Ginesa Suite

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

GINESA SUITE

St John of God Hospital, Stillorgan, Co. Dublin

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2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Child and Adolescent Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
17 May 2019

Registered Proprietor:
St. John of God Hospital CLG

Registered Proprietor Nominee:
Ms Emma Balmaine, Chief Executive

Inspection Team:
Fergal Duffy, Lead Inspector
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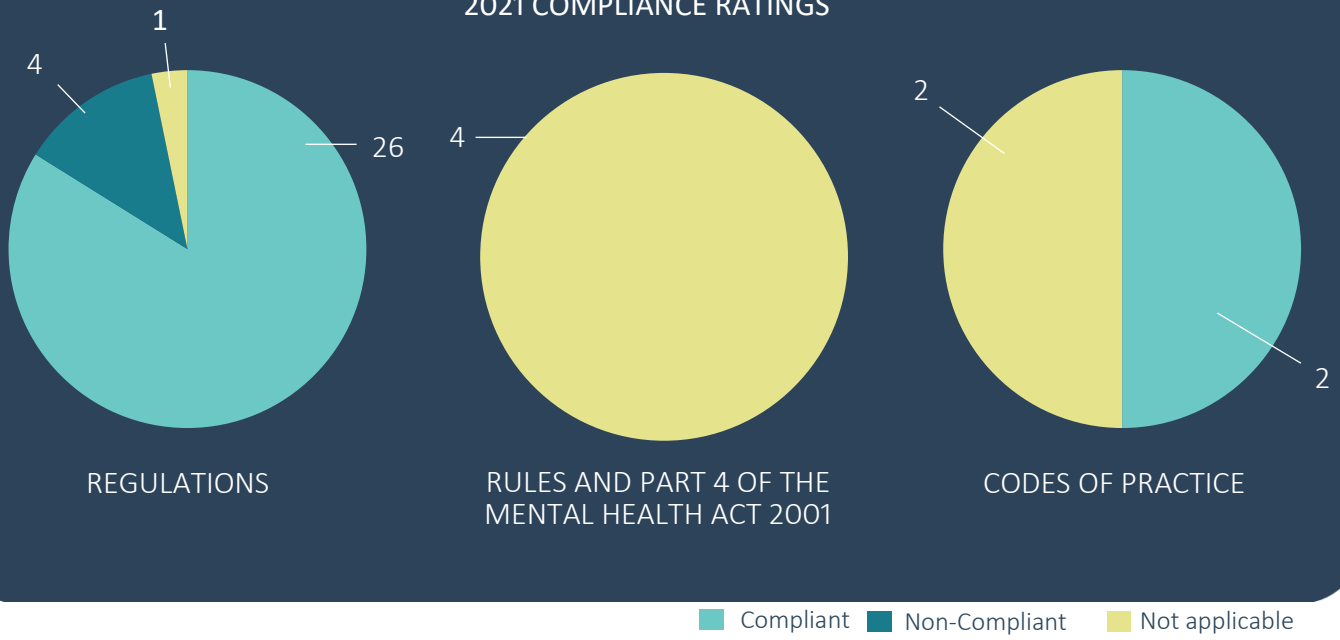
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
10 – 13 August 2021

Previous Inspection date:
23 – 26 November 2020

Inspection Type:
Announced Annual Inspection

2021 COMPLIANCE RATINGS

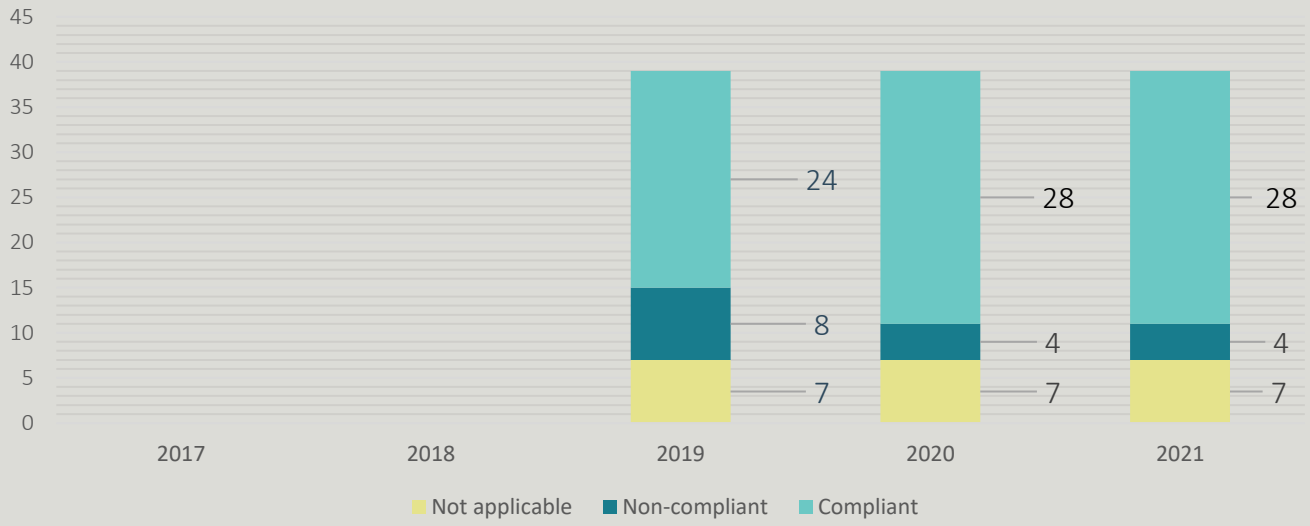


RATINGS SUMMARY 2017 – 2021

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

The approved centre opened in June 2019.

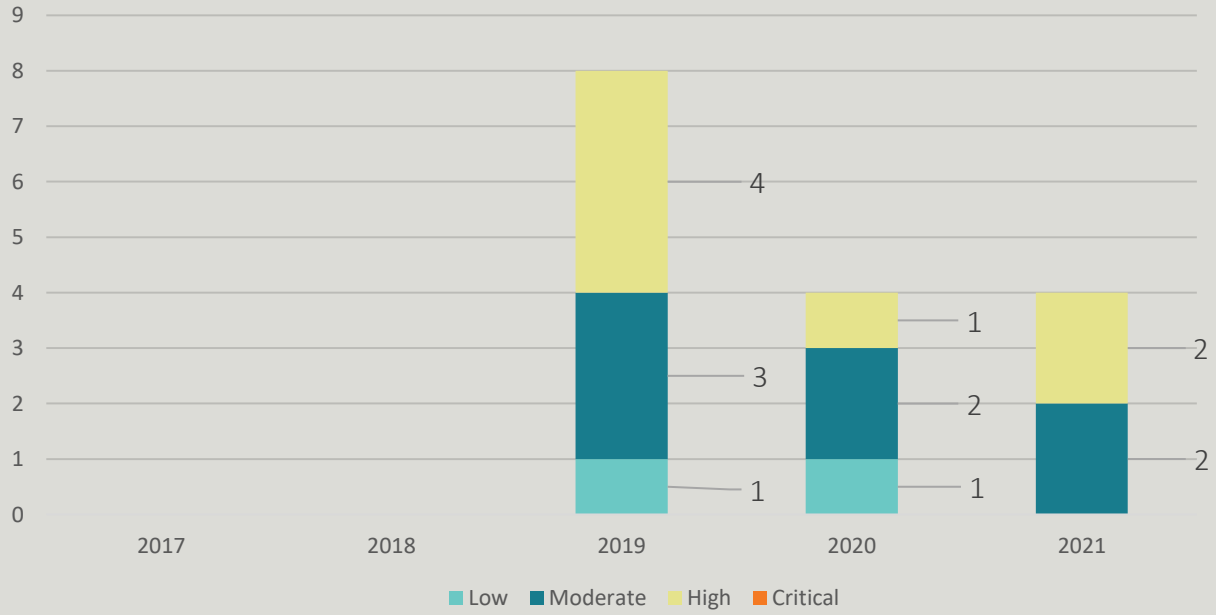
CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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 2017 – 2021

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 a 12-bed Child and Adolescent Mental Health in-patient unit located on the St. John of God Hospital campus in Stillorgan, Co. Dublin. It provided treatment to young people aged from thirteen to seventeen years of age from all over Ireland. All residents were under the care of a single multi-disciplinary team (MDT). A school facility was available to residents on the ground floor of the main hospital building.

Compliance Summary	2019	2020	2021
% Compliance	75%	88%	88%
Regulations Rated Excellent	12	N/A	N/A

The average rate of compliance across all approved centres in 2020 was 87%.

Conditions to registration

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

Escalation and enforcement actions since last inspection

There were no escalation and enforcement actions since the last inspection.

Safety in the approved centre

We found that the approved centre operated safe practices in most circumstances, which reduced risk of harm to residents.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.

However:

- While works were underway and on-going at the time of the inspection to reduce identified and documented ligature points, not all ligature points had been minimised at the time of the inspection.
- Two out of five medication prescription and administrative records did not document a record of all the medications administered to a resident.

Appropriate care and treatment of residents

We found that the approved centre did not provide a full range of therapeutic services.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- Residents had access to complementary therapies such as yoga. A music therapist and art therapist attended the approved centre weekly. There was access to a speech and language therapist and a dietitian for residents. The approved centre ordinarily had access to pet therapy, but this was on hold due to COVID-19 Pandemic. Psychology was a 0.57 whole time equivalent (WTE) post, and the psychologist provided 1:1 work. Nursing staff delivered some group work on topics such as anxiety management, post-meal support and relaxation.

However, residents did not have any access to social work (SW) and occupational therapy (OT) services since late 2020. At the time of the inspection there was an occupational therapy manager, but this individual did not provide OT services to Ginesa Suite. A SW was due to commence the week after this inspection.

Respect for residents' privacy, dignity, and autonomy

We found that facilities and processes respected residents' privacy and dignity.

- There were two single bedrooms and five double bedrooms, none of which were en suite. There were separate communal washing and toileting facilities.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- Noticeboards did not display resident names or other identifiable information.
- Residents 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 residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of young people and their families.

- Recreational activities and equipment included a pool, table, table football, musical instruments, computer games, books, board games, TV, internet access, art materials and table tennis inside. Outside there was exercise equipment in the garden, a soccer pitch, tennis and basketball courts, pitch and putt and a garden area for residents.
- The information booklet was clearly and simply written. Residents 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.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

- The approved centre was under the governance of St. John of God Hospital CLG. The service was governed by a board of directors and there was an established organisational and clinical governance structure. The hospital CEO and Clinical Director reported to the board monthly.
- The Clinical Governance Quality and Safety Executive Committee (CGQSE) convened monthly and reported to a board sub-committee for clinical governance, quality, and safety.
- 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 database, the approved centre's electronic risk management system.
- 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.
- 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.

COVID-19 response

In response to the COVID-19 pandemic, the approved centre implemented a comprehensive and proactive COVID-19 Response Plan to help prevent the spread of the COVID-19 virus.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. **Lean Six Sigma Quality Improvement:** A new on-line day support service was commenced for Ginesa suite service users. An electronic transfer of prescriptions facility was developed to support outreach services.

2. **Verbal Complaints Management process moved to Datix system:** This electronic method of reporting verbal complaints made by residents or their advocates to any staff member has been developed. The system immediately notifies the Complaints Officer that a verbal complaint has been reported. This ensured timely response to the complainant, improved gathering of information, and quicker follow up and action in response to verbal complaints.

3. **Online Datix dashboards for suites for incident trending & statistics:** The Ginesa suite has an online dashboard to view their incident trends and statistics. Datix system training was provided to staff on orientation and is part of the overall risk management strategy.

4. **Individualised auto-reports for management team for corporate risks on the risk register:** The senior management team had access to real time automatic electronic risk reports for their area of responsibility, facilitating prompt review of risks and clear oversight by the management team and risk officer.

5. **ViClarity Project:** ViClarity was a database system used to provide a centralised platform for clinical audit, risk management and regulatory compliance with access to real time data, facilitating oversight and rapid response to areas of concern.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Ginesa suite was located on the St. John of God Hospital campus in Stillorgan, Co. Dublin. The approved centre was situated on the first floor of the main building. It was registered as an individual approved centre for child and adolescent mental health services on the 17th June 2019. It provided treatment to young people aged from thirteen to seventeen years of age from all over Ireland. All residents were under the care of a single multi-disciplinary team (MDT).

The centre was registered for twelve beds. There were two single bedrooms and five double bedrooms, none of which were en suite. There were separate communal washing and toileting facilities. The unit had adequate therapeutic and communal areas and residents had access to an indoor gym and outdoor recreational facilities located on the grounds of St. John of God Hospital. A school facility was available to residents on the ground floor of the main hospital building.

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

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

3.2 Governance

The approved centre was under the governance of St. John of God Hospital CLG. The service was governed by a board of directors and there was an established organisational and clinical governance structure. The hospital CEO and Clinical Director reported to the board monthly. The Clinical Governance Quality and Safety Executive Committee (CGQSE) convened monthly 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. Governance was further strengthened by sub-committees for specific aspects of service provision, under the umbrella of risk and clinical effectiveness and quality improvement. 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 suite 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. All incidents were recorded and risk-rated in a standardised format on the Datix database, 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 since late 2020. As a result, residents had no access to social work or occupational therapy in the approved centre. A social worker was appointed and due to commence as part of the MDT the week after the inspection. A senior occupational therapy post was advertised by the service during the inspection.

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 suite management meeting. The approved centre had portable electronic devices and internet access facilitating residents to maintain contact with their natural supports.

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. In response to the COVID-19 pandemic, the approved centre implemented a comprehensive and proactive COVID-19 Response Plan to help prevent the spread of the COVID-19 virus.

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 2017 and 2021 and the relevant risk rating when the service was non-compliant:

The approved centre opened in June 2019.

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 16: Therapeutic Services					✓		✗	Moderate	✗	High
Regulation 22: Premises					✗	High	✗	High	✗	Moderate
Regulation 23: Medications					✗	High	✓		✗	Moderate
Regulation 26: Staffing					✗	Low	✗	Moderate	✗	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 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 have a seclusion facility, 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

5.1 Service-user feedback

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:

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.

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

The feedback provided to the inspection team was by way of completed questionnaires, of which the inspection team received four. No resident availed of the opportunity to speak with inspectors. All four questionnaire respondents reported being provided with information about their diagnosis, care, and treatment. All four respondents said staff were available to provide therapeutic assistance for any worries or concerns they had. All respondents expressed satisfaction with how staff talk to them and felt that their dignity and privacy were respected. Every respondent said they were free to communicate with family, friends, and advocacy services. All four respondents said they were familiar with their care plan. All respondents said they were involved in goal setting as part of the care planning process. The average standard of care rating was seven out of ten.

There were some issues highlighted, mainly the lack of organised activities for residents outside of school terms. Visits was highlighted as an issue but had been addressed in so far as practicable in line with public health guidelines.

5.2 Advocacy

The approved centre did have an advocacy service. The Inspectors did not receive a report from the YAP representative. The YAP representative was not available to speak to the inspectors due to being on annual leave. The approved centre provided the inspection team with copies of recent YAP advocacy reports submitted to the Ginesa suite management team. These reports were examined by the inspection team. The residents reported enjoying trips out of the hospital such as to the cinema, found playing with the pet rabbits

to be a positive distraction and stated community meetings were beneficial (where they were able to discuss issues pertaining to the running of the unit with staff). Residents said they would like more facilitated activities such as baking, art, playing games in the garden, more frequent cinema trips and they would like the therapy dog to return to Ginesa suite (temporarily removed due to COVID-19 restrictions).

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
- Director of Nursing
- Senior Occupational Therapist
- Head of Psychology
- Clinical Nurse Manager II
- Head of Operations and Quality
- Human Resources Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The service did not seek any clarifications relating to the initial findings. The inspection team were not requested to make any corrections to the feedback provided.

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

Each resident was readily identifiable by staff when receiving medication, health care, and other services. At least two appropriate resident identifiers were used, which included resident name, resident photograph, resident date of birth, and local mental health information system number. The identifiers, detailed in each resident's clinical file, were checked when staff administered medications, undertook medical investigations, and provided 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 choices within the approved centre. Food was properly prepared and comprised of servings from different food groups as per the Food Pyramid. Residents received at least two choices for meals. Residents had sufficient supplies of safe and fresh drinking water at all times in easily accessible locations. The needs of residents identified as having special nutritional and dietary requirements were assessed, addressed, and documented in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre had a main kitchen where food was prepared. Ginesa suite had a kitchenette. There was appropriate and adequate catering equipment, crockery, and cutlery to suit the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

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 did not wear nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with emergency personal clothing that was appropriate and considered their preferences, dignity, bodily integrity, and religious and cultural practices. The emergency clothing was made up of kits categorised by size and gender. The emergency clothing kits were signed out when used by Ginesa suite and were re-stocked by the accommodation team.

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 policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2020. Residents could bring in personal property and possessions on admission, and these were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP).

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The approved centre had secure facilities for the safekeeping of residents' valuables.

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 range of recreational activities appropriate to the resident group profile during the week and at the weekend. Recreational activities and equipment included a pool, table, table football, musical instruments, computer games, books, board games, TV, internet access, art materials and table tennis inside. Outside there was exercise equipment in the garden, a soccer pitch, tennis and basketball courts, pitch and putt and a garden area for residents.

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 had a Roman Catholic Church and residents could attend mass on site which was also streamed to the Ginesa suite. There was also a multi-faith room in the approved centre.

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

There was a written policy and procedures in relation to visits. The policy was last reviewed in June 2021. Visiting times were appropriate and reasonable. Due to COVID-19 precautions the visiting arrangements in place at the time of the inspection were two visits per week for each resident, with one parent and one sibling allowed in per visit. More visits could be granted on compassionate grounds through multi-disciplinary team (MDT) discussion.

There was a separate visitor room available where private visits could take place, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting room was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to resident communication. The communication policy was last reviewed in October 2019. Residents had access to the approved centre's portable telephone, their own personal mobile phones but only if they were not smartphones, the internet and five electronic tablets. There was a computer in the communal area for young people to use.

The senior staff member only examined incoming and outgoing resident communication on the basis of risk assessment - 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 in relation to the implementation of resident searches. The policy was last reviewed in July 2020.

The policy addressed all of the requirements of the regulation, 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.

The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches, and a written record was kept of all environmental searches. The clinical file of one resident who was searched was inspected. The resident's consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident's dignity and privacy. One of the staff members who conducted one of the searches was of the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to caring for residents who are dying. The policy was last reviewed in July 2021. As no resident had died in the approved centre since the last inspection compliance for this regulation was assessed on the basis of policy 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

Each resident had an Individual Care Plan (ICP). Five ICPs were inspected. All ICPs were a composite set of documentation, with allocated space and sections for goals, treatment, care, resources required, and reviews. ICPs were stored within the clinical file, were identifiable and were not interrupted. ICPs were not integrated with progress notes.

All ICPs for resident admissions were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

All ICPs identified appropriate goals for the resident. All ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICP's identified the resources required to provide the care and treatment.

A multi-disciplinary team reviewed and updated individual care plans in all five ICPs. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances and goals, this was documented. The school was on summer holidays at the time of the inspection and the ICP of one resident from a previous admission period was reviewed. The resident's educational requirements were documented.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Residents did not have any access to social work (SW) and occupational therapy (OT) services since late 2020. At the time of the inspection there was an occupational therapy manager, but this individual did not provide OT services to Ginesa suite. A senior OT post was advertised for recruitment purposes on the last day of the inspection. There was no SW on the multi-disciplinary team (MDT). A SW was due to commence the week after this inspection.

Residents had access to complementary therapies such as yoga. A music therapist and art therapist attended the approved centre weekly. There was access to a speech and language therapist and a dietitian for residents. The approved centre ordinarily had access to pet therapy, but this was on hold due to COVID-19 Pandemic. Psychology was a 0.57 whole time equivalent (WTE) post, and the psychologist provided 1:1 work. Nursing staff delivered some group work on topics such as anxiety management, post-meal support and relaxation.

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 registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. Residents did not have any access to both social work and occupational therapy services, 16 (2).

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 to child residents in the approved centre. Sufficient personnel resources were 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 in place in relation to the transfer of residents. The policy was last reviewed in July 2020. As no resident had been transferred from the approved centre since the last inspection compliance for this regulation was assessed on the basis of policy only.

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 management of medical emergencies policy which included procedures for responding to medical emergencies. The policy was last reviewed in December 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. No resident was in the approved centre for a period of six months or more 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 policy and procedures in relation to the provision of information to residents. The policy was last reviewed in July 2021.

Residents were provided with a resident information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on their 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. Provided diagnosis information was part of the individual care plan (ICP) process.

Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. 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. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Resident's privacy and dignity was appropriately respected at all times. The manner in which staff spoke with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Where a resident shared a room the bed screening ensured that their privacy was not compromised.

Residents were facilitated to make private phone calls. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. All bathrooms, showers, and toilets had locks on the inside of the door unless there was an identified risk to a resident.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating **MODERATE**

(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

The approved centre was adequately lit, heated, and ventilated. Appropriate signage and sensory aids were provided to help residents orientation needs. Hazards were minimised. There was a sufficient number of toilets and showers for residents in the approved centre. Resident bedrooms were appropriately sized to address resident needs. Residents were accommodated in two single and four double bedrooms – none of which had an en suite facility.

Not all ligature points had been minimised to the lowest practicable level, based on risk assessment. While works were underway and on-going at the time of the inspection to reduce identified and documented ligature points, not all ligature points had been minimised at the time of the inspection.

Residents had access to sufficient indoor and outdoor space including communal rooms and two gardens, a soccer pitch, a pitch and putt course, and tennis and basketball courts. The approved centre was kept in a good state of repair inside and outside. It was clean, hygienic, and free from offensive odours. Suitable furnishings were provided to support resident independence and comfort.

The approved centre was non-compliant with this regulation because not all ligatures were minimised to the lowest practicable level based on risk assessment, 22 (3).

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

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in July 2020.

Each resident had a Medication Prescription and Administration Record (MPAR), and five of these were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, frequency of medication and a record of the date of discontinuation for each medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases. Two out of five MPARs did not document a record of all the medications administered to the resident. Specifically, one MPAR was missing a record of medication administered to the resident in seven instances. Another MPAR was missing a record of medication administered to the resident in five instances.

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, and 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. 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 press unless it required refrigeration. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The registered proprietor did not ensure that the approved centre had appropriate and suitable practices in relation to administration of medicines to residents as two MPARs did not detail all medications administered, 23 (1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy, and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in December 2020.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in July 2021.

The registered proprietor ensured that the existence and use of CCTV was disclosed to the resident and their representative. There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe residents were incapable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the 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 Mental Health Commission had been informed about the approved centre's use of CCTV.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in relation to the recruitment, selection and Garda vetting requirements. The policy was last reviewed in November 2018. An appropriately qualified staff member was on duty at all times, and this was documented. The number and skill mix of staffing were insufficient to meet resident needs. At the time of the inspection there was no designated occupational therapist or social worker employed and available to residents. A senior occupational therapist (OT) post was advertised for recruitment purposes on the last day of the inspection. There was no social worker (SW) on the multi-disciplinary team (MDT). A SW was due to commence the week after this inspection for a one-year term.

There were five staff nursing posts vacant at the time of inspection and the recruitment of nurses to fill those vacancies with new graduates was underway. These shortages were managed with agency and overtime. There was one clinical nurse specialist (CNS) post in Adolescent Mental Health vacant which had been advertised for recruitment purposes.

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) have been deferred until 2022.

The following shows the number and percentages of staff trained in the Mental Health Act (2001).

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (12)	12	100%
Medical (2)	2	100%

Occupational Therapist (0)	0	0%
Social Worker (0)	0	0%
Psychologist (1)	1	100%

The approved centre was non-compliant with this regulation because the numbers and skill mix of staffing were not sufficient to meet resident needs at the time of the inspection for the following reasons:

a) **There was no designated occupational therapist and social worker employed and available to residents, 26 (2).**
b) **There was one clinical nurse specialist (CNS) post in Adolescent Mental Health vacant, 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 creation of, access to, retention of and destruction of records. The policy was last reviewed in August 2021. All residents' records were secure, up to date, in good order, with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements.

Resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained to a logical sequence. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation relating to 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 and up-to-date electronic register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 to the Mental Health Act 2001.

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 required by the regulations were reviewed within the required three-year time frame.

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 relating to the making, handling, and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre. The policy was last reviewed in January 2020. There was a nominated individual responsible for dealing with all complaints available and based in the approved centre.

The complaints procedure and the nominated person’s contact details were publicly displayed, but this public notice had the previous complaints officers name on it. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. The Youth Advocacy Programme was in place and provided assistance to residents in how to make a complaint.

All complaints were handled promptly, appropriately, and sensitively. The nominated person maintained a record of all complaints relating to the approved centre. Any resident who had made a complaint was not adversely affected by reason of the complaint having been made. The Regulation was without prejudice to Part 4 of the Health Act 2004 and any regulations made thereunder. All complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded; these records were in addition to and distinct from a resident’s individual care plan.

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

There were three comprehensive written policies in relation to risk management, and medical and major emergency management processes. The risk management policy was last reviewed in December 2020. The policies included all of the policy related regulation requirements, including:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. There was a local risk register and corporate risk register. Risks rated 8 or lower were managed by the Clinical Nurse Manager 2 (CNM 2) on the unit. Risks rated 9 to 14 were on the local risk register and reviewed at the governance meetings. Risks of 15 or above were escalated to the corporate risk register and reviewed at the monthly Board of management meeting.

The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified and existing ligature risks to

the lowest level of risk, as was reasonably practicable. Structural risks including ligature points were removed or effectively mitigated. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical and corporate risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of resident seclusion and physical restraint and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration.

Incidents were risk-rated in a standardised format using the Datix electronic portal system. 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 reviewed incidents for any trends or patterns occurring in the service.

A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. 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 house is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre was adequately insured against accidents and injury to residents. The approved centre's insurance certificate and indemnity scheme statement was available 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 which was displayed prominently.

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 4.2 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

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

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

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

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: There were two written policies in relation to the use of physical restraint on children. The physical restraint policies were reviewed annually and were last reviewed in February 2021. The policies covered:

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

Training and Education: There was a written record that all staff involved in 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 file of one resident who had been physically restrained was inspected. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident's unsafe behaviour.

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident's next of kin were informed about the physical restraint and this was documented in the clinical file.

Physical restraint was initiated by a registered medical practitioner (RMP), and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the resident within three hours after the start of the episode of physical restraint.

The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team

(MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The parent had been informed of the child's physical restraint as soon as possible. Child protection policies and procedures were in place. There were also policies and procedures in place that addressed appropriate training for staff in relation to child protection.

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 a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in July 2020, the transfer policy was last reviewed in July 2020, and the discharge policy was last reviewed in July 2021. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident's parent was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: risk assessment, presenting problem, past psychiatric history, family history, medical history, current and historic medication, and current mental health state. The resident received a full physical examination.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was coordinated by the resident's keyworker. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident's family. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, informational needs, a current mental state examination, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to primary care on the day of discharge. A comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, and names and contact details of key people for follow-up.

The discharge summary also included risk issues such as signs of relapse. A timely follow-up appointment took place eight days after the resident being discharged.

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 : 10002371		**The registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. Residents did not have any access to both social work and occupational therapy services, 16 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Recruitment of Social Worker and Occupational Therapist	Posts filled	Achievable Note the social work post was filled on the Monday after the inspection i.e. 16th August 2021 The occupational therapist post has been recruited and is due to commence duty on 31st January 2022.	31/01/2021	HR Manager, Head of Social Work, Head of Occupational Therapist
Preventative Action	Advertisement of posts when resignations/retirements occur	Posts filled	Achievable	31/01/2022	HR Manager and relevant head of department in which the vacancy arises

Regulation 22: Premises					
Reason ID : 10002373		Not all ligatures were minimised to the lowest practicable level based on risk assessment, 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.	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, decorative and ligature minimisation work for this centre is included in rolling maintenance schedule which is budget dependent and the impact of COVD-19 restrictions. Annual Maintenance and CAPEX Budget for 2022 has been drafted. Ligature Minimisation plan to be implemented by end of Q2 2022.	Achievable	31/12/2022	Clinical Director and Director of Nursing in respect of the audit of the observation policy. CEO, Board of Directors and Head of Operations & Quality in respect of monitoring of the Ligature Minimisation Policy.
Preventative Action	Hospital has in place Observation Policy which continues to	Audit of adherence to procedures set out within Observation	Achievable	31/12/2022	Clinical Director and Director of Nursing in respect of the audit of

	be implemented. Hospital has Ligature minimisation plan which continues to be implemented	Policy occurs on an annual basis. Audit of adherence to procedures set out within Ligature Minimisation Policy occurs on an annual basis. Structural, decorative and ligature minimisation work for this centre is included in rolling maintenance schedule which is budget dependent and the impact of COVD-19 restrictions. Annual Maintenance and CAPEX Budget for 2022 has been drafted. Ligature Minimisation plan to be implemented by end of Q2 2022.			the observation policy. CEO, Board of Directors and Head of Operations & Quality in respect of monitoring of the Ligature Minimisation Policy.

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10002375		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices in relation to administration of medicines to residents as two MPARs did not detail all medications administered, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The administration sections of the MPAR were reviewed and missing information documented.	All documentation completed	Completed	30/11/2021	Nurses responsible for medication administration
Preventative Action	The administration of medication audit has been updated to increase focus on documentation of the administration of medication. A pharmacist has been assigned to Ginesa to enhance medicines optimisation. Nursing staff continue to maintain high standards of professional practice in relation to medicines management.	Audit of administration of medication on quarterly basis.	Implemented in December 2021	31/12/2021	Nurse Practice Development Manager, Clinical Nurse Manager, Senior Pharmacist

Regulation 26: Staffing					
Reason ID : 10002376		**The approved centre was non-compliant with this regulation because the numbers and skill mix of staffing were not sufficient to meet resident needs at the time of the inspection as there was no designated occupational therapist and social worker employed and available to residents, 26 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Recruitment of OT and social worker	Posts filled Social worker has been in post since 16th August 2021 OT will commence on 31st January 2022	Achievable	31/01/2022	HR Manager, Head of OT, Head of Social Work
Preventative Action	Advertise posts when resignations received.	Posts filled	Achievable	31/01/2022	Head of HR and relevant head of department
Reason ID : 10002377		**The approved centre was non-compliant with this regulation because the numbers and skill mix of staffing were not sufficient to meet resident needs at the time of the inspection as there was one clinical nurse specialist (CNS) post in Adolescent Mental Health vacant, 26 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Post advertised and interviews scheduled week commencing 13.12.2021	Post filled	Achievable	31/01/2022	HR Manager and Director of Nursing
Preventative Action	Advertise posts when resignation received	Posts filled via recruitment campaign	Achievable	31/01/2022	HR Manager and DON

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.

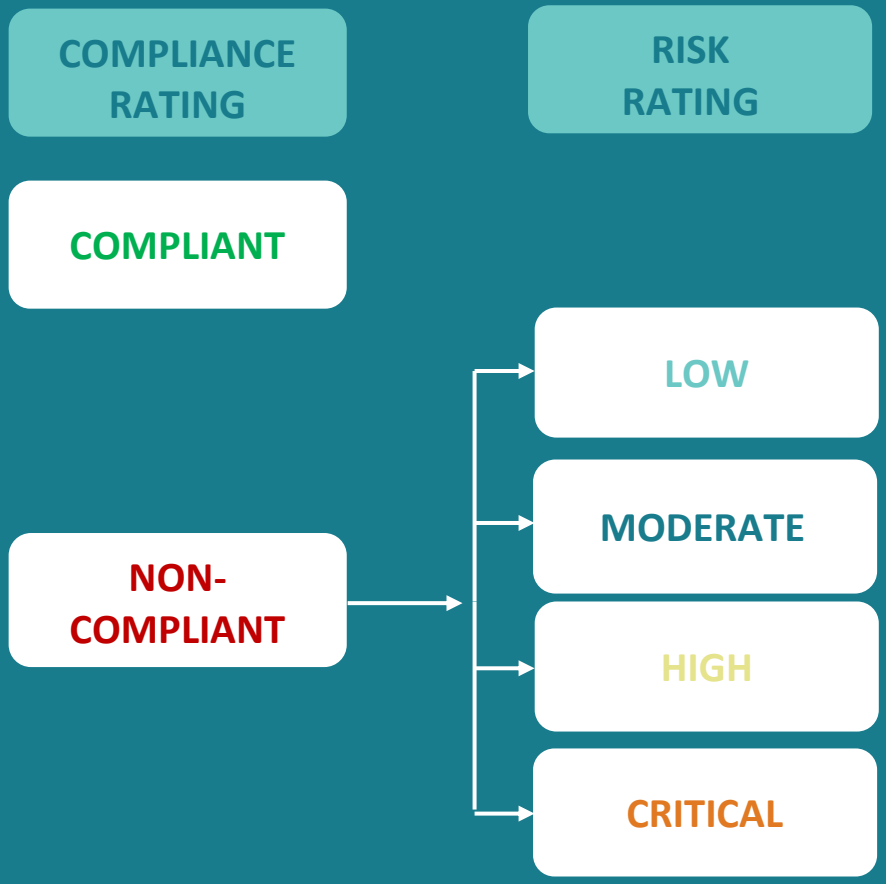
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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