%	0	0%	1	100%	1	100%
Medical (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%

Psychologist (1)	1	100%	1	100%	0	0%	1	100%	1	100%

The following is a table of clinical staff assigned to the approved centre.

Ward or Unit	Staff Grade	Day	Night
	CNM 2 x 1 CNM 1 x1 RPN x 17	Mon-Fri: 4 staff Sat–Sun: 3 staff	Mon-Fri: 2 (plus twilight relief nurse 20.00-00.00) Sat-Sun: 2 (plus twilight relief nurse if needed)
Ginesa Suite	Child and Adolescent Consultant Psychiatrist	1	
	Non-consultant hospital doctor	2	
	Occupational Therapist	1	
	Social Worker	1	
	Psychologist	0.57 WTE	

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

The approved centre was non-compliant with this regulation because not all health care professionals had up-to-date mandatory training in the management of violence and aggression and Basic Life Support 26(4).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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

Processes: The approved centre had written policies and procedures in relation to the maintenance of records. The maintenance of records policy was last reviewed in March 2019 and the approved centre's code of practice for healthcare records management was dated October 2017. The approved centre's data protection policy and their policy on record retention were both last reviewed in April 2019. The policies and procedures addressed all requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents' records.
- Record retention periods.
- The destruction of records.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policies. Not all clinical staff had been trained in best-practice record keeping.

Monitoring: This was the approved centre's first inspection under its own registration. At the time of inspection, as the approved centre was registered in June 2019, monitoring of the provision of information and analysis to identify opportunities to improve the processes for providing information to residents had not yet been completed. Analysis had been completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: An electronic record and a hard copy paper file was initiated for every resident assessed or provided with care and services by the approved centre. All residents' records were

secure, up-to-date, generally in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. All resident records were physically stored together, where possible. Resident records were reflective of the residents' current status and the care and treatment being provided, and were maintained using an identifier that was unique to the resident or some other effective method.

Paper based resident records were not developed and maintained in a logical sequence. There were some unfiled pages stored in the back cover of the paper files, which had a pocket section dedicated to cardexes and labels. These documents were varied in nature, ranging from food intake charts to observation charts and ECGs. No loose pages were observed within the records.

Resident records were accessible to authorised staff only and staff only had access to the data and information needed to carry out their job responsibilities. Residents' access to their records was managed in accordance to the Data Protection Acts and only authorised staff made entries in residents' records, or specific sections therein.

Records were written legibly in black, indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Each entry included the date, used the 24-hour clock, and was followed by a signature. The approved centre also maintained a record of all signatures used in the resident record. Two appropriate resident identifiers were recorded on all documentation. Where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre. Where information or advice was given over the phone, this was documented as such by the member of staff who took the call and the person giving the information or advice was clearly identified. Records were retained or destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was non-compliant with this regulation because not all paper based records were not maintained in a logical sequence and good order as some documents were observed to be filed in the incorrect file section, 27(1).

Regulation 28: Register of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up-to-date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record the residents' address, gender, country of birth, next of kin, and diagnosis upon admission.

The approved centre was non-compliant with this regulation because the register of residents did not include all information as specified in Schedule 1 of the regulation, 28(2).

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in February 2019. It included all requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately approved and communicated to all relevant staff.

Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained but removed from access by staff. The format of policies was standardised and included the title of the policy, the document owner, its approvers, and the scope of the policy and procedure.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

(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

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in September 2019. The policy and procedures addressed all requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre and a consistent and standardised approach was implemented for the management of all complaints. Information on the complaints procedure was provided at

admission to residents and their next of kin or representatives through approved centre's information booklet. The complaints procedure, including how to contact the nominated person, was publicly displayed and residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

Residents and their representatives were facilitated to make complaints verbally, in writing, electronically by email, over the telephone, and through complaint feedback, and suggestion forms. The registered proprietor ensured access, insofar as was practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. A method for addressing minor complaints within the approved centre was provided and a minor complaints log was maintained on the unit. There was only one recorded complaint since the registration of the approved centre. This was made verbally and was dealt with locally: the complainant chose not to formalise the complaint. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's ICP.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being made. All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the relevant data protection acts.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

(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

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in December 2018. The approved centre had a number of other associated policies relating to risk and incident management procedures. Combined, the policies addressed all requirements of the *Judgement Support Framework*, including the following:

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation and the person with responsibility for risk was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level of risk and both clinical risks 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. Health and safety risks were identified, assessed, treated, reported, and monitored by the approved centre in accordance with relevant legislation and were documented within the risk register, as appropriate.

Individual risk assessments were completed prior to and during physical restraint, resident discharge, at admission to identify individual risk factors, and in conjunction with medication requirements or administration. Individual risk assessments were not, however, completed prior to or during resident transfer. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education and evidence of implementation pillars.

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 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. The certificate was displayed prominently in the reception area of St. John of God Hospital.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.3 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre at the time of the inspection. Please see Section 4.3 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.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated November 2019. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: The clinical files of three residents who had been physically restrained were examined during the inspection process. In all three cases, physical restraint was only used in rare and exceptional circumstances, when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour.

A designated staff member was responsible for leading in the physical restraint of a resident and for monitoring their head and airways. The consultant psychiatrist or duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable and this was recorded in the clinical file. In each case, a registered medical practitioner completed a medical examination no later than three hours after the start of an episode of physical restraint. In all cases, the restraint order lasted for a maximum of thirty minutes. All episodes were recorded in the resident's respective clinical files. A clinical practice form was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode. The clinical practice form was signed by the consultant psychiatrist within 24 hours.

Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint examined. In each case, the resident's parent or guardian was informed of the use of physical restraint. Child protection policies and procedures were in place and policies and procedures were in place that addressed appropriate training for staff in relation to child protection. Each of the residents was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode. The resident was given the opportunity to discuss the episode with members of MDT as soon as was practicable.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was dated December 2019, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was dated December, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in December 2019, included all of the policy-related criteria for this code of practice.

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

Monitoring: Audits had been completed on the implementation of and adherence to the transfer and discharge policies. This was the approved centre's first inspection under its own registration and at the time of inspection, as the approved centre was registered in June 2019, an audit on the implementation of and adherence to the admission policy had not yet been completed. Therefore, this was deemed not applicable.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined on inspection. The admission was on the basis of a mental illness or mental disorder. An admission assessment was completed and included the presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental health state, a full physical examination, and a risk assessment. The resident's family member was involved in the admission process. A key worker system was in place within the approved centre.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents.

Discharge: The clinical file of a resident who had been discharged was examined in relation to the discharge process. A discharge plan evidenced the estimated date of discharge, a follow-up plan, a

reference to early warning signs of relapse and risks, as well as documented communication with the relevant general practitioner, primary care team, or community mental health team. The discharge was coordinated by a key worker and the discharge meeting was attended by the resident, key worker, relevant members of the multi-disciplinary team, and the resident's family member. A discharge assessment addressed the resident's informational needs and a current mental state examination. It did not address the resident's psychiatric and psychosocial needs or a comprehensive risk assessment and risk management plan.

A comprehensive discharge summary was issued within 14 days of discharge and included the diagnosis, prognosis, medication, outstanding health or social issues, and risk issues such as signs of relapse. The comprehensive discharge summary did not include the resident's mental state at discharge, the names and contact details of key people for follow-up, or any follow-up arrangements. There was a timely follow-up appointment.

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

a) **The approved centre did not comply with Regulation 18: Transfer of Resident, 30.1.**
b) **The comprehensive discharge summary did not included details of the resident's mental state at discharge, 38.4.**
c) **The comprehensive discharge summary did not include details of follow-up arrangements, 38.4.**
d) **The comprehensive discharge summary did not include names and contact details of key people for follow-up, 38.4.**
e) **The discharge assessment did not address psychiatric and psychological needs, 34.4.**
f) **The discharge assessment did not address a comprehensive risk assessment and risk management plan, 34.4.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 18: Transfer of Residents					
It did not ensure that all relevant information was issued as part of the transfer documentation to the receiving hospital, 18(1).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure when a resident is transferred from Ginesa approved centre for treatment to another approved centre or hospital or other place, that all relevant information about the resident is provided to the receiving facility. External Transfer Checklist for nursing template implemented. Developed in line with Code of practice including documented consent of resident prior to transfer, Copy of Kardex and other relevant documentation sent, External Transfer form for Medical personnel template implemented which includes communication with receiving facility, risk assessment, and list of current medications.	External Transfer Audit carried out in line with code of practice and local policy, every 6 months.	Yes	28/04/2020	Nursing and Medical staff on all suites. Sarah Donnelly, Nurse Practice Development Manager,
Preventative Action	To ensure local procedures of an external transfer of a resident from Ginesa to another approved centre for treatment to another approved centre or hospital or other place is in line with Code of Practice and local policy. Implementation of two	6 monthly audit, results of audit are fed back to audit committee and clinical governance. Action plan agreed	Yes	28/04/2020	Nursing and Medical staff on all suites. Sarah Donnelly, Nurse Practice Development Manager

	templates one for nursing and one for medical staff which meets the Code of practice and local policy on transfer of a resident. To ensure that all relevant personnel are aware of policy, Code of practice and follow standards in line with best practice.				

Regulation 21: Privacy					
The residents' privacy and dignity was not respected during therapeutic interactions within "The Bubble" as the residents could be viewed by staff and residents, 21.					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Frosting has been put in place in the bubble	Completed	Yes	28/04/2020	Accommodation Department
Preventative Action	Area to be added to audit on privacy	Completed Annual Audit	Yes	28/04/2020	Accommodation Department
The residents' privacy and dignity was not respected whilst in the therapeutic group and activities room; this room was overlooked by public areas but did not have all windows fitted with blinds, 21.					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Frosting has been put in place to address non-compliance	Completed	Yes	28/04/2020	Accommodation Department
Preventative Action	Areas to be added to audit on privacy	Completed Annual Audit	Yes	28/04/2020	Accommodation Department

Regulation 22: Premises					
The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and the safety and well-being of residents because the ligature points were not reduced to the lowest practicable level, 22(3).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Hospital has in place Observation Policy which continues to be implemented. Hospital has Ligature minimisation plan which continues to be implemented. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Audit of adherence to procedures set out within Observation Policy occurs on an annual basis. Audit of adherence to procedures set out within Ligature Minimisation Policy occurs on an annual basis. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Yes	28/04/2020	Joe Kelly; Greg Smith
Preventative Action	Hospital has in place Observation Policy which continues to be implemented. Hospital has Ligature minimisation plan which continues to be implemented. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Audit of adherence to procedures set out within Observation Policy occurs on an annual basis. Audit of adherence to procedures set out within Ligature Minimisation Policy occurs on an annual basis. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Yes	28/04/2020	Joe Kelly; Greg Smith
The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and the safety and well-being of residents because there were exposed electrical flexes in the communal lounge area and a broken plant pot with exposed metal wiring within the Ginesa garden area, 22(3).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Hospital has in place Observation Policy which continues to be implemented. Hospital has Ligature minimisation plan which continues to be implemented. Exposed cables in Ginesa will be secured. Broken plant pot was removed on date of inspection. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Audit of adherence to procedures set out within Observation Policy occurs on an annual basis. Audit of adherence to procedures set out within Ligature Minimisation Policy occurs on an annual basis. Garden area now included in horticultural teams' work schedule. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Yes	28/04/2020	Joe Kelly; Greg Smith
Preventative Action	Hospital has in place Observation Policy which continues to be implemented. Hospital has Ligature minimisation plan which continues to be implemented. Broken plant pot was removed on date of inspection. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Audit of adherence to procedures set out within Observation Policy occurs on an annual basis Audit of adherence to procedures set out within Ligature Minimisation Policy occurs on an annual basis. Garden area now included in horticultural teams' schedule.	Yes	28/04/2020	Joe Kelly; Greg Smith
The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and the safety and well-being of residents and did not ensure that the premises were maintained in good structural and decorative condition, 22 (1)(a).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• Hospital has in place Observation Policy which continues to be implemented. Hospital has Ligature	Audit of adherence to procedures set out within Observation Policy occurs on an annual basis. Audit of	Yes	28/04/2020	Joe Kelly; Greg Smith

	minimisation plan which continues to be implemented. Exposed cables in Ginesa will be secured. Broken plant pot was removed on date of inspection. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	adherence to procedures set out within Ligature Minimisation Policy occurs on an annual basis. Garden area now included in horticultural teams' work schedule. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant			
Preventative Action	Hospital has in place Observation Policy which continues to be implemented. Hospital has Ligature minimisation plan which continues to be implemented. Broken plant pot was removed on date of inspection. Structural and decorative work for this centre is included in rolling maintenance schedule which is budget dependant.	Audit of adherence to procedures set out within Observation Policy occurs on an annual basis Audit of adherence to procedures set out within Ligature Minimisation Policy occurs on an annual basis. Garden area now included in horticultural teams' schedule.	Yes	28/04/2020	Joe Kelly; Greg Smith

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Eight MPARs did not contain a clear record of the discontinuation date for each medication, 23(2). Five MPARs did not record all of the medications administered or not administered to the resident, 23(2).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The missing discontinuation dates identified on inspection were completed by the prescriber. The gaps in the administration record were completed by the nurse responsible for administering the medication.	Actions completed	Actions completed	13/07/2020	Dolores Keating; Cathy Shelley
Preventative Action	All staff receive training in prescription writing and administration of medicines. Staff familiarise themselves with policies and procedure relating to the use of the prescription chart. Prescription writing and administration of medicines are part of a continuous audit and feedback programme to raise and maintain standards. Medication safety events relating to prescription writing and medicines administration are recorded on DATIX, and analysed by a pharmacist to identify trends and areas for improvement. Nursing staff receive information on medications administration during their orientation and induction period.	All systems are in place	All systems are in place	13/07/2020	Dolores Keating; Cathy Shelley

Regulation 26: Staffing					
Not all health care professionals had up-to-date mandatory training in the management of violence and aggression and Basic Life Support 26(4).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff will be reminded to complete mandatory training under H&S guidelines and training regulations. Regular training programmes are held. Staff are given dates, times and locations of training, communicated by emails and text reminders.	Training Officer to monitor training compliance.	Achievable with co-operation from staff and management to provide cover to release staff to attend training.	28/04/2020	A Doherty, HR Manager
Preventative Action	Continuous monitoring and audit checks on training compliancy.	Reporting to line managers and at monthly management meetings.	Achievable with co-operation from staff and management to provide cover for releasing staff to complete training. Ensure all new staff complete training in advance or in Induction week. Look at alternative training methods to meet H&S guidelines. Offer training on different days/times to capture part-time staff.	28/04/2020	A Doherty, HR Manager

Regulation 27:Maintenance of Records					
Not all paper based records were not maintained in a logical sequence and good order as some documents were observed to be filed in the incorrect file section, 27(1).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Administration and Nursing to review hard copy clinical records.	Audit to be created based on outcome of inspection.	Yes	30/09/2020	Sarah Donnelly; Bairbre O' Sullivan
Preventative Action	Audit of new sequencing to be completed	Bi-Annually	Sarah Donnelly; Bairbre O' Sullivan	21/12/2020	Sarah Donnelly; Bairbre O' Sullivan

Regulation 28: Register of Residents					
The register of residents did not include all information as specified in Schedule 1 of the regulation, 28(2).					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review current register to ensure all relevant information is captured.	Audit is to be developed based on review.	Yes	30/09/2020	Bairbre O' Sullivan; Lorraine Cameron
Preventative Action	Implement audit ensuring all information is inputted.	Bi-annual audit	Yes	21/12/2020	Bairbre O' Sullivan; Lorraine Cameron

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
The approved centre did not comply with Regulation 18: Transfer of Resident, 30.1.					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Medical staff notified of Admission, Transfer, Discharge Code of Practice requirements. Implement into Discharge Summary immediately.	Bi-annual Discharge Summary Audit	Yes	28/04/2020	Dr David McNamara
Preventative Action	Going forward discharge summary will include required information	Bi-annual Discharge Summary Audit	Yes	28/04/2020	Dr David McNamara
The comprehensive discharge summary did not included details of the resident's mental state at discharge, 38.4. The comprehensive discharge summary did not include details of follow-up arrangements, 38.4. The comprehensive discharge summary did not include names and contact details of key people for follow-up, 38.4. The discharge assessment did not address psychiatric and psychological needs, 34.4. The discharge assessment did not address a comprehensive risk assessment and risk management plan, 34.4.					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Medical staff notified of Admission, Transfer, Discharge Code of Practice requirements. Implement into Discharge Summary immediately.	Bi-annual Discharge Summary Audit	Yes	28/04/2020	Dr David McNamara
Preventative Action	Going forward discharge summary will include required information	Bi-annual Discharge Summary Audit	Yes	28/04/2020	Dr David McNamara

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.

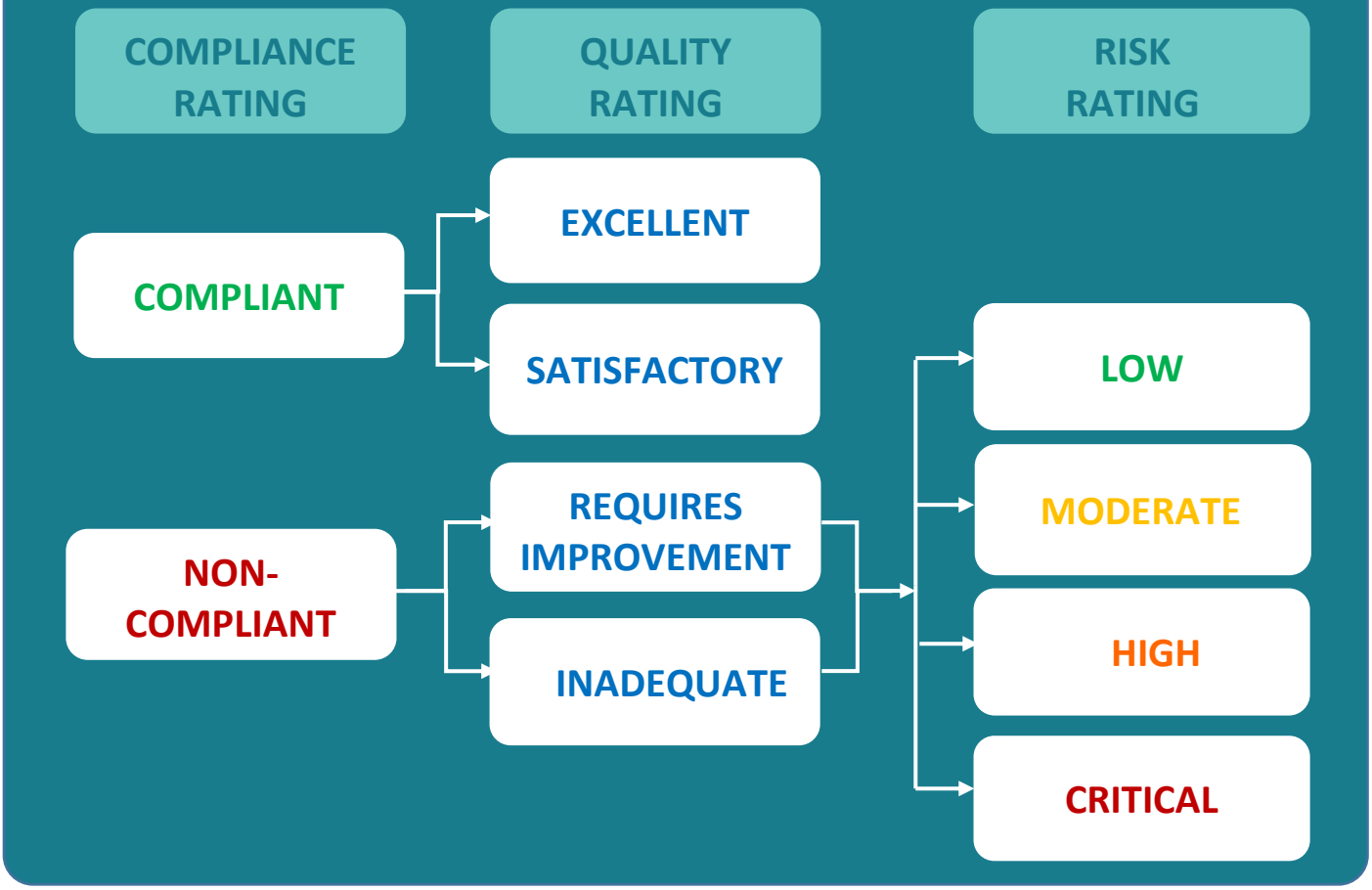
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

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, risk ratings and quality assessments, 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, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
QUALITY RATINGS are generally given for all regulations, except for 28, 33 and 34.
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.