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Ginesa Suite

Annual Inspection Report 2024

Promoting Quality, Safety and Human Rights in Mental Health

GINESA SUITE

St John of God Hospital, Stillorgan, Co Dublin

Date of Publication:
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2024 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:
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Inspection Team:
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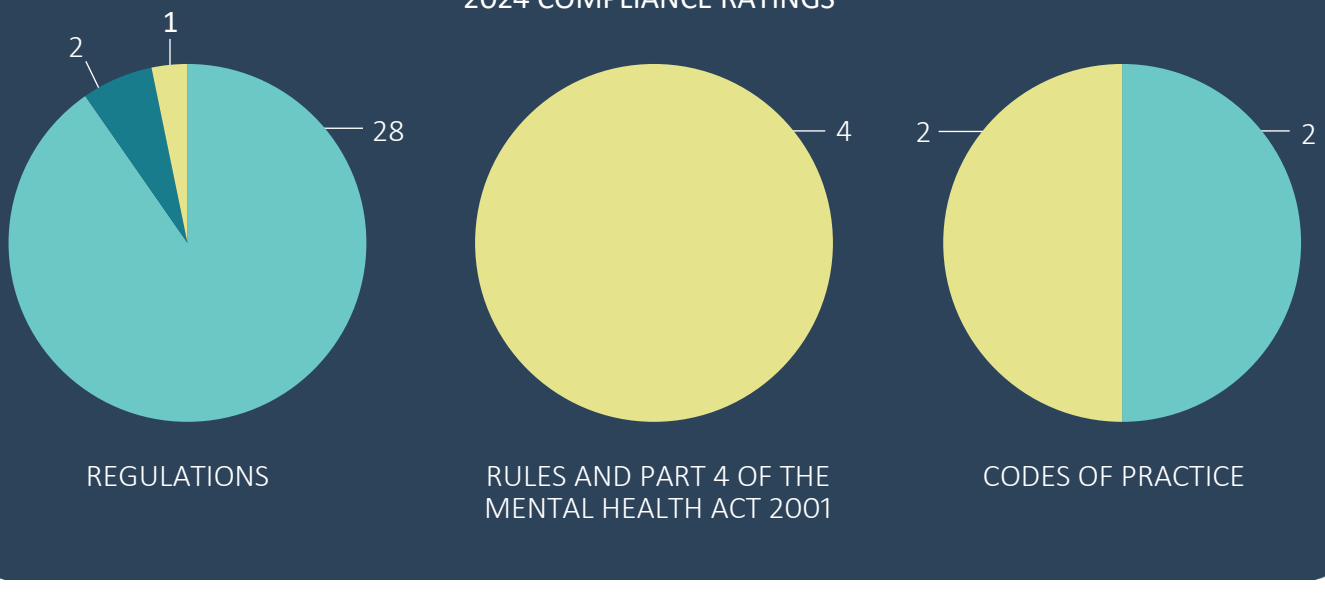
Inspection Date:
23 – 26 April 2024

Previous Inspection date:
18 – 21 April 2023

Inspection Type:
Unannounced Annual Inspection

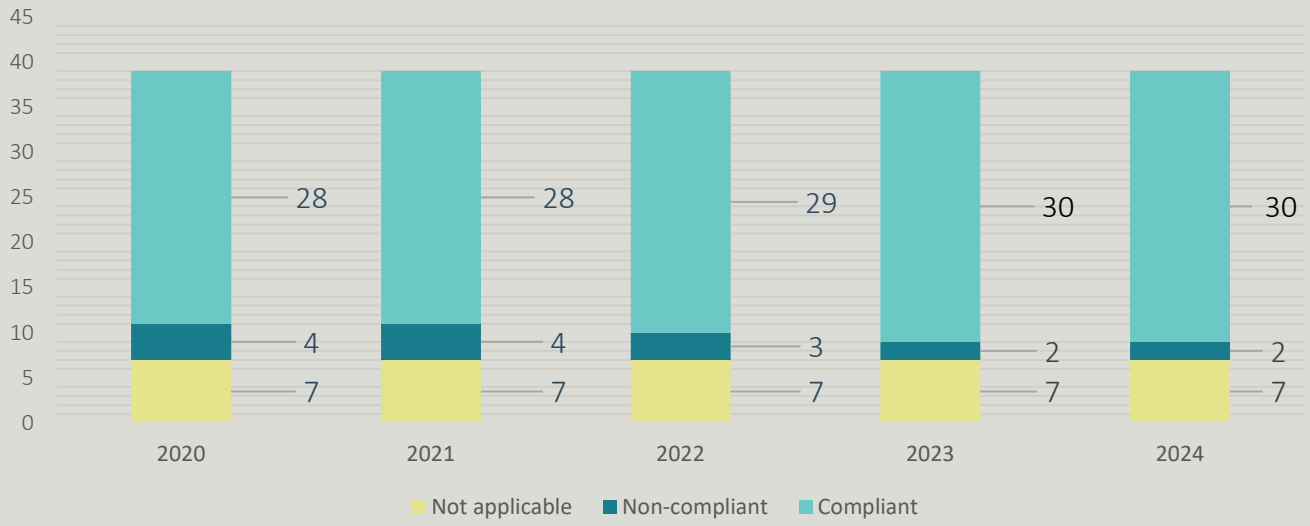
2024 COMPLIANCE RATINGS



RATINGS SUMMARY 2020 – 2024

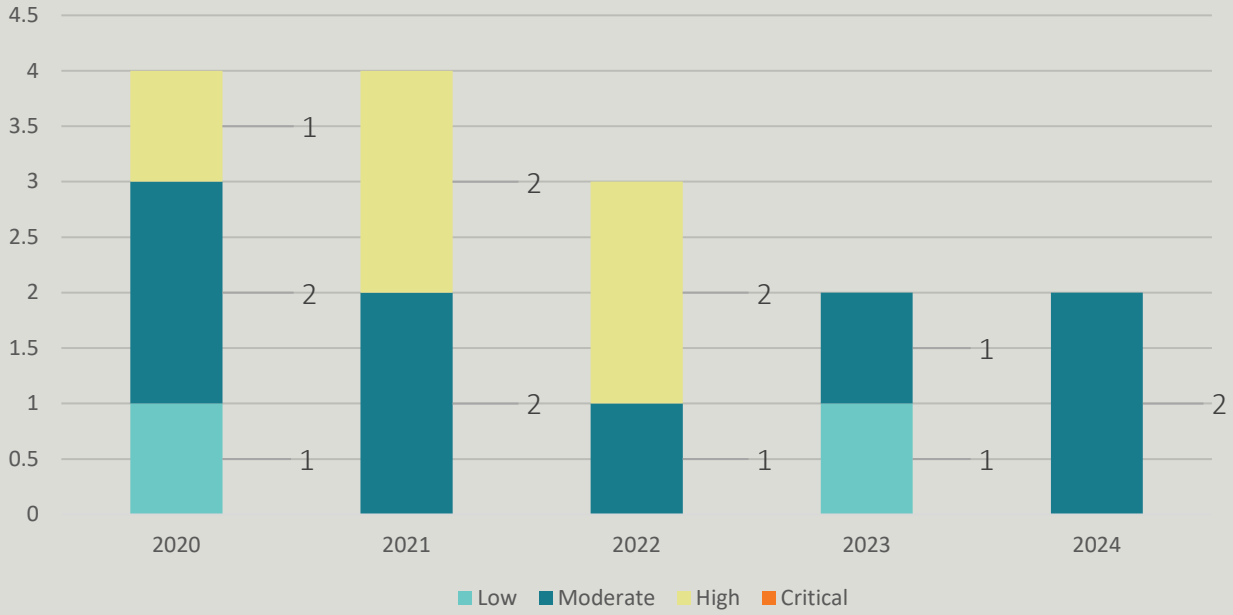
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2020 – 2024



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 2020 – 2024



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

Inspector of Mental Health Services Summary

Ginesa Suite is located on the St. John of God Hospital campus in Stillorgan, Co. Dublin. The approved centre provides treatment to young people aged from 13 to 17 years of age from all over Ireland. The approved centre has a bed capacity of twelve, and there were three residents accommodated at the time of the inspection.

The approved centre has robust clinical governance systems and processes. A more multi-disciplinary approach has been fostered within the governance structures of the approved centre since the previous inspection. It was observed that clinical Head of Discipline's including Head of Social Work, Psychology, Occupational Therapy, and Pharmacy had rejoined the senior management team, and are now attending senior management team meetings every four weeks.

In 2024, the inspection team found two areas of non-compliance, and the previous non-compliances were found to be compliant this year, which is an improvement. The inspection was well co-ordinated by staff and management in the approved centre. The unit itself is well maintained and was spotlessly clean throughout. It is evident throughout the unit that care, and consideration is given to providing a warm and child friendly environment to residents. The passion and drive from staff is evident, inspectors observed positive interaction between staff and the young people.

The approved centre has an annual audit schedule and they had developed new quality initiatives over the year. At the time of inspection resident feedback was overall positive regarding the care and treatment they received in the approved centre, and they spoke warmly of staff.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	88%	88%	91%	94%	94%

Conditions of 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

There were no ongoing escalation and enforcement actions at time of inspection.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Regulatory Compliance Meeting 10000299	*20/10/2023*	*The approved centre was non-complaint with the Code of Practice on the use of Physical Restraint.*	*The approved centre submitted plan to ensure compliance with the code of practice.*

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The Social work department developed a way of recording genograms for therapeutic use by the Multi-disciplinary Team (MDT) enabling the MDT to identify patterns within families which could assist with therapeutic work.

2. A project team was put in place for the implementation of a new Electronic Patient Records system to be put in place called Civica Care Records.

3. Sustainability initiatives were implemented regarding a better recycling system in the dining room.

4. Reinvigoration of the Safewards initiatives – a child friendly version of the getting to know you initiative called 'Guess the Nurse', and a new recovery tree art project to provide messages of hope and encouragement to patients were displayed in the approved centre.

5. The senior social worker undertook training in a child protection e-learning briefing programme developed by TUSLA to support professionals in making referrals or reporting concerns to TUSLA. This training covered the principles and key components of how Signs of Safety is applied at every stage of Child Protection and Welfare Work.

6. The specialist mental health pharmacist in the approved centre led a project in collaboration with Spunout, RCSI and the University of Edinburgh to develop a medicines information resource website called 'youthmed' which provided young people and their families accessible information on mental health medicines. This service www.youthmed.info is operated by a group of volunteer mental health professionals.

7. The psychologist undertook training in Eye Movement Desensitisation and Reprocessing Therapy to support the service on integrating a trauma informed approach into the culture and the care and treatment of the residents.

In addition to the quality initiatives listed, the inspection team also reviewed quality aspects in relation to the following specific regulations:

- **Regulation 11: Visits**
  - The approved centre maintained physical environments and facilities that were fit for purpose, welcoming, well-decorated and well-designed. There were multiple areas to facilitate visits both on the units and outside of the units.
  - The approved centre provided information about visiting in a manner which was accessible and understandable to all. Visiting times were flexible.

- **Regulation 15: Individual Care Planning**
  - The approved centre implemented an effective electronic care planning system.
  - The approved centre provided residents with a key worker to facilitate coordination and communication of interventions in line with their individual care plan.

- **Regulation 19: General Health**
  - The approved centre had a health promotion nurse and promoted positive physical, mental health, and psychological wellbeing through general and targeted health promotion and preventive mechanisms.
  - The approved centre focused on the promotion of positive physical and mental health, wellbeing, and wellness. A tennis court, football pitch, basketball court, pitch and putt course, the Slí Na Sláinte walk area, and a garden for Ginesa Suite with exercise equipment was available to residents. Residents also had equipment for individual and team sports available to them and access to the gym.
  - The activity programme had groups directed at promoting physical, mental health, and psychological wellbeing such as art therapy, music therapy, pet therapy, decider skills, eating disorder recovery planning, nutrition, exercise and activation groups, and Yoga.

- **Regulation 20: Provision of Information to Residents**
  - The approved centre promoted resident advocacy groups. A Youth Advocacy Programme advocate met with residents regularly and provided a report to the Ginesa Suite management team monthly with a summary of interactions they had with residents.
  - The approved centre provided information in a manner which was accessible and understandable to all. Information was provided to residents and their families and/or carers in various different formats which included printed booklets, information boards, and online.

- **Regulation 21: Privacy**
  - The approved centre provided culturally appropriate services to ethnic minorities and marginalised communities. A multifaith room was available to residents and staff in the approved centre. Staff had completed an Intercultural Awareness eLearning programme.
  - The approved centre promoted the principles of equity, inclusion, and respect for diversity.

- **Regulation 29: Operating Policies and Procedures**
  - The approved centre incorporated feedback from residents, families and carers into its policies, procedures, protocols, and guidelines by linking in with liaison officer of the Consumer Care Council.

- **Regulation 31: Complaints Procedures**
  - The approved centre had a complaints process which was visible and easily accessible to families and carers in addition to residents. The approved centre had a process in place to gather feedback from families and residents.
  - The Healthcare Risk Officer provided staff with training on the complaints management process.
  - The Patient Satisfaction, Complaints and Compliments committee discussed complaints and reviewed emerging trends on a monthly basis. A report was compiled, and any learning outcomes were shared with the senior management team and also reported to Clinical Governance/Quality and Safety Executive Committee.

- **Regulation 32: Risk Management Procedures**
  - All risk registers were reviewed and updated by the department manager/risk owner. Each quarter a selection of risk registers were audited by the Healthcare Risk Officer in conjunction with the Risk Committee, Services Manager and Director of Nursing, the monitor the existing controls and provide assurances to the Board.
  - Monthly incident trend analysis reports were submitted to the Senior Management Team, and Clinical Governance Quality and Safety Executive Committee. Incident trends were also brought to the Risk Committee and Health and Safety Committee as required. An annual trend analysis was also conducted.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Ginesa Suite is 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 en suite. There were communal washing and toileting facilities adjacent to the bedrooms. The unit had therapeutic and recreational areas internally and the 'Elvira room' was available to young people to partake in recreational and therapeutic activities. Residents had access to a gym and outdoor recreational facilities located on the grounds of St. John of God Hospital. A tennis court, football pitch, basketball court, pitch, and putt course, the Sli Na Sláinte walk area, and a garden for Ginesa Suite with exercise equipment was available to residents. 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	**3**
Number of detained patients	0
Number of wards of court	0
Number of children	3
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), Deputy CEO, and Clinical Director reported to the board monthly. The Executive Management team met weekly and comprised of the CEO, Deputy CEO, Clinical Director, Director of Nursing, Director of Information and Communications Technology, Interim Head of Finance, Head of Operations, and Interim Human Resources Manager. All clinical and non-clinical Heads of Service including the Head of Occupational Therapy, Head of Social Work, Head of Psychology, and Head of Pharmacy attended this meeting every four weeks. Agenda items such as service development and strategy, operations which included departmental updates, finance and performance, human resources and workforce planning, recruitment and retention, regulation and compliance, risk/data protection/complaints/safeguarding, and

items escalated from the Clinical Governance Quality and Safety Executive committee (CGQSE) were discussed at these meetings.

The 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 management, drugs and therapeutics, restrictive practices reduction, 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 local 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. At the time of inspection, the numbers and skill mix of staffing were sufficient to meet resident needs. The mental health team comprised of various disciplines including medical, nursing, occupational therapy, social work, and psychology staff. The approved centre also had a clinical pharmacy service. A music therapist, and an art therapist held groups weekly. Other specialist services such as speech and language therapy and dietetics were available on a sessional basis or via referral pathways. There was a school for residents of Ginesa Suite.

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 healthcare staff had not received up to date mandatory training in basic life support, fire safety, management of violence and aggression, the protection and welfare of children, or safeguarding training. It was predominantly the nursing staff that were not up to date with their training. Management in the approved centre gave assurances that it was an immediate priority to rectify this deficit and that they would review their processes for accurately recording training levels, and the governance arrangements for ensuring all staff were up to date with mandatory training.

The approved centre had several risk registers at both an organisational and local level. All risk registers were reviewed on a quarterly basis and updated by the department manager/risk owner. A selection of risk registers were audited quarterly by the healthcare risk officer in conjunction with the risk committee and an audit schedule was in place to ensure that every risk register was audited at least annually. All incidents were recorded and risk-rated in a standardised format on DATIX, the approved centre's web-based 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 a Local Incident Management Team to review incidents when required.

All heads of discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, pharmacy, chaplaincy, social work, and psychology. Clinical heads of discipline outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and

encouraging staff performance and personal development. All disciplines had formal and informal clinical supervision arrangements in place where appropriate. A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a multi-disciplinary approach to policy development, review, approval and dissemination and all policies were up to date at the time of inspection.

Operational risks identified by staff included: difficulties with accessing electronic medical records at times, lone working, medication shortages, recruitment, and retention of staff, maintain mandatory training, limited access to Continuing Professional Development (CPD). The identified risks were effectively mitigated by escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. 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 weekly basis and met with residents as a group. Monthly feedback reports were 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 were clear processes in place to follow up on any issues identified by service users or family members. There were two Designated Officers for Child Protection and Welfare in the approved centre.

In line with the Mental Health Commissions updated Rules on Seclusion and Mechanical Restraint and the Code of Practice on Physical Restraint, the approved centre had updated their policies and procedures. There was a named senior manager who was chair of a newly established multi-disciplinary review and oversight committee for restrictive practices. This committee met quarterly, and an identified action plan had been devised. The physical restraint documentation had been updated. All the elements required by the new code of practice were evident within the clinical files.

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 2020 and 2024 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2020		2021		2022		2023		2024	
Regulation 26: Staffing	✗	Moderate	✗	High	✗	High	✓		✗	Moderate
Regulation 28: Register of Residents	✓		✓		✓		✓		✗	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. To that end, the inspection team engage with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- 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.
- Set times and a private room were available to talk to residents.
- 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 were happy with the choice and quality of food provided but commented that the menus could be difficult to read as meals were sometimes described in different languages. The residents stated that there were suitable and sufficient therapeutic and recreational facilities provided in the approved centre and commented that they enjoyed art therapy and music therapy very much. 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 youth advocate.

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 who their multi-disciplinary team members were, understood what their care plan was, and were "always" involved in goal setting as part of the care planning process. One resident indicated they did not know their treating team or what their care plan was. All respondents said they could talk to staff, give feedback to the team, and discuss worries or concerns with staff.

All residents indicated there were enough leisure activities, group activities and talking therapies provided and were complimentary of the recreational and therapeutic programmes. Two residents indicated that they "always" felt safe in the approved centre, one indicated they "never" 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.

Residents felt that the most positive aspects of their experience in the approved centre was the kindness of staff and how much they show you that they care for you. One resident stated that they felt safe and supported and that the staff were so helpful. There was a sense of overall satisfaction with the approved centre. On a scale of 1-10, with 1 being poor and 10 being excellent, all residents scored eight out of ten for overall care and treatment.

5.2 Advocacy

The approved centre had an advocacy service. The Youth Advocacy Programme advocate provided a monthly report to nursing management with a summary of interactions they had with residents. These reports were made available to the inspection team. The reports indicate Ginesa Suite provides a client-centred and therapeutic environment conducive to recovery. Feedback to the advocate about staff, therapeutic programmes, recreational activities, and resident involvement in their individual care plan was predominantly positive. The young people stated that they enjoyed having the therapy dog come into the unit once a week.

There were issues identified by the young people around difficulty understanding menus, and dining room facilities such as there only being one large table available to them and they would prefer the option to sit in smaller groups. The young people expressed dissatisfaction regarding their clinical services. They were concerned at the lack of psychological input with no psychologist available to them for several months.

A recurrent theme in the reports was that the young people were finding difficulties with the bathrooms for example not having a place to store their clean, dry clothes, due to the ligature free system. Also, that the alarm was activated by shower steam and the young people felt that this was impacting on their privacy when a staff member needed to come and check on them following the alert. The young people also relayed issues with the shower curtains causing the floors to flood regularly.

Young people suggested that it would be helpful for agency and night staff to wear badges with their names on them when they are on shift and expressed the need for updating of the staff pictures and names on the board. The young people also expressed wanting staff to have a coffee with the group in the dining room during meals to have a more homely feel.

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 (CEO)
- Deputy CEO
- Head of Operations
- Director of Nursing
- Assistant Director of Nursing
- Consultant Psychiatrist
- Non-Consultant Hospital Doctor (NCHD)
- Head of Pharmacy
- Senior Clinical Psychologist
- Head of Occupational Therapy
- Clinical Nurse Manager 2
- Head of HR
- Director of Finance

Apologies:

- Clinical Director
- Head of Social Work
- Head of Psychology

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 resident identifiers that were appropriate to the resident group profile and individual residents' needs when administering medication, undertaking medical investigations, and providing other healthcare services.

An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

Appropriate identifiers and alerts were used for residents with the same or similar name.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

A source of safe, fresh drinking water was made available to residents at all times in easily accessible locations throughout the approved centre.

Nutritional and dietary needs were assessed with the use of an evidence-based nutrition assessment tool and addressed in the resident's individual care plan. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre had suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, preparation, cooking and serving of food.

Hygiene was maintained to support food safety requirements. Food and fridge temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored with clearly identified actions if the temperature breached cold chain parameters.

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 to the resident and considered the residents' preferences, dignity, bodily integrity, and religious and cultural practices.

Residents changed out of night clothes during daytime hours unless specified otherwise in their individual care plan.

Residents were supported to manage and maintain their own laundry through family and carers; internal laundry services were also provided.

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

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Lockable wardrobes in resident bedrooms were provided for the safekeeping 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, listing their personal property and possessions. The checklist was updated on an ongoing basis and in line with the approved centre's policy, was kept separate to the resident's individual care plan and was available to the resident.

Residents were supported to manage their own property except where this posed a danger to the resident or others, as indicated in their individual care plan or in accordance with the approved centre's policy.

The access to and use of resident monies was overseen by either two staff members or the resident and two staff members. A process to record, secure and manage the personal property and possessions of the resident, including money, was in place.

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 recreational activities appropriate to the resident group profile. Recreational activities were available both on weekdays and during the weekend.

Indoor activities included television, Netflix, board games, books, newspapers, DVDs, videogames, pool and foosball. A large selection of musical Instruments and arts and crafts materials were available to the residents. Outdoor recreational activities included tennis, basketball, pitch and putt and various exercise equipment for individual and team sports. There was access to a gym, a football pitch, a garden area and the Sli Na Sláinte walking area or trail.

The recreational facilities provided by the approved centre were appropriately resourced.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Residents could attend Catholic mass in the church on the St John of God Hospital campus. This service was also streamed to the unit. A multi-faith room available to residents.

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 operational policies and procedures relating to visits. The policy was last reviewed in March 2022.

Visiting times were appropriate and reasonable. A separate visitors room was provided where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

A dedicated family room was available in the approved centre, which 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 operational policies and procedures on communication. The policy was last reviewed in March 2022.

Residents had access to the means of sending or receiving messages or goods, except where the resident was otherwise risk assessed with due regard to their wellbeing, safety, and health. Residents had restricted internet access.

The clinical director, or a senior member of staff designated by the clinical director, only examined incoming and outgoing resident communication where there was reasonable cause to believe that the communication would result in harm to the resident or to others based on the risk assessment.

Any restrictions applied to a resident's means of communication were supported by an individual risk assessment.

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 written operational policies and procedures on:

- The searching of a resident, their belongings, and their environment.
- Carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
- The finding of illicit substances.

The policy was last reviewed in March 2022.

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches. The request for consent and the reply was documented for every search of a resident and every property search. General written consent was sought for routine environmental searches.

The resident search policy and procedure was communicated to all residents. Relevant staff were able to articulate the searching processes as set out in the policy. Residents were informed by those carrying out the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times while searches were being carried out.

The resident’s dignity, privacy and gender were respected during searches and at least one of the staff members conducting the search was the same gender as the resident being searched. Residents were

given the opportunity to give feedback regarding their experience of the search in relation to their dignity and privacy.

A written record of every search of a resident and every property search was available, and 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. A written record was kept of all environmental searches.

Policy requirements were implemented when illicit substances were found during a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and protocols for care of residents who are dying. The policy was last reviewed in February 2023.

As there had been no death of a resident in the approved centre since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Three ICPs were inspected. The ICPs were a composite set of documents which addressed the resident's goals, mental health care and treatment needs based on a multi-disciplinary team (MDT) assessment of the person and where practicable, in consultation with them. The documents within the ICPs were identifiable and uninterrupted and were not amalgamated with progress notes.

The ICPs were developed by the MDT following a comprehensive assessment of the resident within seven days of admission. The ICPs was discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

The ICPs identified appropriate goals for the resident, the care and treatment required to meet the goals, the responsibilities for implementing the care and treatment and the resources required to provide the care and treatment identified.

The ICPs were reviewed by the MDT in consultation with the resident. Following this review, the ICPs were updated contemporaneously to reflect any changes to the goals, treatment, care, best practice and required resources. The ICP of a child resident included their educational requirements.

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

Individual sessions and group sessions were facilitated by the occupational therapist and psychologist. A music therapist and an art therapist attended weekly. Irish therapy dogs also visited the approved centre weekly. Therapeutic services and programmes included decider skills groups, eating disorder recovery planning, yoga, nutrition, exercise, and activation groups, planning groups, cognitive behavioural therapy, dialectical behavioural therapy and psychoeducation groups.

The approved centre arranged therapeutic services for residents when the services was not provided internally. External services were 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 regarding their individual educational requirements. Their individual needs and age on admission were taken into consideration as part of the assessment. Appropriate to the needs and age of the child resident, the education provided by the approved centre reflected the required educational curriculum. Educational facilities and staff were available within the approved centre.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the transfer of residents. The policy was last reviewed in November 2023.

The clinical file of one resident who had been emergency transferred from the approved centre to another facility was inspected. Communications between the approved centre and the receiving facility were documented and followed up with a written referral. A letter of referral, a list of current medications and a resident transfer form were sent to a named individual.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre has written operational policies and procedures for responding to medical emergencies. The policy was last reviewed in November 2023.

The approved centre had an emergency trolley and staff always had access to an automated external defibrillator (AED).

Residents were provided with general health services and received appropriate health care interventions in line with their individual care plans. At the time of inspection, none of the residents admitted to the approved centre had been there for longer than six months. As a result, no six-monthly general health assessment had been undertaken.

Residents' general health needs were monitored. Arrangements were in place for residents to access general health services and for their referral to other health services as required.
Residents had access to national screening programmes according to age and gender.

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 written operational policies and procedures for the provision of information to residents. The policy was last reviewed in November 2023.

Residents were provided with required information at admission, including the approved centre's information booklet that detailed the care and services provided. The booklet was available in a format that supported resident needs and clear and simple-to-read information was provided on housekeeping arrangements, personal property, mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies and residents' rights.

Residents were provided with the details of their multi-disciplinary team. Residents were provided with written and verbal information regarding their diagnosis, except where the resident's psychiatrist deemed the provision of such information as prejudicial to the resident's physical health, mental health, well-being, or emotional condition.

Medication information sheets and verbal information were provided in a format appropriate to the resident's needs. The medication information sheets included information on indications for use of all medications administered to the resident, including possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Residents were called by their preferred name based on their self-identification. Staff appeared and dressed professionally and interacted with residents in a professional, engaging, and compassionate manner. Staff showed discretion when discussing the resident's condition or treatment needs. Permission was sought before entering a resident's room.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, except where there was an identified risk to a resident. Locks had an override function.

Where residents shared a room, bed screening ensured that their privacy was not compromised. Observation panels on treatment room doors and bedroom doors had blinds, curtains, or opaque glass. Rooms were not overlooked by public areas.

Noticeboards did not detail resident names or other identifiable information. Residents were facilitated to make private phone 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 in the approved centre had access to personal space and all resident rooms were adequately sized. Communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were sized and furnished to remove excessive noise. Lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs.

Residents had space to move about, including outdoor spaces. Hazards such as large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces were minimised in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

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. Records were maintained. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Water temperature in taps did not exceed 50°C. Current national infection control guidelines were followed.

There were sufficient toilets and showers for residents in the approved centre, with at least one assisted toilet per floor. The approved centre had a designated cleaning room. All resident bedrooms were

appropriately sized to address the residents' needs and furnished to support resident independence and comfort. Assisted devices and equipment were available to address resident needs.

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 appropriate and suitable practices and written operational policies relating to:

- Ordering medicines.
- Prescribing medicines.
- Storing medicines.
- Administering medicines to residents.

The policy was last reviewed in November 2023.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident. The MPARs of three residents were inspected. The MPARs recorded allergies and sensitivities to any medication or recorded that the resident had no allergies. The MPARs detailed medication administration routes, a record of all medications administered to the resident and a clear date of discontinuation for each medication. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was recorded. Each entry was legible and signed by the prescribing medical practitioner.

Medication was reviewed and re-written at least six-monthly, or whenever there was a significant change in the resident's care or condition. This was documented in the clinical file. When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file.

Medication was appropriately stored. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication was stored securely. Schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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 written operational policies and procedures relating to the health and safety of residents, staff, and visitors. 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 clear written policy and protocols in relation to the use of CCTV for observing residents. The policy was last reviewed in July 2021.

Clear signs in prominent positions indicated where CCTV cameras or other monitoring systems were located throughout the approved centre. The existence and use of CCTV or other monitoring systems was disclosed to all residents and their representatives. Residents were monitored solely for the purposes of ensuring the health, safety, and welfare of that resident.

The use of CCTV, or other monitoring systems, had been disclosed to the Mental Health Commission or the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe residents were incapable of recording or storing a resident's image on a tape, disc, hard drive or in any other form. CCTV cameras or other monitoring systems only transmitted images to a monitor that was viewed solely by the health professional responsible for the resident.

CCTV was not used to monitor a resident if they started to act in a way which compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had 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 mental health team was comprised of various disciplines including medical, nursing, occupational therapy, social work, and psychology staff. The approved centre also had a clinical pharmacy service, a music therapist, and an art therapist. Other specialist services such as speech and language therapy and dietetics were available on a sessional basis or via referral pathways.

The mandatory training programme included training on the following subjects: basic life support, management of violence and aggression, fire safety, the protection and welfare of children, safeguarding, and mental health legislation. All healthcare staff had not received up to date mandatory training in basic life support, fire safety, management of violence and aggression, the protection and welfare of children, or safeguarding training. Training in basic life support, fire safety and the management of violence and aggression was delivered on site by external training companies. Training on the protection and welfare of children, safeguarding, and the mental health legislation consisted of on-line web-based training modules. Managers monitored mandatory training and alerted staff when they needed to update their training.

The following is a table of staff showing the numbers and percentages of staff trained in the six mandatory training topics:

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (14)	11	79%	11	79%	12	86%	14	100%	12	86%	12	86%
Medical (3)	2	66%	2	66%	2	66%	3	100%	3	100%	3	100%
Occupational Therapist (1)	0	0%	0	0%	0	100%	1	100%	0	0%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

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

a) **Not all healthcare staff in the approved centre had up to date training in fire safety, basic life support, management of violence and aggression or safeguarding, 26(4).**
b) **Not all mandated persons in the approved centre had up to date training in Children First, 26(4).**

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 written policies and procedures relating to the:

- Creation of records.
- Access to records.
- Retention of records.
- Destruction of records.

The policy was last reviewed in November 2023.

All residents' records were secure, up to date and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were physically stored together, where possible, and reflected the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Documentation of food safety, health and safety and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

The approved centre had a documented electronic register of residents, which was up to date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record a diagnosis on admission for four residents and did not record a diagnosis on discharge for 32 of the 37 residents discharged from the approved centre since the last inspection.

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

a) **The register of residents did not contain the admitting diagnosis for four residents, 28(2).**
b) **The register of residents did not contain a discharge diagnosis for 32 out of the 37 residents discharged from the approved centre since the last inspection, 28(2).**

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 applicable operating policies and procedures were reviewed within the required three-year time frame, having due regard to any recommendations made by the Inspector or the Commission.

Where regional or national policies were used, the approved centre had a written statement confirming this, which was reviewed at least every three years.

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 written operational policies and procedures relating to the:

- Making of complaints.
- Handling of complaints.
- Investigating complaints from any person about any aspects of the service, care and treatment provided in or on behalf of the approved centre.

The policy was last reviewed in March 2023.

A nominated person was responsible for dealing with all complaints and was available to the approved centre. The approved centre’s processes for managing complaints were well publicised and accessible to residents and their representatives. This included providing information about the complaint’s procedure to the resident and their representative 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 given to a resident were not adversely affected by any complaint made.

Minor complaints were documented. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, and subsequent investigations and outcomes,

were fully recorded and kept distinct from the resident's individual care plan. Complainants were informed promptly of the outcome of the complaint investigation; details of the appeals process were made available to them, and this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in March 2024, and outlined the roles and responsibilities for risk management, including:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The responsibilities of the multi-disciplinary team.
- The person responsible for the completion of six-monthly incident summary reports.
- A defined quality and safety oversight and review structure as part of the governance process for managing risk.

The policy also included:

- The process for identifying, assessing, treating, reporting, and monitoring risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling specific risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register.
- The record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.

- The process for responding to specific emergencies, including the roles and responsibilities of key staff, the sequence of required actions, the process for communication and escalating emergencies to management.
- The process for the protection of children and vulnerable adults within the care of the approved centre.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff.

Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks, health and safety risks and corporate risks were identified, assessed, treated, reported and monitored. Clinical risks, health and safety risks and corporate risks were documented in the risk register, as appropriate. Structural risks, including ligature points, were removed, or effectively mitigated.

The approved centre implemented a plan to reduce risks to residents while works to the premises were ongoing.

Individual risk assessments were completed prior to and during physical restraint. Individual risk assessments were also completed at admission, transfer, and discharge, and in conjunction with medication requirements.

Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of the individual risk management processes. Residents or their representatives were also involved in the individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT and a record was maintained of this review and recommended actions.

The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission.

An emergency plan was 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's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration that 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 written policy on the use of physical restraint. The policy had been reviewed annually and was dated December 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.
- Who could initiate and who may carry out physical restraint.
- The safety, safeguarding and risk management arrangements that should be followed during any episode of physical restraint.

Policies and procedures regarding staff training included:

Who would 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:
    - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
    - Alternatives to physical restraint.
    - Trauma-informed care.
    - Cultural competence.
    - Human rights, including the legal principles of restrictive interventions.
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional, or somatic causes or triggers of the person's behaviours.
- The monitoring of the safety of the person during and after the physical restraint.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in physical restraint.

The approved centre had a reduction of physical restraint policy which addressed the following:

- How the approved centre aimed to reduce, or where possible eliminate, the use of physical restraint within the approved centre.
- 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.
- How the approved centre would provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

Monitoring: An annual report was published on the registered proprietor's website. A multi-disciplinary review and oversight committee met at least quarterly and:

- Determined if each episode of physical restraint reviewed complied with the code of practice on the use of physical restraint.
- Determined if each episode of physical restraint reviewed complied with the approved centre's own policies and procedures relating to physical restraint.
- Identified and documented any areas for improvement.
- Identified the actions, the persons responsible, and the timeframes for completion of any actions.
- Assured the registered proprietor nominee that each use of physical restraint was in accordance with the Mental Health Commission's code of practice.
- Produced a report following each meeting of the review and oversight committee which was available to the Mental Health Commission on request.

Evidence of Implementation: Three episodes of physical restraint undertaken on one individual were inspected. Physical restraint was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy. The consultant psychiatrist (CP) or the duty CP was notified as soon as was practicable and the order for physical restraint lasted for a maximum of 10 minutes.

Staff involved in the use of physical restraint treated the person safely and with dignity.

The person who led the physical restraint ended the restraint. An in-person debrief with the person who was restrained followed every episode of physical restraint. This debrief was person-centred and gave the person the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. The person's individual care plan was updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.

The episodes of physical restraint were recorded in the clinical file and in the clinical practice form (CPF). The episodes of physical restraint were reviewed by members of the multi-disciplinary team within five working days from the date of the restraint.

For child residents, a risk assessment pertaining to physical restraint was carried out on admission by a registered medical practitioner or registered nurse which determined whether physical restraint could be safely used or not. The reasons for, and the circumstances which led to the discontinuation of restraint, were explained to the child in a way that they could understand and in a format that was appropriate to their age.

The child's parent or guardian was informed as soon as possible of the child's physical restraint and the circumstances which led to the child being physically restrained. The child's parent or guardian was informed when the episode of physical restraint ended.

The approved centre had child protection policies and procedures in place that were in line with the relevant legislation and regulations, and staff were appropriately trained in relation to child protection.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in November 2023, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in November 2023, 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 had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, family history, medical history, current and historic medications, current mental health state, risk assessment, and all other relevant information. A full physical examination was carried out. A key worker system was in place, and a family member or carer was involved in the admission process with the resident's consent.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse or other risks and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, their key worker, relevant members of the resident's multi-disciplinary team (MDT) and a family member or representative, where appropriate.

The discharge assessment addressed the resident's psychiatric and psychological needs and included a current mental state examination, a comprehensive risk assessment and risk management plan, social and housing needs, and informational needs. The discharge was coordinated by the key worker. A preliminary discharge summary was sent to the relevant healthcare provider and a comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge and outstanding health or social issues. It provided follow-up arrangements, names and contact details of key people for follow-up and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate.

A timely follow-up appointment was arranged.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 26: Staffing					
Reason ID : 10005564		**Not all healthcare staff in the approved centre had up to date training in fire safety, basic life support, management of violence and aggression or safeguarding, 26(4). Not all mandated persons in the approved centre had up to date training in Children First, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Compliance ratings have been issued to the relevant Heads of department with a request to ensure non-compliant staff attend upcoming training. Additional training sessions have been scheduled to enable staff attendance.	Compliancy ratings will be provided to HOD's monthly and to the management team monthly also. These will be reviewed monthly at management team meetings with focus on individual cases of non-conformance and escalated where necessary. Corrective action will be taken where compliancy does not improve.	Achievable.	31/12/2024	Head of Human Resources
Preventative Action	Compliancy ratings will be provided to HOD's monthly. These will be monitored at Local departmental meetings. These will also be reviewed monthly at management team meetings, with a focus on individual cases as necessary. Preventative action will	Monthly statistics will be provided to HOD's to update them on their department's compliance. Training compliance will be a focus monthly at the management team meeting. Heads of departments will be asked to report on reasons for non compliances within	Achievable.	31/12/2024	Head of Human Resources.

	be taken to monitor and measure compliancy, with involvement from Head of HR - working closely with Training Officer. Non compliancy will be escalated as appropriate should staff not attend or if HOD's fail to make the necessary improvements.	their dept. and feedback to the management team.			

Regulation 28: Register of Residents					
Reason ID : 10005566		**The register of residents did not contain the admitting diagnosis for four residents, 28(2). The register of residents did not contain a discharge diagnosis for 32 out of the 37 residents discharged from the approved centre since the last inspection, 28(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	a) Admission Diagnosis: Communication to the consultant team and administration support team to provide diagnosis on admission and record on the electronic patient record. The administration team will continuously update the admitting diagnosis. Prior to go live of new EPR, a new database will be implemented to capture diagnosis on admission and this process will be embedded into an admissions SOP ensuring these details are captured at first point of contact. Follow up and weekly monitoring provided by the Administrative Officer and escalated to the Clinical Director , Director of Nursing or Head of Operations as	Weekly checks on admissions and discharge diagnoses to ensure compliance.	No barriers to implementation, achievable.	01/11/2024	Clinical Director

	appropriate. b) Discharge Diagnosis: A new report to capture the full regulation requirement on the register of residents will be created to include the previously omitted discharge diagnosis. The administration team will review all planned discharges on a weekly basis to ensure diagnosis on discharge has been populated. Follow up and weekly monitoring provided by the Administrative Officer and escalated to the Clinical Director , Director of Nursing or Head of Operations as appropriate.				
Preventative Action	a) Admissions diagnosis: This will be a mandatory field in the new EPR from end of April 2025. b) Discharge Diagnosis: This will be a mandatory field in the new EPR from end of April 2025.	Weekly monitoring	Achievable.	30/04/2025	Director of Nursing & Head of Operations

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.

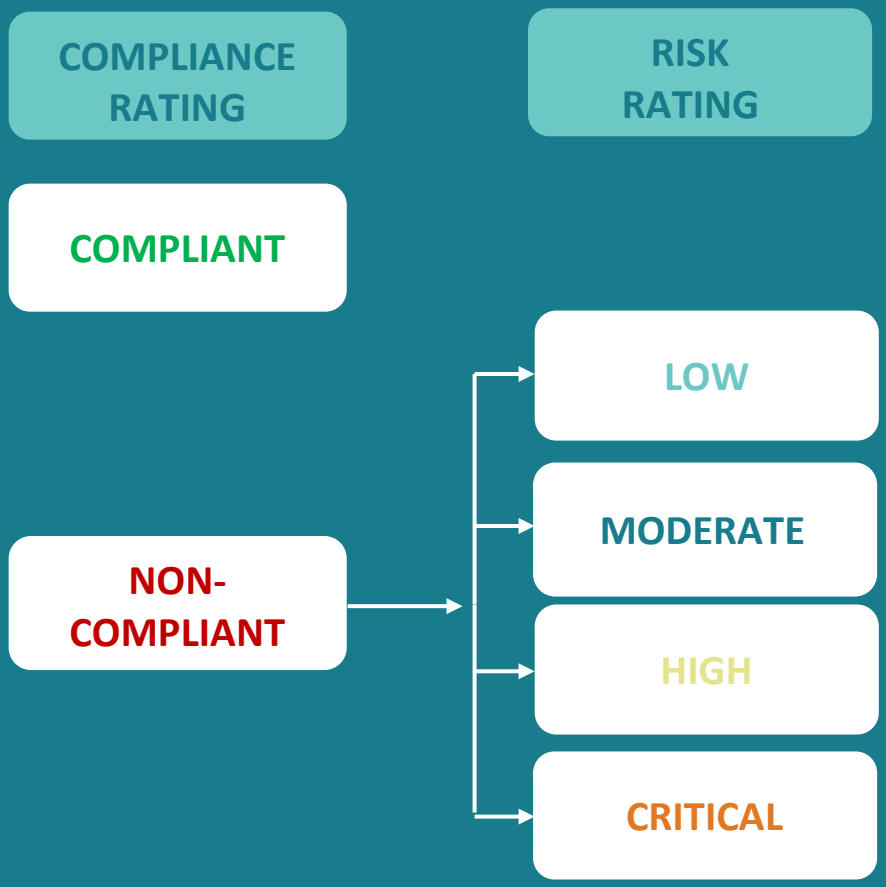
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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