Ginesa Suite

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mental health commission

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

GINESA SUITE

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

Date of Publication:
13 December 2023

ID Number: AC0212

2023 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 2022

Registered Proprietor:
St. John of God Hospital CLG

Registered Proprietor Nominee:
Emma Balmaine, Chief Executive Officer

Inspection Team:
Fergal Duffy, Lead Inspector
Aoife Gallaher
Barbara Murphy

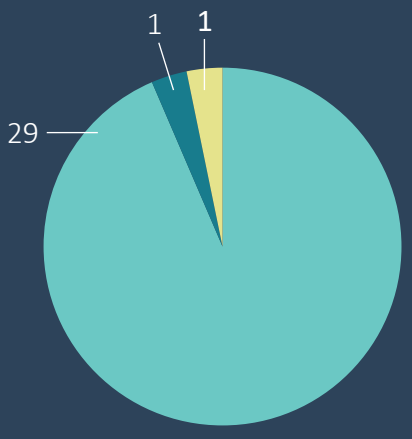
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
18 – 21 April 2023

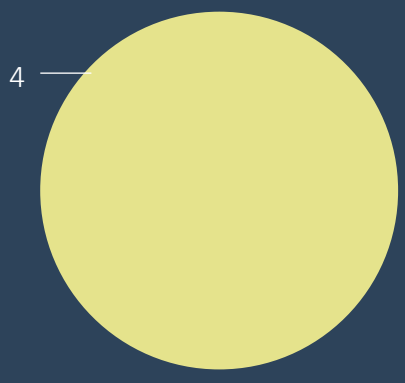
Previous Inspection date:
29 March – 1 April 2022

Inspection Type:
Announced Annual Inspection

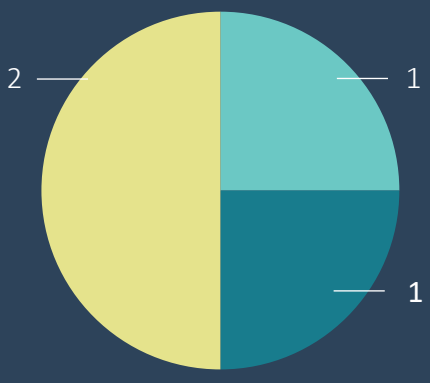
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



CODES OF PRACTICE

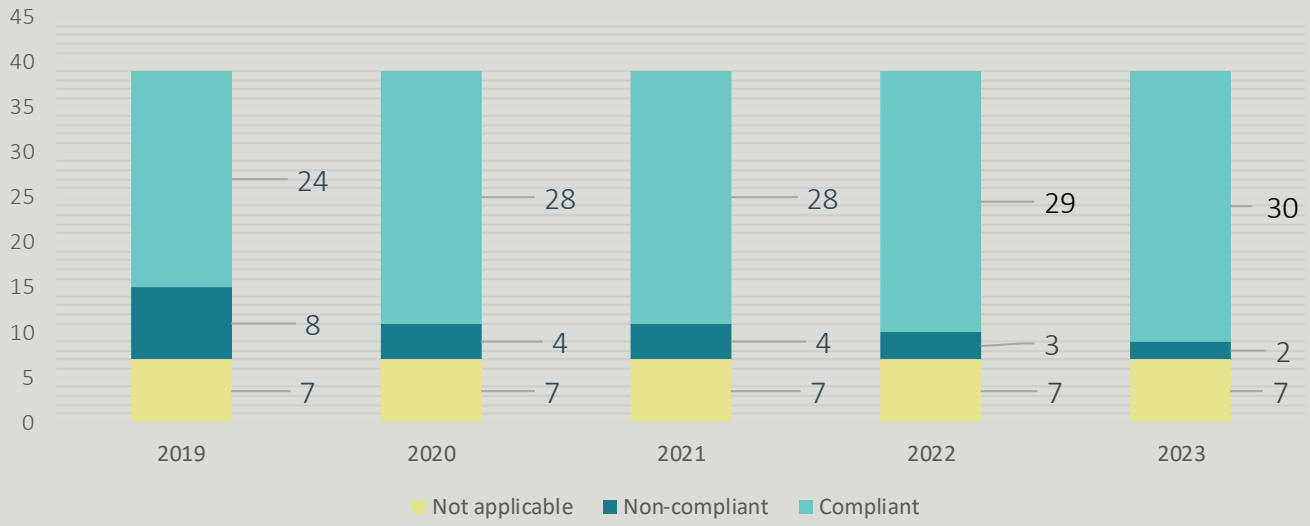
Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2019 – 2023

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

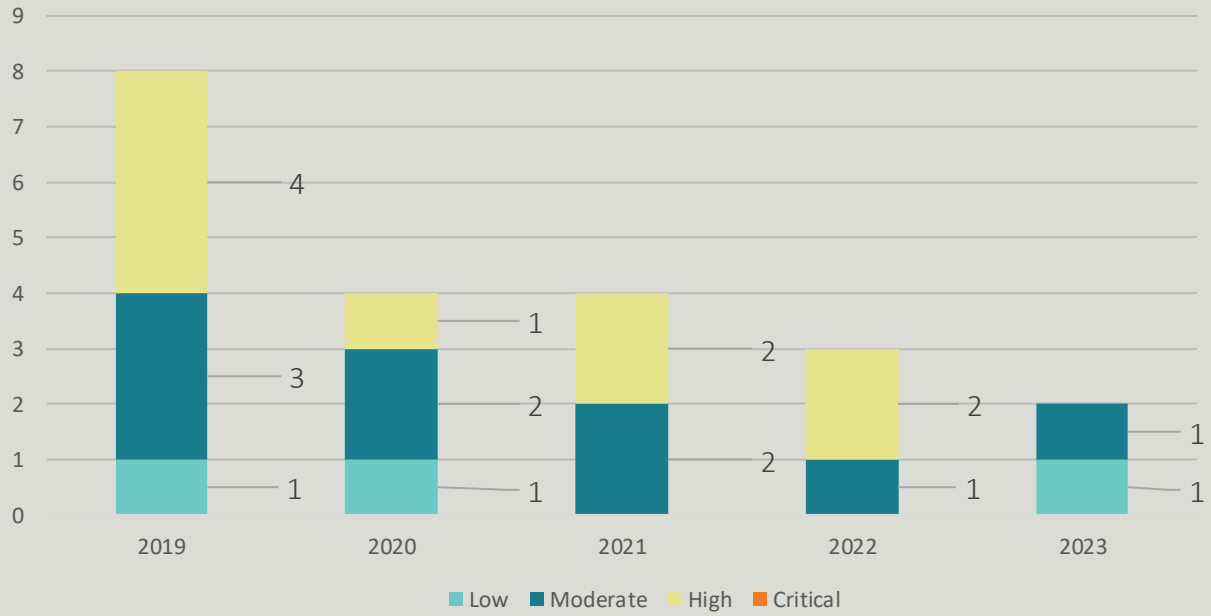
The approved centre opened in June 2019.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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 2019 – 2023



Contents

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. 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 Adolescent Inpatient Unit located in St. John of God Hospital campus in Stillorgan, Co. Dublin. It was an independent not-for-profit facility. It provided treatment to young people aged from 13 to 17 years of age from all over Ireland. All residents were under the care of a single multi-disciplinary team (MDT).

The unit had therapeutic and recreational areas internally. Residents access to a gym and outdoor recreational facilities located on the grounds of St. John of God Hospital. A school facility was also available to young people in Ginesa Suite.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	75%	88%	88%	91%	94%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

The approved centre demonstrated that they provided safe care in the following areas:

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** All staff were trained in fire safety, safeguarding, basic life support, management of violence and aggression, and the Mental Health Act.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Ligature anchor points:*** Ligature points were minimised to the lowest level, based on individual risk assessment.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Safeguarding:*** Staff were aware of safeguarding procedures.
- ***Access to essential information*****:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Alarms*****:** Staff were provided with alarms that were in working order.
- ***Infection control*****:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

Appropriate care and treatment of residents

The approved centre demonstrated that they provided appropriate care and treatment in the following areas:

- **Appropriateness of environment:** The layout and the decoration of Ginesa Suite was of met the needs of the young people.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. Residents had access to a physical assessment and any treatment required.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. There was evidence of significant engagement with residents in respect of their ICP. There was an identified staff member to deliver the interventions. Each ICP had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** The multi-disciplinary team was resourced with medical, nursing, social work, and psychology professionals. There was no occupational therapist (OT) at the time of

the inspection, but there were provisions in place to provide OT services if needs were identified. There was a clinical pharmacy service for Ginesa Suite. Other specialist services such as speech and language therapy were available on a sessional basis.

- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan. They were delivered in groups and on a one-to-one basis that was based on the identified needs of the residents. There was art therapy, sports and exercise group, meditation through movement, functional cookery, recovery through activity and an eating disorder recovery programme. The full time psychologist based in Ginesa Suite who provided one-to-one work with residents and group work such as Cognitive Behavioural Therapy (CBT), managing difficult thoughts, and also an eating disorder group. A psychoeducation group was delivered online with the parents of the residents. There was a structured assessments of side effects of medications for residents of Ginesa suite by the pharmacy department .
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.
- ***School:*** There was a school for residents of Ginesa Suite. This facility had only one teacher, which was below the staffing level of two teachers for a resident cohort of twelve, identified in the Department of Education "Review of educational provision for children attending hospital schools" (2021).

However:

- ***Discharge:*** The discharge records of a resident did not include documentary evidence of a meeting taking place attended by the resident, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate.

Respect for residents' privacy, dignity and autonomy

The approved centre demonstrated that they respected people's privacy, dignity and autonomy in the following areas:

- ***Sleeping accommodation:*** There were two single bedrooms and five double bedrooms, none of which were en suite. There were communal washing and toileting facilities adjacent to the bedrooms.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected. All bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialising. Clinical files were securely stored.
- ***Use of restrictive practices:*** Physical restraint was rarely used in the approved centre and only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team had developed a new policy of care for physical restraint. There was no seclusion room in the approved centre and should seclusion be required, the young person was transferred to St John of God approved centre

in the same building. This was a rare occurrence. The approved centre was compliant with the Code of Practice on Physical Restraint. The approved centre had a reduction of restrictive practices strategy.

- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

Responsiveness to residents' needs

The approved centre demonstrated that they were responsive to people's needs in the following areas:

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Recreational activities included TV, board games, books, newspapers, DVD, Nintendo, some internet access, Netflix, a large selection of musical instruments, pool, and arts and craft materials. There were pet therapy dog visits in the unit also. Outside Ginesa Suite there were tennis facilities, a football pitch, basketball, pitch and putt, Sli Na Slainte walk area, a garden for Ginesa Suite, equipment for individual and team sports, access to the gym, and pet rabbits in the garden.
- ***Residents' feedback:*** The residents were complimentary the care they received. They said that they received information on their treating teams and their individual care plans, when they wished, were aware of their key workers and were able to give feedback about their care to staff. They said they had private spaces, their dignity was respected and were mostly happy with the activities provided.

Governance, Leadership and Accountability

The approved centre had the following governance structures and processes in place:

- ***Structures in place:*** The approved centre was under the governance of St. John of God Hospital CLG. The service was governed by a board of directors. The Chief Executive Officer (CEO) and Clinical

Director reported to the board monthly. The Clinical Governance Quality and Safety Executive Committee (CGQSE) reported to a board sub-committee for clinical governance, quality and safety. The CGQSE was informed by multiple committees including risk, health and safety, clinical audit, and the clinical effectiveness and quality improvement committees. The only committee specifically dedicated to issues relating to the adolescent unit was the Ginesa Management Team meeting which convened six times per annum.

- ***Leadership:*** An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. Effective leadership was evident.
- ***Clinical governance:*** The authority and responsibility of line managers for the various disciplines were clear.
- ***Restrictive practices reduction:*** The service had developed and implemented a policy on the reduction of restrictive practices, including physical restraint and seclusion. This included training for all staff on alternatives to restrictive practices, trauma informed care, cultural competence, and positive behaviour support. There was a senior manager with responsibility for the reduction of restrictive practices in the approved centre.
- ***Risk:*** There was a local risk register which was reviewed on a quarterly basis by Ginesa Suite nursing management and on an annual basis by members of the risk committee. All incidents were recorded and risk-rated in a standardised format on Datix, the approved centre's electronic risk management system. 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 hospital risk register and further to the corporate risk register if required. There was a Healthcare Risk Officer who had overall responsibility for risk and incident management in the approved centre and there was a Local Incident Management Team to review incidents if required.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement.
- ***Policies:*** All policies were regularly updated.
- ***Staff training:*** An induction programme was undertaken by all new staff commencing employment within the approved centre and there was a structured in-service training programme in operation. All staff delivering services to residents of Ginesa Suite had completed mandatory training.
- ***Complaints:*** There was a complaints process (both formal and informal) available to residents. Information on how to contact the nominated person was publicly displayed.
- There was a Designated Officer for Child Protection and Welfare in the approved centre.
- ***Residents' involvement:*** Weekly resident community meetings were held in Ginesa Suite and there were suggestion boxes available to residents for service improvements. Regular feedback was provided by the advocate to Ginesa Suite nursing management and issues arising were discussed at the Ginesa management team meeting
- ***Advocacy services:*** An advocate from the Youth Advocacy Programme (YAP) attended the approved centre on a regular basis and met with residents as a group.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last 5 years of 87%. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The pharmacy department introduced structured assessments of side effects of medications for residents of Ginesa suite since the last inspection.

2. The chefs met with all residents to understand individual needs and dietary requirements. All catering staff had undertaken allergen awareness training since the last inspection.

3. The catering department had received a “Happy Heart” award from the Irish Heart Foundation in recognition of their health-promoting menu for residents and staff.

4. The computer system hardware had been upgraded since the last inspection to enhance performance, reliability, and information security.

5. All accommodation staff had undertaken “Cleanpass” training. This was a level three nationally certified programme that focused on how to prevent and control the spread of infection in healthcare settings.

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 provided treatment to young people aged from 13 to 17 years of age from all over Ireland. All residents were under the care of a single multi-disciplinary team (MDT).

The approved centre was registered for 12 beds. There were two single bedrooms and five double bedrooms, none of which were ensuite. There were communal washing and toileting facilities adjacent to the bedrooms. The unit had therapeutic and recreational areas internally. Residents access to a gym and outdoor recreational facilities located on the grounds of St. John of God Hospital. A school facility was also available to young people in Ginesa Suite.

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

Resident Profile	
Number of registered beds	***12***
Total number of residents	**7**
Number of detained patients	0
Number of wards of court	0
Number of children	7
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 Chief Executive Officer (CEO) and Clinical Director reported to the board monthly. The Clinical Governance Quality and Safety Executive Committee (CGQSE) convened on a monthly basis and reported to a board sub-committee for clinical governance, quality and safety. The CGQSE was, in turn, informed by multiple committees including risk, health and safety, clinical audit, and the clinical effectiveness and quality improvement committees. There was variable direct representation from the Ginesa Suite multi-disciplinary team at the different committee meetings. The only committee specifically dedicated to issues relating to the adolescent unit was the Ginesa Management Team meeting which convened six times per annum.

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 numbers and skill mix of staffing were sufficient to meet resident needs. The multi-disciplinary team was resourced with medical, nursing, social work, and psychology professionals. There was no occupational therapist (OT) at the time of the inspection, but there were provisions in place to provide OT services if needs were identified. There was a clinical pharmacy service for Ginesa Suite. Other specialist services such as speech and language therapy were available on a sessional basis. There was a school for residents of Ginesa Suite. This facility had one teacher, which was below the staffing level of two teachers for a resident cohort of twelve, identified in the Department of Education "Review of educational provision for children attending hospital schools" (2021). An induction programme was undertaken by all new staff commencing employment within the approved centre and there was a structured in-service training programme in operation. All staff delivering services to residents of Ginesa Suite had completed mandatory training.

The approved centre had a local risk register which was reviewed on a quarterly basis by Ginesa Suite nursing management and on an annual basis by members of the risk committee. All incidents were recorded and risk-rated in a standardised format on Datix, the approved centre's electronic risk management system. 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 hospital risk register and further to the corporate risk register if required. There was a Healthcare Risk Officer who had overall responsibility for risk and incident management in the approved centre. There was a Local Incident Management Team to review incidents if required.

On 01 January 2023, the new code of practice on the use of physical restraint in approved centres came into effect. A new policy, accounting for changes to the code of practice, was available at the time of inspection. The service had also developed and implemented a policy on the reduction of restrictive practices, including physical restraint and seclusion. This included training for all staff on alternatives to restrictive practices, trauma informed care, cultural competence, and positive behaviour support. The CEO had appointed a senior manager with responsibility for the reduction of restrictive practices in the approved centre. At the time of the inspection, one resident had been physically restrained on one occasion since the introduction of the new code of practice. Staff had carefully considered the use of physical restraint in the circumstances and risk assessments had been completed. All the elements required by the new code of practice were evident within the clinical file.

Weekly resident community meetings were held in Ginesa Suite and there were suggestion boxes available to residents for service improvements. An advocate from the Youth Advocacy Programme (YAP) attended the approved centre on a regular basis and met with residents as a group. Regular feedback was provided by the advocate to Ginesa Suite nursing management and issues arising were discussed at the Ginesa management team meeting. There was a complaints process (both formal and informal) available to residents. There was a Designated Officer for Child Protection and Welfare in the approved centre.

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

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 2019 and 2023 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 18: Transfer of Residents	✗	Moderate	✓		✓		✓		✗	Low
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	High	✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

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

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. The inspection team were available to engage with residents for face-to-face discussions about their experience of care and treatment in the approved centre. 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.
- The Youth Advocacy Programme representative was contacted to obtain residents' feedback about the approved centre.

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

Two residents spoke with the inspection team in person. Both residents said they felt safe in the approved centre. The two residents said they were happy with the choice and quality of food provided; both attended school which they enjoyed; the residents said there were suitable and sufficient therapeutic and recreational facilities and activities provided in the approved centre; both said they knew the role and function of their treating multi-disciplinary team members and both residents were involved in their care planning. The residents said they were able to receive visits from their families and they could communicate freely with their family, friends and advocates. Both residents said they would like more access to their smartphone but were understanding of the reasons why smartphone use was curtailed in the approved centre.

Three completed feedback questionnaires were received from residents. All residents indicated they were orientated to the unit on admission and provided with information about their diagnosis and care and treatment in a way they could understand. Two residents indicated they knew their multi-disciplinary team, understood what their care plan was, and were "always" involved in goal setting as part of the care planning process. One indicated they did not know their treating team or what their care plan was, but also indicated they did not want to know or be involved in the care planning process. All respondents said they could talk to staff, give feedback to the team, and discuss worries or concerns with staff.

Two residents indicated there were enough activities for them, one indicated that there wasn't. Two residents indicated that they "always" felt safe in the approved centre, one indicated they "sometimes" felt safe. All residents indicated they were happy with the manner in which staff spoke with them, that their dignity and privacy were respected, and they could communicate freely with family/friends/advocates. When asked to numerically rate their care and treatment, with one being poor and ten being excellent, one

resident provided a rating of eight out of ten, one a rating of seven out of ten, and the third resident a rating of one out of ten.

5.2 Advocacy

The approved centre had an advocacy service.

The Youth Advocacy Programme advocate sends a report to the Ginesa Suite management team after each interaction they had with residents. These reports were made available to the inspection team. The reports indicate Ginesa Suite provides a client-centred, safe and therapeutic environment conducive to recovery. Feedback to the advocate about therapeutic relationships, visiting facilities and times, therapeutic services and programmes, recreational activities, and resident involvement in design of their individual care plan was all positive.

There were issues identified by the young people around menus, portion sizes and structures pertaining to meal times. The reports indicate the service was responsive to the will and preference of residents and dialogue between stakeholders was documented. When requested changes were not possible, a comprehensive rationale was provided for the decision.

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
- Chief Operations Officer
- Consultant Psychiatrist
- Director of Nursing
- Deputy Director of Nursing
- Chief Pharmacist
- Senior Psychologist

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two appropriate resident identifiers before administering medications, undertaking medical investigations, and providing other healthcare services. Identifiers included resident identity number, photograph, name, and date of birth. 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 n eeds, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals.

A source of safe, fresh drinking water was available at all times in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

There was a kitchen in the approved centre and a kitchen in the main hospital. Food was cooked in the main hospital and was transported to the kitchen and dining room of the approved centre. The approved centre provided suitable and sufficient catering equipment, and had proper facilities for the refrigeration, storage, preparation and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Emergency clothing was stored in the laundry room of the main hospital. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in March 2023.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. Outside Ginesa Suite there were recreational options to residents, and these included: tennis facilities, a football pitch, basketball, pitch and putt, Sli Na Slainte walk area, a garden for Ginesa Suite, equipment for individual and team sports, access to the gym, and pet rabbits in the garden.

Inside Ginesa Suite, recreational activities comprised TV, board games, books, newspaper, DVD, Nintendo, restricted internet access, Netflix, a large selection of musical instruments, pool, and arts and craft materials. There were pet therapy dog visits in the unit also.

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 practise religion were facilitated within the approved centre insofar as was practicable. There was a church where mass was held that residents could attend, which was also streamed to the unit. There was a separate multi-faith room that residents had access to with religious scripts and space to practice rituals.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written policies and procedures in relation to visits. The policy was last reviewed in March 2022. At the time of inspection, visiting times were flexible, appropriate and reasonable. Visiting times during week days was 4:30-5:30 pm and weekends 2 pm-4 pm. There were exceptions made for visits outside of these times. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Residents could meet visitors in a private visiting area unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. For receiving visitors, residents could use the family room located in the Ginesa Suite, and Darro family room on the ground floor, or in the coffee shop. The visiting area was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had written policies and procedures in relation to communication. The policy was last reviewed in March 2022. Residents in the approved centre had access to postal mail, telephone, and supervised internet unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health.

Residents were permitted to use their own mobile phones in the approved centre, on condition that their phone did not have a camera and did not have internet access. Residents had access to the internet on the computer in the lounge area with supervision. Residents had access to a ward telephone located in the Bubble Room.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in March 2022, and included all requirements related to:

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all the residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by the those implementing the search of what was happening during the search, and why. A minimum of two clinical staff attended all times during the searches, and due regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

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 written policies and procedures on care of the dying. The care of the dying policy was last reviewed in February 2023. There were no deaths in the approved centre since the last inspection and 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

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

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Therapeutic services were delivered in groups and on a one-to-one basis that was based on the identified needs of the residents. Groups included music therapy, a group with the chaplain, art therapy, sports and exercise group, meditation through movement, functional cookery, recovery through activity and an eating disorder recovery programme. There was a full-time psychologist based in Ginesa Suite who provided one-to-one work with residents and group work such as Cognitive Behavioural Therapy (CBT), managing difficult thoughts, and also an eating disorder group. A psychoeducation group was delivered online with the parents of the residents. There was a therapy dog which visited the centre weekly.

A full-time social worker was based in Ginesa Suite who provided one to one with residents and family therapy with residents and family members. There was no occupational therapy (OT) input in Ginesa Suite; however, the Clinical Nurse Specialist (CNS) was providing additional therapeutic groups to supplement the therapeutic timetable. If an individual need was identified that required OT intervention, there was provision to source a private OT to address the need.

Where a resident required a therapeutic service or programme that was not provided internally, such as dietetics, speech and language therapy, or physiotherapy, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 17: Children's Education

COMPLIANT

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

INSPECTION FINDINGS

Child residents were assessed in relation to their educational 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.

Sufficient personnel resources were available for the provision of education to child residents within the approved centre.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

NON-COMPLIANT

Risk Rating LOW

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in September 2020. The clinical file of one resident who had been transferred from the approved centre to a different hospital in an emergency situation was inspected. Communications between the approved centre and the receiving facility were documented and followed up with a written referral.

Not all relevant written information about the resident was transferred to the receiving facility when the resident was moved from the approved centre. A letter of referral that contained a list of current medications and a resident transfer form was not issued to the receiving facility by the approved centre when the resident was transferred there.

The approved centre was non-compliant with this regulation because a letter of referral that contained a list of current medications and a resident transfer form was not issued to the receiving facility by the approved centre when the resident was transferred there, 18.1.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy. The management of medical emergencies policy was last reviewed in November 2022.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans.

At the time of the approved centre, there were no residents there who had been in the approved centre for six months or more.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in March 2022.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. There was a Ginesa Suite information handbook for young people, a Ginesa Suite information booklet for parents and guardians, and a St. John of Gods Inpatient Handbook available in the approved centre.

The information each booklet was clearly and simply written, and available in the required formats to support residents' needs. The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team (MDT).

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics. The lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces.

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

Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre. Ligature points were minimised to the lowest practicable level based on risk assessment. The approved centre had a ligature reduction plan.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was clean, hygienic, and free from offensive odours and rooms were

centrally heated with pipe work and radiators guarded. Current national infection control guidelines were followed.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in April 2022 and included:

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

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

All entries in the MPARs were legible. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in March 2023.

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 2020.

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

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in November 2021, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staffing were sufficient to meet resident needs. The approved centre had one multi-disciplinary team. This included psychiatry, nursing, social work, and psychology staff. There was no occupational therapist for Ginesa Suite at the time of the inspection, however, suitable arrangements were in place to ensure continuity of service for residents. The approved centre also had a clinical pharmacy service. Other specialist service such as speech and language therapy and a dietitian were available on a sessional basis or via referral pathways.

All healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The following is a table of staff showing the numbers and percentages of staff trained in the four mandatory training topics:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (10)	10	100%	10	100%	10	100%	10	100%

Consultant Psychiatrist (1)	1	100%	1	100%	1	100%	1	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in March 2022 and included:

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

Residents' records were secure, up-to-date, and in good order. Residents records were electronic, and clinical files were stored on the Electronic Patient Record (EPR), with the exception of Medical Prescription Administration Records (MPARs) and vital observations. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission or soon thereafter. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person. Details of complaints, actions and outcomes, were fully recorded and kept distinct from the 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 comprehensive written policies in relation to risk management. The risk management policy was last reviewed in November 2022. 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.

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. There was a local risk register and corporate risk register. Incidents were risk-rated in a standardised format using the DATIX Incident Management 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.

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 and during episodes of physical restraint and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration.

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 unit 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.

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a child protection policy and procedures in place in line with relevant legislation and regulations. The approved centre had a written policy on the use of physical restraint (PR). The policy had been reviewed annually and was dated March 2023. It addressed the following:

- The provision of information to the person which included information about the person's rights, presented in accessible language and format; information regarding who can initiate and who may carry out PR; information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of PR.
- Policies and procedures regarding staff training including the following:
- Who will receive training based on the identified needs of persons who are restrained and staff
- The areas to be addressed within the training programme, which included training in:
  Child protection, The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques); alternatives to PR; trauma-informed care; cultural competence, human rights, including the legal principles of restrictive interventions; positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic, and the monitoring of the safety of the person during and after the PR.
  The identification of appropriately qualified person (s) to give the training.
- The mandatory nature of training for those involved in PR.

The approved centre had a policy on the reduction of physical restraint. It addressed the following:

- Details of how the approved centre aimed to reduce, or where possible eliminate, the use of PR within the approved centre, including its use of positive behaviour support.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. All staff who participated or may participate in the use of physical restraint had received appropriate training in the use of physical restraint and in the related policies and procedures regarding staff training. All staff who participated or may participate in the use of physical restraint had received training in cultural competence, and in the positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic. A record of attendance at physical restraint training was maintained by the approved centre.

Monitoring: The approved centre had established a multi-disciplinary review and oversight committee whose responsibilities included the review of compliance with the code of practice on physical restraint, and compliance with the approved centre's own policies and procedures, for each episode reviewed.

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

The Clinical Practice Form (CPF) was signed by the CP within 24 hours. The child was informed of reasons for, likely duration of, and circumstances leading to discontinuation. This was explained in a way that the child could understand and in a way that was appropriate to the child's age. A record of this communication was maintained and clearly outlined how it met the child's individual communication needs.

In this episode of physical restraint, as soon as was practicable, and as it was the child's wish in accordance with their individual care plan, the child's parent was informed of the child's restraint and the circumstances which led to the child being physically restrained. A record of this communication was placed in the clinical file. The Mental Health Commission (MHC) was notified through the Comprehensive Information System (CIS) of the start time and date, and the end time and date of this episode of PR in the format specified by the MHC, within three days of the restraint.

A same sex staff member was present at all times during the episode of PR. In the episode of physical restraint the child was continuously assessed throughout the use of restraint to ensure the child's safety and this was documented. In this episode of physical restraint the child's head and neck was supported where necessary, and the child's airway and breathing were not compromised. The child's parent were informed when the episode of physical restraint ended.

The person who lead the physical restraint did not end it; however, a clear rationale was provided for the lead role changing during the episode of restraint. The time, date, and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended.

An in-person debrief with the child who was restrained followed this episode of PR. This debrief was person-centred and gave the child the opportunity to discuss the PR with members of the multi-disciplinary team (MDT) involved in the child's care and treatment as part of a structured debrief process.

The debrief included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. The debrief included a discussion regarding the child's preferences in the event where a restrictive intervention is needed in the future, such as preferences in relation to which restrictive intervention they would not like to be used. The child's

individual care plan was updated to reflect the outcome of the debrief, and in particular, the child's preferences in relation to restrictive interventions going forward. There was a record of all attendees who were present at the debrief, this was recorded in the clinical file.

The episode of PR was recorded on the clinical practice form located in the clinical file. The episode of PR was reviewed by members of the MDT within five working days from the date of the restraint. The review covered everything required to be covered. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the child. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

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

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

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who was admitted to the approved centre was reviewed on inspection. A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the following: presenting problem; past psychiatric history, family history, medical history, current and historic medication, where relevant, social and housing circumstances, current mental health state, risk assessment, full physical examination, and other relevant information. The resident's family member, carer, or advocate was involved in the admission process, with the resident's consent.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents. As noted under Regulation 18 of this report, not all relevant written information about the resident was transferred to the receiving facility when the resident was moved from the approved centre.

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed on inspection. The discharge records of this resident did not include documentary evidence of a meeting

taking place attended by the resident, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate.
The discharge plan included the following: estimated date of discharge, documented communication with the relevant general practitioner or primary care team or community mental health team (CMHT); a follow-up plan; and a reference to early warning signs of relapse and risks.

The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs. Discharge was coordinated by a key worker. The preliminary discharge summary was sent to the relevant general practitioner, or primary care team or community mental health team within three days.

The comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

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

a) **The approved centre did not comply with Regulation 18: Transfer of Residents, 30.1.**
b) **The discharge records of a resident did not include documentary evidence of a meeting taking place attended by the resident, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate, 34.4.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 18: Transfer of Residents					
Reason ID : 10004120		**A letter of referral that contained a list of current medications and a resident transfer form was not issued to the receiving facility by the approved centre when the resident was transferred there, 18.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The hospital has a predefined template for transfer of a resident on the electronic patient record which was not used in this instance. Registrars will be reminded to use the this template which meets all criteria for the Regulation 18 and the associated code of practice.	The action will be tracked using the ViClarity audit tool and will be marked as completed when this is the case	Achievable	10/11/2023	Dr Nimantha Gamage, CAMHS consultant Psychiatrist
Preventative Action	There is an audit for transfer of a resident. The audit frequency will be raised to bi-annual in order to ensure the approved center is monitoring compliance with regulation 18.	Audits are completed via the Viclarity database. Evidence for completion of these audits will be monitored using this method.	Achievable	08/12/2023	Dr Nimantha Gamage, CAMHS consultant Psychiatrist

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10004118		**The approved centre did not comply with Regulation 18: Transfer of Residents, 30.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The hospital has a predefined template for transfer of a resident on the electronic patient record which was not used in this instance. Registrars will be reminded to use the this template which meets all criteria for the Regulation 18 and the associated code of practice.	The action will be tracked using the ViClarity audit tool and will be marked as completed when this is the case	Achievable	10/11/2023	Dr Nimantha Gamage, CAMHS consultant Psychiatrist
Preventative Action	There is an audit for transfer of a resident. The audit frequency will be raised to bi-annual in order to ensure the approved center is monitoring compliance with regulation 18.	Audits are completed via the Viclarity database. Evidence for completion of these audits will be monitored using this method.	Achievable	08/12/2023	Dr Nimantha Gamage, CAMHS consultant Psychiatrist
Reason ID : 10004119		**The discharge records of a resident did not include documentary evidence of a meeting taking place attended by the resident, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate, 34.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Responsibility for documenting a discharge meeting	Actions related to CAPAs will be uploaded into the	Achievable	10/11/2023	Dr Nimantha Gamage, CAMHS consultant Psychiatrist

	lies with the MDT. This non-compliance will be discussed at an MDT meeting and all team members will be reminded of the necessity to ensure that discharge meetings are documents.	Viclarity system and completion will be tracked via this system			
Preventative Action	The approved centre audits compliance with code of practice in discharge on an annual basis. This will be increased to bi-annual to ensure compliance.	Audits in the hospital are completed via the viclarity system. Therefore, this system will be used to monitor the implementation of the action.	Achievable	08/12/2023	Dr Nimantha Gamage, CAMHS consultant Psychiatrist

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.

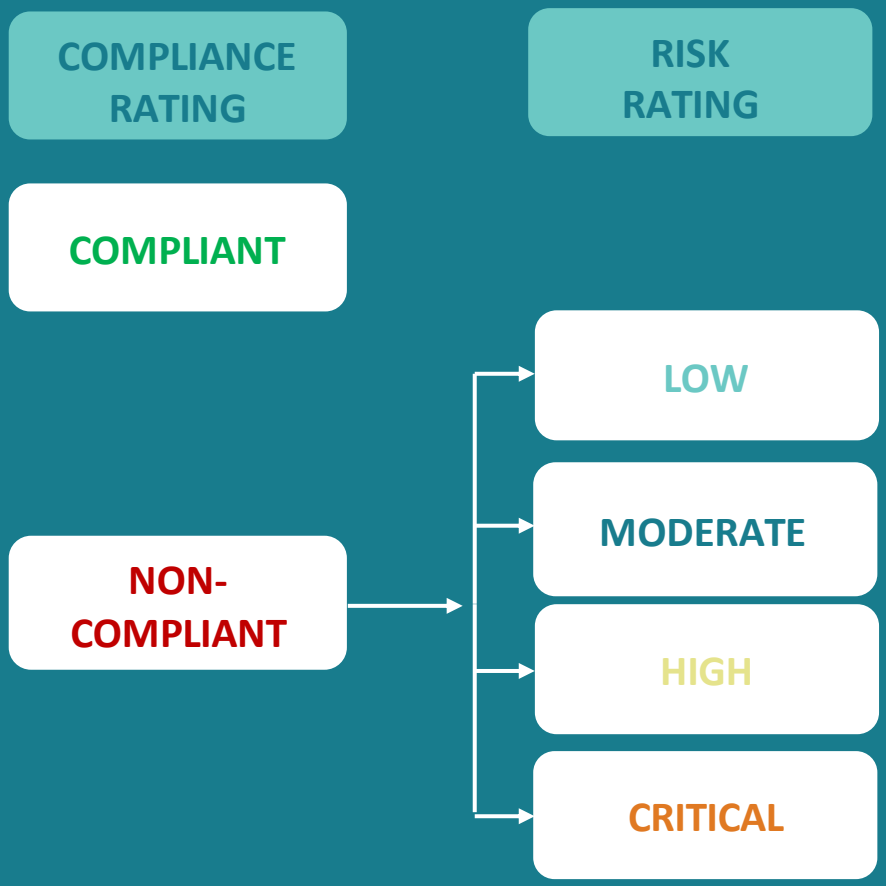
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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