mhc
coimisiún meabhair - shláinte
mental health commission

Ginesa Suite

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

GINESA SUITE

St John of God University Hospital, Stillorgan, Co Dublin, A94YX77.

Date of Publication:
20 November 2025

ID Number: AC0212

2025 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:
Mr Damien O'Dowd

Inspection Team:
Marianne Griffiths, Lead Inspector
Deirdre O'Hara
Siobhán Dinan

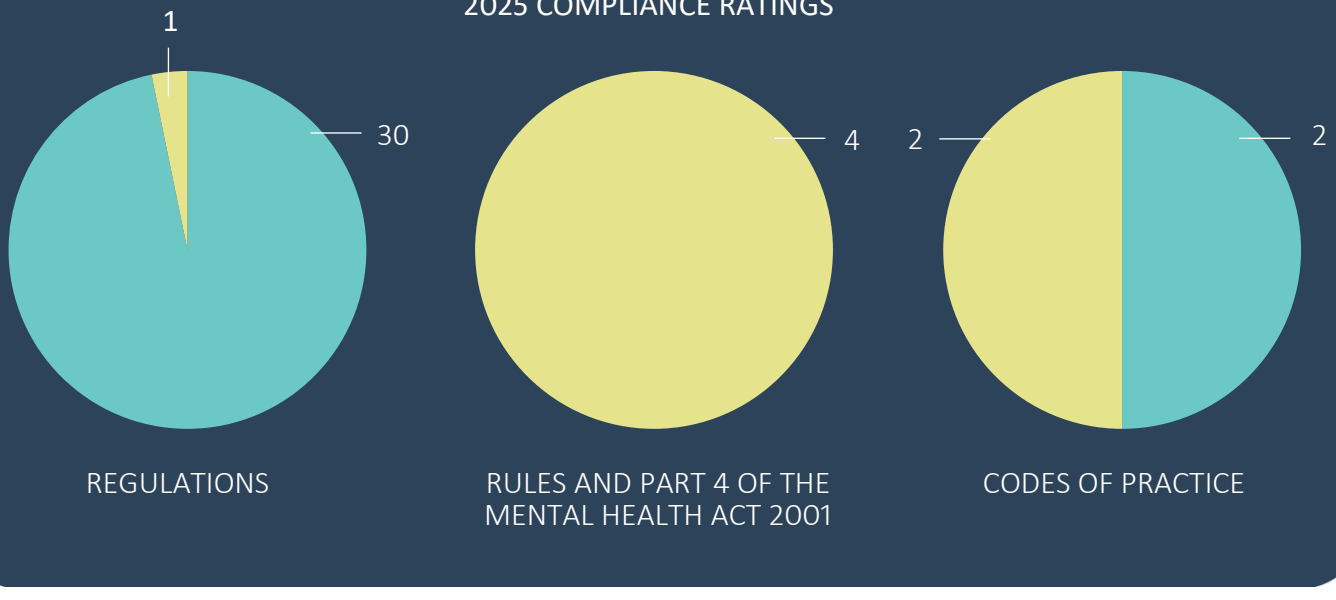
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
06 – 09 May 2025

Previous Inspection date:
23 – 26 April 2024

Inspection Type:
Unannounced Annual Inspection

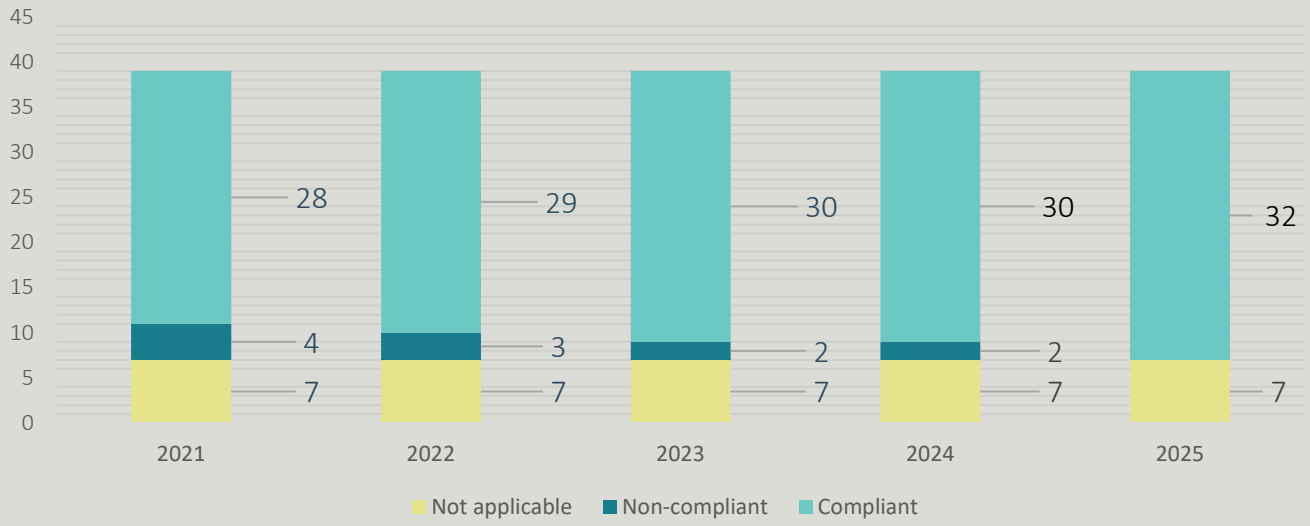
2025 COMPLIANCE RATINGS



RATINGS SUMMARY 2021 – 2025

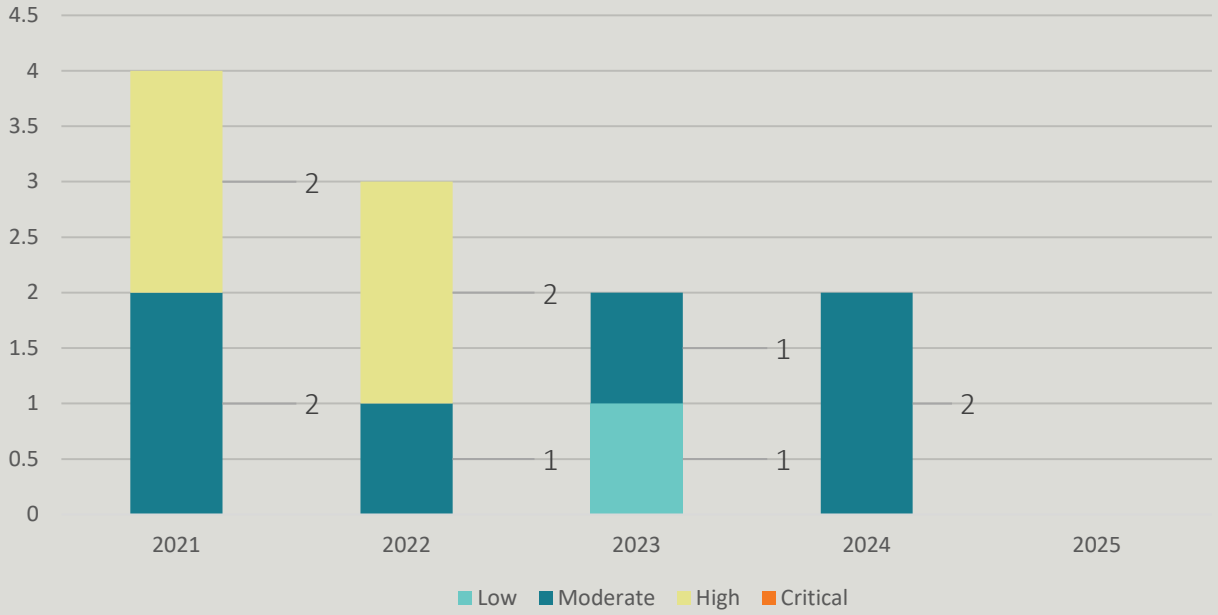
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2021 – 2025



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 2021 – 2025



Contents

1.0 Inspector of Mental Health Services – Review of Findings 6

Description of Approved Centre 6

Inspector of Mental Health Services Summary 6

Compliance summary 7

Conditions of registration 7

Ongoing escalation and enforcement actions at time of inspection 7

Escalation and enforcement actions commenced following this inspection 7

2.0 Quality Initiatives 8

3.0 Governance 10

4.0 Compliance 14

4.1 Compliant areas on this inspection 14

4.2 Non-compliant areas on this inspection 15

4.3 Areas that were not applicable on this inspection 15

5.0 Service-user Experience 16

5.1 Service-user feedback 16

5.2 Advocacy 17

6.0 Feedback Meeting 18

7.0 Inspection Findings – Regulations 19

8.0 Inspection Findings – Rules 20

9.0 Inspection Findings – Mental Health Act 2001 21

10.0 Inspection Findings – Codes of Practice 22

Appendix 1: REGULATIONS, RULES and CODES of PRACTICE 23

Appendix 2: Background to the inspection process 31

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

Description of Approved Centre

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 seven residents accommodated at the time of the inspection. The approved centre comprises of several areas. These include the Elvira Room which is a therapeutic space also used for recreational activities. Within the Elvira room are two small group rooms and a large open indoor area which was colourfully decorated and contained musical instruments, art supplies and relaxation space. The residents of Ginesa Suite had access to their own private garden area. The bedroom accommodation was located in the main Ginesa Suite ward across the garden from the Elvira room. It consisted of five double bedrooms and two single bedrooms. There was a 'chill out area,' a small room used for therapies, a lounge and a communal seating area. The approved centre dining room and classroom were each located downstairs. Residents had access to a gym and outdoor recreational facilities located on the grounds of St John of God Hospital.

All residents were under the care of a single multi-disciplinary team (MDT).

Inspector of Mental Health Services Summary

The annual Mental Health Commission inspection of the Ginesa Suite took place between the 6th and the 9th of May 2025. The findings of this report reflect this time period only.

The inspectors found that the approved centre promoted a culture of person centredness and least restrictive practices. All regulations and Codes of Practice inspected were found to be compliant; a compliance rate of 100%. This represented an improvement on the 2023 and 2024 inspections when compliance was at 94% for each of these years due to two areas of breach.

Approved centre management had worked diligently in order to achieve 100% compliance with the Mental Health Act. Robust governance processes such as ongoing policy development, a programme of clinical audit and a large contingent of committees that communicated their findings with one another all contributed to high quality care and treatment delivery in Ginesa Suite. A focus upon staff training and the appointment of a Compliance and Quality Manager assisted the management team in attaining the high levels of regulatory

compliance within the approved centre. Quality initiatives delivered by the pharmacy department illustrated the service's commitment to research.

The atmosphere within the approved centre appeared to be relaxed, therapeutic and conducive to the promotion of positive mental health for the young people who used the service.

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

Resident Profile	
Number of registered beds	***12***
Total number of residents	**7**
Number of detained patients	0
Number of wards of court	0
Number of residents under the Assisted Decision Making Act	0
Number of children	7
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	88%	91%	94%	94%	100%

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

None.

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

Please note, the information below in relation to the good practices and quality initiatives are as described by the service and provided to the inspection team.

- **Regulation 05: Food and Nutrition**
  - The approved centre has processes in place to identify and provide education and training with regard to the nutritional needs of the residents.
  - The approved centre has processes in place for the involvement of residents in their nutritional care. Catering Department customer feedback questionnaires were available to residents in canteen.
  - The approved centre takes into consideration residents' psychosocial needs by ensuring that the food offered is appetising, visually appealing, well-presented, and enjoyable.

- **Regulation 21: Privacy**
  - The approved centre provides culturally appropriate services to ethnic minorities and marginalised communities.
  - The approved centre promotes the principles of equity, inclusion, and respect for diversity.
  - The approved centre empowers residents to manage their own lives through stronger social relationships and sense of purpose.
  - The approved centre acknowledges the evolving understanding of human rights and maintains policies and practice in line with current requirements.

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

  - St John of God Hospital Services for children and young people have continued to add medicines information videos to their online youth medicines information resource - www.youthmed.info - which now hosts 26 co-designed videos on the most commonly used mental health medicines. The advanced specialist pharmacist meets each young person after admission or following the initiation of a new medicine and shows them the relevant video(s) to ensure that they have access to appropriate information on the medicine(s) they are prescribed.
  - St John of God Services recently published a paper on the development and consensus validation of a guideline on metformin for the prevention of antipsychotic-induced weight gain which is applicable from age 10 and therefore suitable for the young people in Ginesa. As children and young people are often overlooked in the development of mental health treatment guidelines, the approved centre were keen to include those aged under 18 given that children are particularly susceptible to this side-effect (as was noted in the Maskey Report). The guideline algorithm - a one page summary of the recommendations - is displayed on the notice board in the Ginesa clinical room.

- The advanced specialist pharmacist documents the weekly medicines optimisation review. The review incorporates both person-facing and clinician-facing interventions and is adapted for the adolescent population from the St John of God Medicines Optimisation Checklist which was published in the Irish Journal of Psychological Medicine in 2023. The medicines optimisation checklist is attached to each young person's electronic patient record and notes all pharmacist interventions including medicines reconciliation, provision of medicines information, systematic assessment of medicine side-effects, young person/parent consultations, physical health monitoring, deprescribing, high dose antipsychotic monitoring and a drug-drug interactions check.
- St John of God Hospital employed a Quality and Compliance Manager who is responsible for fostering and encouraging a culture of compliance and quality within the organisation. A structured compliance monitoring system was successfully implemented in the approved centre, covering the Mental Health Commission Regulatory Standards. To improve oversight, weekly compliance reports were introduced, tracking key performance indicators identified by the committee and regular monitoring allowed for the identification of compliance gaps, ensuring timely action plans were put in place.

3.0 Governance

The approved centre was under the governance of St John of God Hospital. 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 St John of God Hospital Clinical Governance, Quality and Safety Executive meeting (CGQSEC) took place every month. This meeting had representation from the Ginesa Suite and was attended by senior clinical and administrative management. Agenda items included: the results of KPI reports, regulatory compliance and emerging themes from the Youth Advocacy Programme. Several committees presented their updates at this meeting including the Clinical Audit Committee, the Drugs and Therapeutics Committee, the Health and Safety Committee and the Risk Committee. The CGQSEC committee also received a monthly update detailing the status of the ligature risk reduction works which were ongoing throughout the hospital. Current research projects and any ongoing data privacy or GDPR issues were also discussed at these meetings as were trends detected from adverse incident reports.

The Ginesa Management meeting convened every two months and addressed issues directly relating to the management of the approved centre. Topics raised by the Youth Advocacy Programme pertaining to the approved centre were discussed at these meetings as well as: the Ginesa Risk Register, complaints and compliments and occupancy trends. They also discussed the potential delivery of a new programme of care for young people which was delivered by the team as part of a homecare package. Continuous improvement of the Ginesa Suite care planning document and strategies to ensure full staffing of the unit were also discussed.

The St John of God Hospital Risk Meeting took place monthly and incorporated discussion of risk issues potentially impacting the Ginesa Suite. Other items discussed at this meeting included: the risk register audit, safeguarding of residents, an update from the Fire Committee and a review of the transition between the current electronic records system and the system that was under development.

There was a named senior manager who was chair of a multi-disciplinary review and oversight committee for restrictive practices. This committee met quarterly, and an identified action plan was documented each quarter in order to continuously review and improve practice in the area. All documentation completed for the few episodes of physical restraint that had taken place since the 2024 inspection contained the requirements of the Mental Health Commission Code of Practice on Physical Restraint.

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. Staff training in the mandatory areas was of a high standard and there was a process in place to ensure that all staff received the required training in a timely fashion. Each department had a strong culture of performance appraisal and supervision. Since the 2024 inspection, the approved centre had recruited a Quality and Compliance Manager who took responsibility for ensuring that practices in the approved centre were in accordance with the requirements of the 2001 Mental Health Act.

Governance information for the following departments was made available to the inspection team in the form of a completed questionnaire and a meeting with their Head of Discipline or a member of their team: medical, nursing, psychology, social work, occupational therapy and pharmacy. The Registered Proprietor was also available to the inspection team over the course of the inspection.

The following risks were identified by each department:

- Difficulties with the online patient records system - the Mental Health Information System [MHIS]/WI FI access at times: limited access to patient records [medical].
- Operational risks were variable in the nursing department but included issues such as staffing (i.e. covering shortfalls), training, lone working, manual handling and clinical risk issues, for example violence and aggression, suicide, self-harm, slips, trips and falls) [nursing].
- Medication shortages were an operational risk which was actively managed. Periodic staff shortages. [pharmacy].
- Difficulty accessing MHIS at key times, thereby limited access to patient records and lone working [psychology].
- Risk of staff burnout due to increased demands of Designated Officer and Designated Liaison Person roles as well as some challenges with MHIS [social work].

These risks were mitigated in various manners and a large investment for the acquisition of a new Electronic Patient Record system had recently been acquired. It was anticipated that the new system would resolve the identified difficulties associated with the current MHIS system.

Each department also outlined the aims and objectives that they had for the Ginesa Suite:

- Assisting the Ginesa Suite Child and Adolescent Mental Health Services (CAHMS) Consultant Psychiatrist in developing a plan specifically for the Ginesa Inpatient and Outpatient services and enhancing educational opportunities for Trainees [medical].
- Provision of high quality evidenced base nursing care to residents in Ginesa Suite. Engagement in the nursing quality improvement committee and continued clinical audits [nursing].
- Provide a range of therapeutic groups to meet the varying needs of the patient population offering choice and the opportunity for decision making and scope to practise autonomy and to use a trauma informed approach by offering choice in the group programme [OT].
- To enhance pharmacy practice in CAMHS. To continue to lead the development of medicines optimisation services in the hospital by increasing multi-disciplinary team membership [pharmacy].
- Maintain current level of clinical activity and support psychologist to contribute effectively to MDT activity [psychology].
- Social work team to continue to raise awareness of impact of coercive control and violence in the home on children and young people as part of an academic programme. The Social Workers on the addictions team are developing a booklet for children living with parental addiction in context of Mental Illness [social work].

The approved centre had a risk register in place which was updated as required. All incidents were recorded and risk-rated in a standardised format on DATIX, the approved centre's web-based risk management system. 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.

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.

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

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	100%	14	100%	12*	86%	14	100%	14	100%	14	100%
Medical	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Occupational Therapist	1	100%	0**	0%	1	100%	1	100%	1	100%	1	100%
Social Worker	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian*	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Pharmacist**	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
ArtPsychotherapist	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

*2 nursing staff booked for training on 3rd June
**1 OT staff booked for training on 26th May

Therapeutic Services and Programmes

One multi-disciplinary team provided care and treatment to the young people in the approved centre. This team comprised of; nursing, medical, social work, occupational therapy and psychology. The Pharmacy service provided input into the approved centre and met with the young people as appropriate.

An integrated recreational and therapeutic timetable was available in the approved centre. Psychology, OT and dietetics provided individual and group sessions in the unit each week. The OT collated the integrated recreational activities and therapeutic time table in consultation with the other members of the MDT.

There was a balance of different types of activities between leisure, physical and psychosocial education. The psychologist provided one-to-one sessions and group work which was tailored towards the needs of the young people in the unit. Sessions provided included, coping skills, distress tolerance, core regulation, self esteem and eating disorders. A Clinical Nurse Specialist provided a session on eating disorder recovery. The OT supported individual and group work focused on self care school, hobbies and interests. They provided groups in baking, relaxation and life skills, and organised and facilitated outings to promote community engagement and further development of life skills. During the inspection residents visited a local Irish Society for the Prevention of Cruelty to Animals (ISPCA) centre and other outings organised included visits to an equestrian centre and an alpaca farm. Residents could also attend talks on sleep hygiene, general anxiety and depression. A dietitian attended MDT meetings and ward rounds and actively contributed to care plans and the monitoring of care delivery for those who had received dietetic services. Art and Music therapists provided group work each week. An external contractor provided sessions on physical education.

4.0 Compliance

4.1 Compliant areas on this inspection

Please refer to **Appendix 1** for further guidance for compliance in relation to these regulations, rules and codes of practice.

Regulation/Rule/Act/Code		2025
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 15: Individual Care Plan	✓	Compliant
Regulation 16: Therapeutic Services and Programmes	✓	Compliant
Regulation 17: Children's Education	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 22: Premises	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed Circuit Television	✓	Compliant
Regulation 26: Staffing	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 32: Risk Management Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Code of Practice on the Use of Physical Restraint	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

4.2 Non-compliant areas on this inspection

No areas were non-compliant on this inspection.

4.3 Areas that were not applicable on this inspection

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

The inspectors met with five residents. Feedback included:

- They would like more time in the coffee shop
- When therapeutic groups were cancelled they were not consistently replaced
- The majority of staff were helpful and nice while some were difficult to approach
- All residents indicated that they felt the food was of a good quality
- They would like to see more art-based recreational activities
- They enjoyed the relaxation techniques
- They liked the school within the approved centre and this was less pressured than school at home
- The remote control for the TV often goes missing
- All residents reported that they felt safe in the approved centre
- Some residents felt bored at times and had requested that staff procure more board games
- The young people could make phonecalls from a device that did not have internet access
- Direct quotes from the residents included: 'I feel like I am listened to in relation to my treatment plan' 'I would like more one to one therapy' and 'Staff check in regularly and have a chat with me to see how I am doing.'

Two young people chose to complete and return the 'Your Views' questionnaire. Responses to the questions are outlined below:

- When you arrived, did a member of staff explain what was happening, in a way that you could understand? Both responded 'yes'
- How often do staff give you information about your diagnosis, care and treatment in a way that you understand? Both responded 'sometimes'
- I understand what my individual care plan is? Both responses were 'yes'
- I am involved in setting goals for my individual care plan:; Resident indicated 'sometimes' and 'never.'
- I know who my multi-disciplinary team are: Both indicated 'yes'
- How often are you able to discuss worries or concerns with a member of staff as soon as you need to? One indicated 'never' and the other 'sometimes'
- There are enough leisure activities for me to do during the day? Response was 'no – it's mainly school' and the second indicated 'yes'
- There are enough group activities for me during the day? Both responses were 'no' with one commenting 'it gets boring sometimes'
- There are enough talking therapies if I need them? Both responded 'no' with comments 'only once a week' and 'not enough one to one'
- Both respondents answered 'yes' to the question; 'I am happy with how staff talk to me' and to 'I feel my privacy and dignity are respected' and I can communicate freely with my family and friends
- On a scale of 1-10, with 1 being poor and 10 being excellent, how would you rate your overall experience of care and treatment? One resident gave the approved centre a score of '6' and the other rated it '5'.

5.2 Advocacy

The approved centre had an advocacy service; The Youth Advocacy Programme.

The inspectors did not receive a report from the Youth Advocacy Programme representative.

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:

- Consultant Psychiatrist
- Director of Nursing
- Chief Executive Officer
- Head of Operations
- Clinical Nurse Manager
- Psychology
- Pharmacy
- Occupational Therapy
- Risk and Complaints Manager
- Quality and Compliance Manager
- Deputy Director of Nursing
- Head of Human Resources

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The management reassured the inspection team as to the imminent installation of a new Electronic Patient Record system within the approved centre.

7.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

*Please see **Section 4.1: Compliant areas on this inspection** for the list of compliant regulations on this inspection.*

None of the Regulations (numbered 4 to 34) were found to be non-complaint on this inspection.

*Please see **Section 4.3: Areas that were not applicable on this inspection** for the list of regulations that were not applicable on this inspection.*

8.0 Inspection Findings – Rules

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

None of the rules were applicable on this inspection. Please see ***Section 4.3: Areas that were not applicable on this inspection*****.**

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 on inspection. Please see ***Section 4.3: Areas that were not applicable on this inspection****.*

10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51(1)(b)(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.

*Please see **Section 4.1: Compliant areas on this inspection** for the list of compliant codes of practice on this inspection*

*Please see **Section 4.3: Areas that were not applicable on this inspection.***

Appendix 1: REGULATIONS, RULES and CODES of PRACTICE

REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

Regulation 4: Identification of Residents

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

Regulation 5: Food and Nutrition

(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.

Regulation 6: Food Safety

(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.

Regulation 7: Clothing

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.

Regulation 8: Residents' Personal Property and Possessions

(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.

Regulation 9: Recreational Activities

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

Regulation 10: Religion

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

Regulation 11: Visits

(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.

Regulation 12: Communication

(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.

Regulation 13: Searches

(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 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.

Regulation 14: Care of the Dying

(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.

Regulation 15: Individual Care Plan

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".]

Regulation 16: Therapeutic Services and Programmes

(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.

Regulation 17: Children's Education

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.

Regulation 18: Transfer of Residents

(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.

Regulation 19: General Health

(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.

Regulation 20: Provision of Information to Residents

(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.

Regulation 21: Privacy

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

Regulation 22: Premises

(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.

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

(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).

Regulation 24: Health and Safety

(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.

Regulation 25: Use of Closed Circuit Television

(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.

Regulation 26: Staffing

(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.

Regulation 27: Maintenance of Records

(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.

Regulation 28: Register of Residents

(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.

Regulation 29: Operating Policies and Procedures

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.

Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.
(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

Regulation 31: Complaints Procedures

(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.

Regulation 32: Risk Management Procedures

(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.

Regulation 33: Insurance

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

Regulation 34: Certificate of Registration

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.

RULES UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

Rule: Section 59: The Use of Electro-Convulsive Therapy

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

Rule: Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

Rule: Section 69: The Use of Mechanical Restraint

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 Consent to Treatment

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –
a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.
57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
(2) This section shall not apply to the treatment specified in section 58, 59 or 60.
60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-
a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,
And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.
61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –
a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,
And the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51(1)(b)(iii)

Code of Practice: Use of Physical Restraint

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.

Code of Practice: Admission of Children

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

Code of Practice: Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

Code of Practice: Admission, Transfer and Discharge

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.

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.

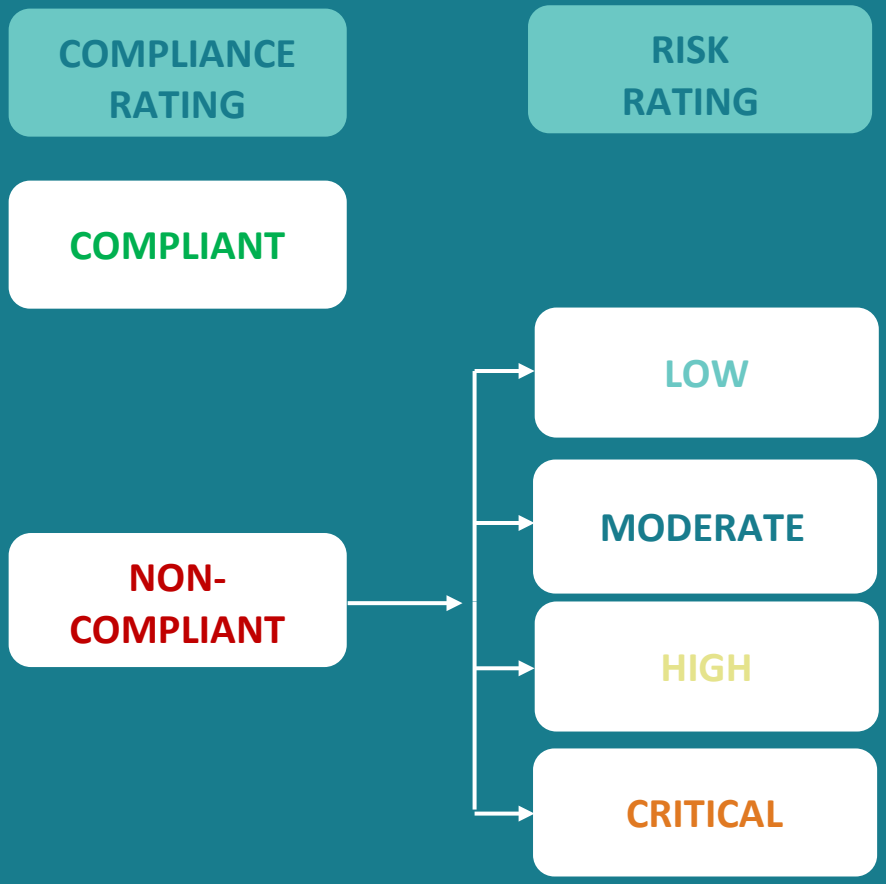
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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