MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Ginesa Suite
Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

GINESA SUITE

St. John of God Hospital, Stillorgan, Co. Dublin

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2020 Approved Centre Inspection Report (Mental Health Act 2001)

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:
Siobhán Dinan, Lead Inspector
Karen McCrohan

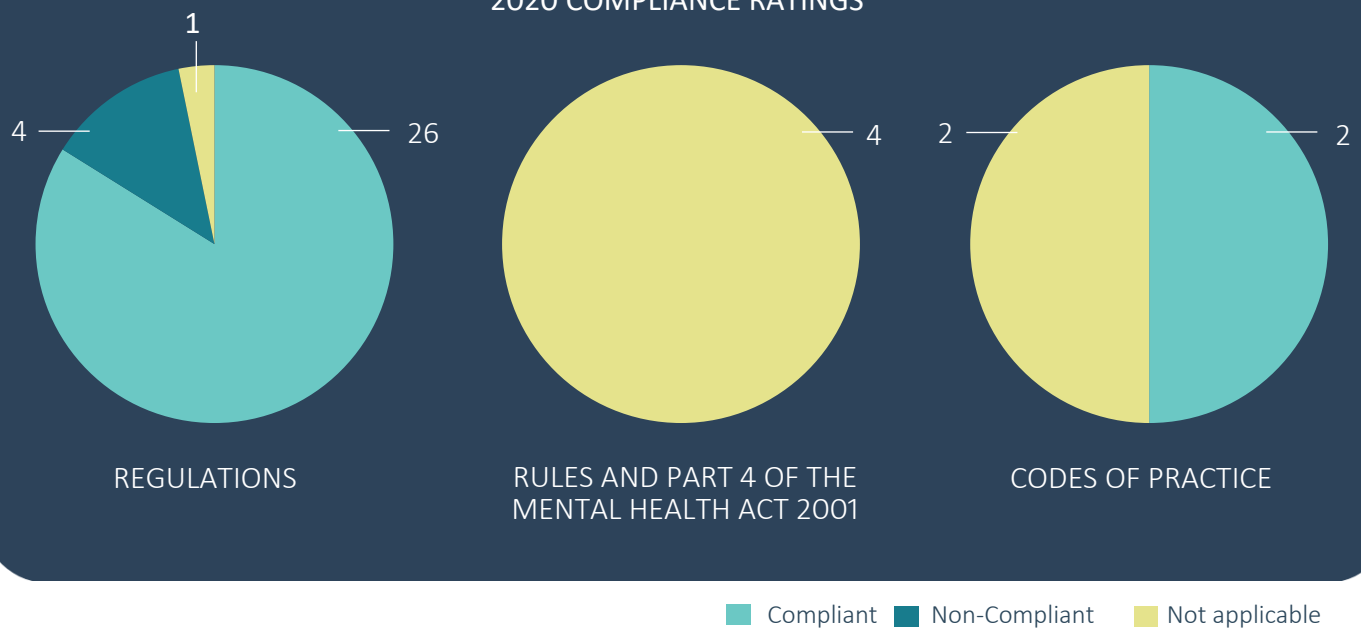
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
23 – 26 November 2020

Previous Inspection Date:
2 – 5 December 2019

Inspection Type:
Announced Annual Inspection

2020 COMPLIANCE RATINGS

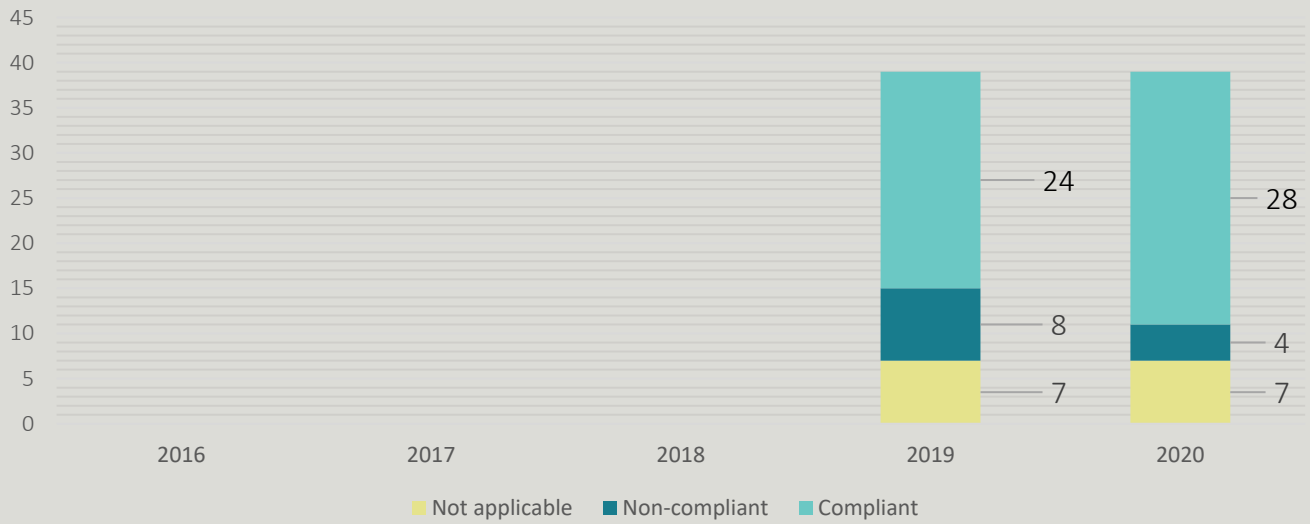


RATINGS SUMMARY 2016 – 2020

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

The approved centre opened in June 2019.

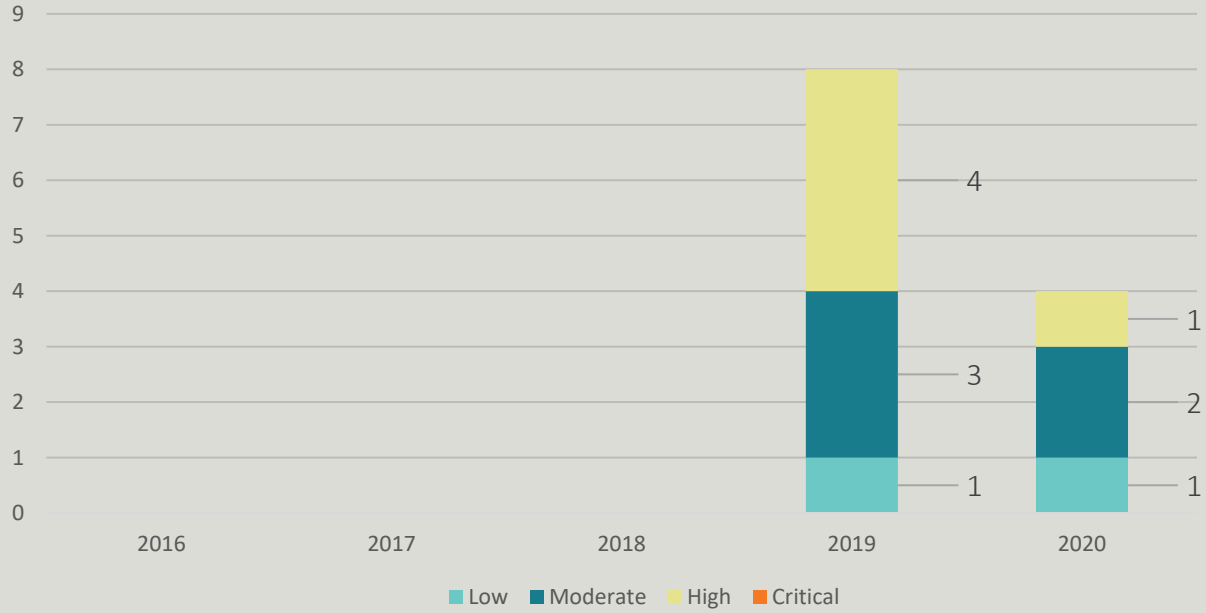
CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2016 – 2020

The approved centre opened in June 2019.



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with Regulations, Rules and Codes of Practice.

In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

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

Compliance Summary	2019	2020
% Compliance	75%	88%
Regulations Rated Excellent	12	N/A

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

- There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Kitchen areas were clean.
- Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces were all minimised in the approved centre.

- Medication was ordered, prescribed, stored, and administered in a safe manner.
- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.

However, ligature points were not minimised to the lowest practicable level.

Appropriate care and treatment of residents

- Each young person had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident.
- Each young person had a general health assessment on admission and afterwards, as necessary.

However:

- There was no occupational therapist in Ginesa at the time of the inspection, nor was there cross care cover available. Occupational therapy needs identified in individual care plans were not met.
- There was no access to a social worker at the time of inspection as the post was vacant.

Respect for residents' privacy, dignity and autonomy

- There were two single bedrooms and five double bedrooms with separate communal washing and toileting facilities.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, and where residents shared a room, bed screening ensured that their privacy was not compromised.
- Noticeboards did not display the young peoples' names or other identifiable information.
- Young people were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where young people could meet their visitors in private.
- The approved centre was compliant with the Code of Practice on the Use of Physical Restraint.

However, CCTV was recording residents passing through the foyer to go into the dining room.

Responsiveness to residents' needs

- Recreational activities included TV, music, books, daily newspapers, board games, arts and crafts. Residents also had access to a gym, pitch and putt course, soccer pitch, tennis court, table tennis, and bicycles. Recreational activities were provided on weekdays and weekends.

- The information booklet was clearly and simply written. Young people and their families or carers were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- Young people had at least two choices of food at mealtimes.
- To meet the needs and preferences of the young people, the approved centre introduced the option of video consultation as a service support option.
- The approved centre developed and implemented a COVID-19 information resource booklet for carers.

Governance of the approved centre

- The approved centre was part of the St John of God Hospital services and fell within the remit of overall service governance processes. The service was governed by a board of directors.
- The Clinical Governance Quality and Safety Executive Committee (CGQSE) 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.
- The Ginesa Management Team meeting convened six times per annum.
- The local risk register had been reviewed at least quarterly 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. All incidents were recorded and risk-rated in a standardised format on the Datix system, the approved centre's electronic risk management system.
- There were weekly resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal). An advocate from the Youth Advocacy Programme (YAP) attended the approved centre on a regular 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.
- Performance was measured through the regular review of key performance indicators; comments, compliments and complaints; incident reports and audit findings. The inspection highlighted a significant improvement in compliance since 2019.
- In response to the COVID-19 crisis, the approved centre implemented a well-developed and proactive COVID-19 Response Plan including teleconferencing for patient consultations and staff meetings, restricted visiting, and weekly emergency planning meetings which dealt specifically with COVID-19 requirements/controls, government updates to guidelines, suppliers and further contingency planning. COVID-19 was now a standing item on the agenda of CGQSE. There were separate and regular COVID-19 management meetings since the onset of the pandemic.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. To meet the needs and preferences of residents, the approved centre introduced the option of video consultation as a service support option.

2. The approved centre developed and implemented a COVID-19 information resource booklet for carers.

3. The approved centre developed and implemented a Mental Health & Wellbeing, Social Distancing and Cocooning information booklet.

4. The approved centre was awarded the Green Healthcare Award 2020 from the Business & Sustainability Green Awards.

5. As part of the approved centres Green Initiative, solar panels had been installed.

6. The approved centre received the Ibec Keep Well mark - Wellbeing accreditation by focusing on key areas of workplace well-being.

7. The approved centre implemented Lean Six Sigma training during 2020. There were six nursing staff engaged in greenbelt projects.

8. A Nursing Quality Improvement Committee had been established within the approved centre. This committee reviewed nursing audits, polices and quality improvement initiatives.

9. The approved centre installed whiteboards in each bedroom in Ginesa so that residents had the opportunity to personalise their bedrooms if they wished to do so.

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. 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	**8**
Number of detained patients	0
Number of wards of court	0
Number of children	8
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 St 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. COVID-19 was now a standing item on the agenda, although there were separate and regular COVID-19 management meetings since the onset of the pandemic. 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 six times per annum.

The approved centre had a standardised process for the management of risks and incidents. The local risk register had been reviewed at least quarterly 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. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The inspected risk management procedures actively reduced identified risks to the lowest practicable level of risk. The risk of COVID-19 was actively managed through the approved centre's risk management processes. All incidents were recorded and risk-rated in a standardised format on the Datix system, the approved centre's electronic risk management system. An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The authority and responsibility of line managers for the various disciplines were clear. The number of social work and occupational therapy staff were not sufficient to meet resident needs. At the time of inspection, the posts for social worker and occupational therapist were vacant. As a result, residents had no access to social work or occupational therapy in the approved centre.

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 regular 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. The approved centre demonstrated a commitment to improving quality. Performance was measured through the regular review of key performance indicators; comments, compliments and complaints; incident reports and audit findings. The inspection highlighted a significant improvement from the previous year as the approved centre's non-compliances had reduced from eight to four. In response to the COVID-19 crisis, the approved centre implemented a well-developed and proactive COVID-19 Response Plan to help prevent the spread of the COVID-19 virus. During an outbreak of COVID-19, the approved centre implemented protocols across the Ginesa Suite to safeguard residents, staff, contractors and visitors. Some of these protocols included virtual attendance through technological solutions such as teleconferencing for patient consultations and staff meetings, restricted visiting, and weekly emergency planning meetings which dealt specifically with COVID-19 requirements/controls, government updates to guidelines, suppliers and further contingency planning.

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. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 16 : Therapeutic Services and Programmes							✓		✗	Moderate
Regulation 21: Privacy							✗	High	✗	Low
Regulation 22 : Premises							✗	High	✗	High
Regulation 26: Staffing							✗	Low	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

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

Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- As this was an approved centre for children and adolescents, the Youth Advocate Programme (YAP) representative was contacted to obtain residents' feedback about the approved centre.

Resident feedback was by way of questionnaire and a report furnished by the Youth Advocate Programme (YAP) representative. 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.

Four completed service-user questionnaires were returned. All young people ticked to indicate that on admission to the approved centre a member of staff had explained what was happening in a way that they could understand. Three respondents indicated that staff 'always' gave information regarding diagnosis and care and treatment, in a way that was understood. One indicated 'sometimes' for this question. All completed questionnaires indicated that the young person knew who their multi-disciplinary team members were, with three of the four indicating that they were 'always' involved in setting goals for their individual care plan. The remaining one stated that they were 'sometimes' involved. All questionnaires indicated that the young person understood their individual care plan. Three of four young people stated that they knew who their keyworker was, with one young person leaving that question blank. Three young people indicated that they always felt able to discuss their worries or concerns with a staff member with the remaining one indicating 'sometimes'. All four indicated that they were happy with how staff talked to them.

All the respondents felt that there were not enough activities during the day. Young people commented that there was a lack of resources such as an occupational therapist and a clinical nurse specialist, that there was a lack of therapies overall and that the occupational therapist had not yet been replaced. All indicated that they had space for privacy and that their privacy and dignity was respected. Three young people ticked that they 'always' felt safe in the approved centre, and the one remaining indicated 'sometimes' for this question. On a scale of 1-10, with 1 being poor and 10 being excellent, one young person rated ten out of ten for overall care and treatment, one resident rated 9, one resident rated 7 and the remaining resident rated 5 out of ten.

The report furnished by the YAP representative indicated that residents expressed that staff in the unit were fast to respond to issues raised. The main themes that arosed through group advocacy sessions were concerns regarding restrictions on visiting due to COVID-19 and the need for more activities and groups to be run on the unit.

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:

- Chief Executive Officer
- Clinical Director
- Consultant Psychiatrist
- Director of Nursing
- Deputy Director of Nursing
- Head of Operations
- Head of Psychology
- Head of Pharmacy
- Head of Human Resources
- Customer Service & Quality Assurance Officer
- Head of Occupational Therapy
- Head of Social Work

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals and a source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless otherwise specified in their individual care plans. No residents wore nightclothes during the day at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in November 2019. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP or in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile. Activities included TV, music, books, daily newspapers, board games, arts & crafts. Residents also had access to a gym, pitch & putt course, soccer pitch, tennis court, table tennis, and bicycles. Recreational activities were provided on weekdays and weekends.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in December 2019. There were no visits allowed at the time of inspection due to pandemic events. The approved centre had a separate visitor's room available for when visits resumed. The visitors' room provided residents with a private space to meet visitors, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting room was suitable for children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in October 2019. Residents had access to Wi-Fi, electronic tablets, and computers. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches, which was last reviewed in July 2020. It included all requirements related to:

- 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.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

Risk was assessed prior to the search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches and the request for consent and the received consent were documented for every search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents and relevant staff were documented to have read and understood the policy on searches.

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; 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. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in November 2019.

No deaths had occurred in the approved centre since the previous inspection and no end of life care was provided. Compliance was assessed on the policy aspect (section 1), of the regulation only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICP was reviewed by the MDT weekly, in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. The ICPs included the resident's educational requirements.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of one resident, as documented in their individual care plan. One resident had occupational therapy-based assessed needs. These were not met as there was no occupational therapist in Ginesa at the time of the inspection, nor was there cross care cover available. This post had been vacant for four weeks. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre did not arrange for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was non-compliant with this regulation because the therapeutic services and programmes provided by the approved centre did not meet the assessed needs of one resident, as documented in their individual care plan, 16(1).

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

All residents were assessed regarding their individual education requirements, with consideration of their individual needs and age on admission. Where appropriate to the needs and age of the young person, the education provided by the approved centre was reflective of the required educational curriculum. Appropriate facilities were available for the provision of education; there was a dedicated classroom onsite. Sufficient personnel resources were also available for the provision of education to the residents within the approved centre.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the transfer of residents. The policy was last reviewed in July 2020. The clinical file of one resident who had been transferred was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information about the resident was sent to a named individual, including a letter of referral that contained a list of current medications, a resident transfer form, and the required medication for the resident during the transfer process.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy, a medical emergencies policy and procedures for responding to medical emergencies. The general health policy was last reviewed in July 2020. The medical emergencies policy was last reviewed in June 2020. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED), both of which were checked weekly. Residents received appropriate general health care interventions in line with individual care plans.

No residents had been in the approved centre for more than six months at the time of the inspection.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in February 2020. The required information was provided to residents and their representatives at admission, including the approved centre's information booklets that detailed its care and services. The booklets, one for residents and one for their families, were available in the required formats to support resident needs and information was clearly and simply written. They contained details of: housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and; residents' rights.

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Medication information was provided to residents through a medication website, as well as verbally, in a format appropriate to resident needs. The content of the medication information website used included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

Residents were called by their preferred name and the general demeanour of staff and the way in which they dressed and communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs and sought the resident's permission before entering their room, as appropriate.

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy. Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls. However, CCTV was recording residents passing through a foyer into the dining room.

The approved centre was non-compliant with this regulation because it did not ensure that the resident's privacy and dignity was appropriately respected at all times as CCTV was recording residents passing through the foyer to go into the dining room.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics. The lighting in communal rooms suited the needs of residents and staff. 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.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet per floor. There was a designated cleaning room and all resident bedrooms were appropriately sized to address the resident needs. The approved centre provided assisted devices and equipment to address resident needs, as well as suitable furnishings to support resident independence and comfort.

Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre. Ligature points were not minimised to the lowest practicable level based on risk assessment. The approved centre had a ligature reduction plan. However, remedial works were delayed due to COVID-19.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was clean, hygienic, and free from offensive odours and rooms were centrally heated with pipe work and radiators guarded. Current national infection control guidelines were followed.

The approved centre was non-compliant with this regulation because ligature points were not minimised to the lowest practicable level, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had multiple written policies and procedures on the ordering, prescribing, storing and administration of medicines. The policies were last reviewed in July 2020 and included:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident, and; a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the electronic signature of the medical practitioner for each entry.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition: this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. 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, such as the refrigerator.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had several written policies and operating procedures relating to health and safety. The policies were last reviewed in November and December 2019.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedure on the use of CCTV. The policy was last reviewed in December 2019 and included the purpose and function of using CCTV for observing residents in the approved centre.

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 had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services.

CCTV cameras within the Ginesa Suite ward area used to observe residents did not record or store the residents' image on a tape, disc or hard drive. CCTV cameras 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 foyer 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 in close proximity to the dining room specifically used by Ginesa Suite residents.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had three written operational policies and procedures in relation to staffing. The policies were last reviewed in October 2019. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staffing was not sufficient to meet resident needs, as at the time of inspection the occupational therapy and social work posts were vacant. Cross care cover was available for social care needs but not for occupational therapy needs. As a result, residents had no access to occupational therapy in the approved centre. An appropriately qualified staff member was on duty and in charge at all times. This was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) & 26(5) have been deferred until 2021.

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

Staff in Approved Centre		
Staff Grade	**Day**	**Night**
Clinical Nurse Manager 2	1	1
Clinical Nurse Manager 1 (Acting)	1	0
Registered Psychiatric Nurse	5	2
Consultant Psychiatrist	1	-
Non Consultant Hospital Doctor	2	-

Occupational Therapist	0	-
Social Worker	0	-
Psychologist	0.57	-

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Dietician	As required	
Speech & Language Therapist	As required	
Yoga Teacher	As required	
Music Teacher	As required	
Pet Therapist	As required	
Wellbeing Therapist	As required	
Art Therapist	As required	

Whole time equivalent (WTE)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

The approved centre was non-compliant with this regulation because the numbers and skill mix of staffing were not sufficient to meet resident needs. Residents had no access to occupational therapy in the approved centre, 26(2).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in March 2019 and included:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

Residents' records were secure, up-to-date, and in good order. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were appropriately secured 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.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures requiring a three-yearly review were reviewed appropriately.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in January 2020 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon thereafter. The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s ICP. Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them: this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in December 2019. There were also a number of associated policies, including: a Major Emergency Plan, which was last reviewed in February 2017; a Fire Policy, which was last reviewed in January 2018; Infection Control Operational Procedures, which was last reviewed in November 2019, and; a Patient Observation Policy, which was last reviewed in August 2019. The policies contain all necessary requirements.

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

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

Health and safety risks were identified, assessed, treated, reported, monitored and documented within the risk register as appropriate. 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 approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered 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 approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

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

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. The record was available to the inspector.

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

Evidence of Implementation: The clinical file of a resident that had been physically restrained was examined on inspection. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Completed clinical practice forms had been placed in the resident's clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in July 2020, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in July 2020, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in November 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 admission, transfer, and discharge policies.

Evidence of Implementation:

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

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

Discharge: The clinical file of a resident who had been discharged was examined. The discharge plan included the estimated date of discharge, a follow-up plan, and documented communication with the relevant general practitioner, primary care team, or community mental health team (CMHT). The discharge meeting was attended by the resident, their key worker, relevant members of the multi-disciplinary team (MDT), and their family, carer, or advocate.

The discharge assessment addressed the resident's psychiatric and psychological needs, a current mental state examination, and a comprehensive risk assessment and risk management plan. The discharge was coordinated by a key worker and a comprehensive discharge summary was sent within 14 days to the relevant general practitioner, primary care team, or CMHT that detailed the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, the names and contact details of key people for follow-up, and risk issues.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10001865		**The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of one resident, as documented in their individual care plan, 16(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The service user identified in the inspection has been discharged. However, where a specific need for Occupational Therapy arises during this post vacancy, the approved centre will arrange for the service to be provided by an approved, qualified health professional in an appropriate location. A Recruitment process for vacant Occupational Therapy Post will be commenced.	Post filled	Should be achievable	30/06/2021	Head of Occupational Therapy and Human Resources Manager
Preventative Action	Vacancies arise from time to time when staff resign/move to a different job, therefore it is sometimes hard to predict when	Measure time between vacancies arising and filling the posts	Achievable but will depend on the job market at the time the vacancy arises	31/12/2021	Relevant Heads of Department where the vacancies arise and the Human Resources Manager

	vacancies may arise. Posts within the approved staffing complement and budget will be advertised once the vacancies are notified to HR via the MPP process which is in place for this service.				

Regulation 21: Privacy					
Reason ID : 10001866		**The approved centre did not ensure that the resident's privacy and dignity was appropriately respected at all times as CCTV was recording residents passing through the foyer to go into the dining room.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Reduce the arc of observation of the camera to permit security but avoid coverage of residents entering the dining room.	Arc of observation altered.	Achievable	30/04/2021	Head of Technical Services
Preventative Action	Adjust the arc of observation on the security camera to prevent coverage of the residents entering the dining room.	Arc of observation altered.	Achievable.	30/04/2021	Head of Technical Services

Regulation 22: Premises					
Reason ID : 10001867		**Ligature points were not minimised to the lowest practicable level, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure that the physical structure of the approve centre environment is developed and maintained with due regard to the specific needs of residents and their saferty & well-being and that of staff and visitors, the approved centre has in place an Observation Policy that continues to be implemented and a Ligature Minimisation Plan which continues to be implemented in line with National Covid 19 Resilience & Recovery 2021 governent guidelines and the restrictions in force with regard to Construction at any given time. The actions relating to the minimisation of ligature points in	Completion of 2021 ligature minimisation works in Ginesa.	Achievable but dependent on contractors being allowed on site once Covid 19 restrictions permit.	31/12/2021	Chief Executive and Head of Operations and Quality

	Ginesa Suite are listed for completion in 2021 subject to contractors being allowed on site once Covid 19 restrictions permit.				
Preventative Action	Observation Policy and Ligature Minimisation Policy in place.	Monthly review of adverse incidents. Updates to Management Team and Board CGQS Sub-committee on implementation of the 2021 - 2023 Ligature Minimisation Plan	Dependant upon Covid 19 restrictions in place at any given time.	31/12/2021	Chief Executive and Head of Operations and Quality in relation to ligature minimisation and Clinical Director and Director of Nursing in relation to Observation Policy.

Regulation 26: Staffing					
Reason ID : 10001868		**The numbers and skill mix of staffing were not sufficient to meet resident needs. Residents had no access to occupational therapy in the approved centre, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Recruitment for vacant Occupational Therapy Post and Social Work Post	Posts filled	Should be achievable	30/06/2021	Head of Occupational Therapy, Head of Social Work and Human Resources Manager
Preventative Action	Vacancies arise from time to time when staff resign/move to other jobs/are promoted etc. Posts within the approved staffing complement and budget will be advertised once they are notifed to HR via the MPP process that is in place for this service.	Measure times between vacancies arising and filling the posts.	Achievable but will depend on the job market at the time the vacancy arises.	31/12/2021	Relevant Heads of Departments and Human Resources Department

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

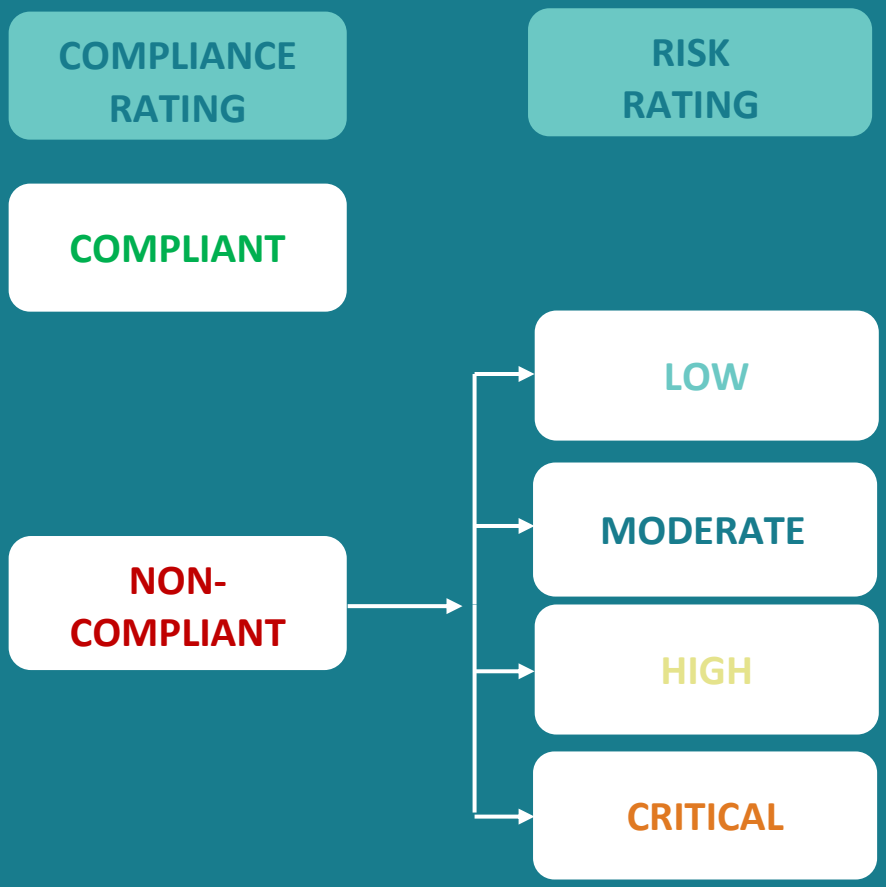
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.