Lois Bridges

ID Number: AC0079

2017 Approved Centre Focused Inspection Report (Mental Health Act 2001)

Lois Bridges
3 Greenfield Road
Sutton
Dublin 13

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
19 January 2016

Conditions Attached:
None

Registered Proprietor:
Ms Melanie Wright

Registered Proprietor Nominee:
N/A

Inspection Team:
Dr Susan Finnerty, Lead Inspector
David McGuinness

Inspection Date:
17 – 18 August 2017

Previous Inspection Date:
21 – 24 March 2017

Inspection Type:
Focused Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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Contents

1.0 Introduction 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.

On a focused inspection, the Inspector does not assess all regulations, rules, code of practice, and Part 4 of the 2001 Act. The focus of the inspection will be on specific legislative requirements, or parts of legislative requirements where it is determined that there may be a risk to the safety, health and wellbeing of residents and/or staff members.

Following the focused 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.

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.

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of findings from the focused inspection of Lois Bridges.

The focused inspection was carried out as there had been serious concerns following the annual inspection in March 2017, regarding safety of the residents and staffing of the approved centre. Non-compliance in risk management procedures and staffing were risk rated as critical. In particular, the inspectors were concerned about the number of ligature anchor points in the approved centre and the lack of registered psychiatric nurses on duty and in charge at all times. It was determined that a focused inspection should be undertaken to gather further information in relation to these areas and to ascertain whether appropriate actions had been taken to address the risks identified.

During this focused inspection, the inspectors found that the ligatures and ligature anchor points remained. Although the inspectors were informed that these would be rectified imminently, no work had commenced.

Despite the fact that Lois Bridges was a specialist Eating Disorder unit, there was no arrangement for specialist medical input. The approved centre relied on a GP and the emergency department of general hospitals.

The non-compliance with Regulation 32: Risk Management was again risk rated as critical.

A registered psychiatric nurse was not on duty and in charge of the approved centre at all times and the skill mix of staff was not appropriate to the assessed needs of residents.

The clinical director was on duty 24 hours a day, seven days a week and also in another full-time post in another approved centre.

Not all staff had up-to-date, mandatory training in Basic Life Support and fire safety.

Non-compliance with Regulation 26 Staffing was again risk-rated as critical.

The approved centre was again non-compliant with Regulation 23: Ordering, Prescribing, Storage and Administration of Medicines and this was risk-rated as high.

There were numerous deficits in the admission, transfer and discharge processes. On the previous inspection there had been no admission criteria; on this inspection admission criteria were in place.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Lois Bridges was a private Eating Disorder unit for adults located in Sutton Co. Dublin. It was located in a residential area. Lois Bridges provided care and treatment for up to seven adults with eating disorders. The majority of admissions were planned and voluntary. Residents were generally funded by private health insurance, the HSE, or self-funded.

The approved centre comprised a five-bedroom, two-storey house with a private garden. It had a homely and relaxed environment and there were communal and personal spaces.

There were six residents in Lois Bridges at the time of the inspection. The treatment programme featured group and individual therapies provided by a range of therapists who were contracted for services provided.

There was no specialist medical input or adjacent medical facility. A GP assessed the residents and provided medical interventions. The only access to specialist medical assessment and treatment was to be sent as an emergency referral to an emergency department of a general hospital.

The clinical director, who was a consultant psychiatrist, provided a service to the approved centre 24 hours a day and seven days a week. This psychiatrist also had a full-time position in another approved centre at the same time, providing acute psychiatric care. The senior registrar did not provide clinical input for the approved centre and there was no other registered medical practitioner in the approved centre.

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

Resident Profile	
Number of registered beds	7
Total number of residents	6
Number of detained patients	0
Number of Wards of Court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0

3.2 Conditions to registration

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

3.3 Governance

Lois Bridges, approved centre, provided care and treatment for up to seven residents. The approved centre was independently run and the management team comprised the registered proprietor, the clinical director, and the director of services. The management team met quarterly and a record of meetings was maintained.

There was an organisational chart, and governance structures and processes were in place. Nursing staff reported to the director of services.

4.0 Background

4.1 Reason for focused inspection

The previous inspection of the approved centre on 21 – 24 March 2017 identified the following areas of concern:

Regulation/Rule/Act/Code	Risk Rating
Regulation 20: Provision of Information to Residents	Moderate
Regulation 22: Premises	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	High
Regulation 26: Staffing	Critical
Regulation 27: Maintenance of Records	Low
Regulation 32: Risk Management Procedures	Critical
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	High

In view of the critical risk rating for the non-compliance with Regulation 26: Staffing and Regulation 32: Risk Management Procedures, an Immediate Action Notice was issued to the registered proprietor.

It was determined that a focused inspection should be undertaken to gather further information in relation to these areas to ascertain whether appropriate actions had been taken to address the risks identified.

4.2 Focus of inspection

The focus of the inspection was as follows:

- To determine whether the medical and nursing care in Lois Bridges was appropriate.
- To determine whether the care and treatment provided was safe.
- To determine whether the admission and discharge processes to Lois Bridges were appropriate.

Specific legislative requirements, or parts thereof, inspected as part of the focused inspection were as follows:

Regulation/Rule/Act/Code	Part (or full regulation)
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Full
Regulation 26: Staffing	Full
Regulation 32: Risk Management Procedures	Full
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Full

5.0 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:

- Clinical Director
- Registered Proprietor nominee
- Clinical Nurse Manager 2

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 inspectors were informed that there was a plan in place to remove the ligature anchor points by the end of September 2017. The inspectors were also informed that attempts were being made to come to a formal arrangement with Beaumont Hospital to provide medical assessment and treatment of Lois Bridges residents but this had not progressed. It was stated by Lois Bridges management team that a registered psychiatric nurse was completing induction training and would soon be in a position to take up post.

6.0 Focused Inspection Findings

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 FOCUS

The full regulation was inspected, including adherence to the Judgement Support Framework to ascertain whether appropriate actions have been taken to address the risks identified.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in October 2016. It addressed requirements of the *Judgement Support Framework,* with the following exceptions:

- The professional codes of practice to be complied with during the ordering, prescribing, storing, and administration of medication.
- The external reporting requirements in relation to medication errors and/or adverse effects.
- The processes for the following:
  - Ordering resident medication.
  - Self-administering medication.
  - Managing medication at transfer and discharge.
  - Reconciliation of medication.
  - Reviewing resident medication.

Training and Education: Not all nursing and medical staff had signed the signature log, to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to up-to-date information on all aspects of medication management. Not all clinical staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) by Lois Bridges had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Audits had been completed on medication and emergency drugs. Incident reports were recorded for medication issues. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: An MPAR was maintained for each resident, and all six of these were inspected. Two appropriate resident identifiers, including name, date of birth, and photograph, were used on each MPAR. A record of allergies or sensitivities to medications was maintained, the names of medications were written in full, and the generic names of medications were recorded where applicable. The frequency of administration, the dosage, and the administration route for medications were documented.

The MPARS did not contain dedicated space for recording once-off or as-required medications. Two of the MPARS examined did not include the Medical Council Registration Number of every medical practitioner prescribing medication to the resident. Two prescriptions were not signed by the medical practitioner/nurse prescriber.

Where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines were administered by a registered nurse or registered medical practitioner. The expiration date of medication was checked prior to administration, and good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. No controlled drugs were being administered on the day of inspection, and the approved centre did not crush medications.

Medicinal products were not always administered in accordance with the directions of the prescriber. Sixteen separate administration records were not signed within the six MPARs inspected, and there was no record of whether residents had received or refused medication or whether medication had been withheld.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Medication storage areas were clean and tidy. The medication cabinet was locked and secured, and a system of stock rotation was implemented. An inventory of medications was conducted monthly, and medications that were no longer required were stored securely and returned to the pharmacy for disposal.

A daily log of medication fridge temperatures was not available to the inspectors, and the thermometer in the fridge was reading 11°C. Food was observed in the medication fridge.

The approved centre was non-compliant with section 1 of this regulation for the following reasons:

a) **The policy did not include the requirements relating to: codes of practice, external reporting of medication errors and/or adverse incidents and the processes for medication: ordering, self-administration, management on transfer and discharge, reconciliation and review.**
b) **The MPARs did not contain dedicated space for recording once-off or as-required medications.**
c) **Two of the MPARs examined did not include the Medical Council Registration Number of the prescribing medical practitioner.**
d) **Two prescriptions were not signed by the medical practitioner/nurse prescriber.**
e) **Sixteen separate administration records were not signed within the six MPARs inspected and there was no record of whether the residents had received or refused medication or whether medication had been withheld.**
f) **Medication was inappropriately stored: The thermometer in the medication fridge was reading 11°C, there was no evidence of regular monitoring of fridge temperatures, and food was stored in the medication fridge.**

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating CRITICAL

(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 FOCUS

The full regulation was inspected, including adherence to the Judgement Support Framework to ascertain whether appropriate actions have been taken to address the risks identified.

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies in relation to staffing, which were dated October 2016. Together, these addressed the policy-related regulatory requirements, and the requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment of staff.
- The approved centre's recruitment, selection, and appointment process, including Garda vetting requirements.

The policies did not detail the following:

- The job description requirements.
- The staff performance and evaluation requirements.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- The orientation and induction training for new staff.
- Ongoing staff requirements and frequency of training required.
- The required qualifications of training personnel.
- The evaluation of training programmes.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes relating to staffing.

Monitoring: There was documentary evidence that the approved centre had reviewed the implementation and effectiveness of the staff training plan. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: The approved centre had an organisational chart to identify the leadership and management structure and lines of authority and accountability of staff. A planned and actual staff rota was maintained. Staff were recruited, selected, and vetted in line with the approved centre's policy and procedures for recruitment, selection, and appointment.

The skill mix of staff did not meet resident needs, as at times there was no registered psychiatric nurse on duty and, therefore, an appropriately qualified staff member was not on duty and in charge at all times. One nurse in charge was an intellectual disability nurse, not a registered psychiatric nurse.

The clinical director, who was a consultant psychiatrist, provided a service to the approved centre 24 hours a day and seven days a week. This psychiatrist also had a full-time position in another acute approved centre at the same time. The senior registrar did not provide clinical input for the approved centre and there was no other registered medical practitioner in Lois Bridges.

A written staffing plan for the approved centre was not available to the inspection team. There was a record of staff training and documented annual staff training plans for staff to identify required training and skills development in line with the assessed needs of the resident group profile.

Orientation and induction training was completed for all staff, and at least one staff member had Children First training. There was training in manual handling, infection control, mental health care for people with an intellectual disability, Dialectical Behaviour Therapy, and incident reporting. Some staff had also received training in eating disorder programmes. Not all staff had up-to-date, mandatory training in Basic Life Support and fire safety.

All staff training was documented, and staff training logs were maintained. Resources were available to staff for further training and education, and in-service training was delivered by appropriately qualified individuals. The Mental Health Act 2001, the associated regulation, Mental Health Commission rules and codes, and all other documentation and guidance were available to staff throughout the approved centre.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Lois Bridges	CNM1	0-1	0-1
	RPN or RIDN	1	1
	HCA	1	1

Clinical Nurse Manager (CNM), Registered Intellectual Disability Nurse (RIDN), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA).

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

a) **The skill mix of staff was not appropriate to the assessed needs of residents, 26(2).**
b) **An appropriately qualified staff member was not on duty and in charge at all times, 26(3).**
c) **Not all staff had up-to-date, mandatory training in fire safety or Basic Life Support, 26(4).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating CRITICAL

(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 FOCUS

The full regulation was inspected, including adherence to the Judgement Support Framework to ascertain whether appropriate actions have been taken to address the risks identified.>>

INSPECTION FINDINGS

Processes: The approved centre had several policies in relation to risk management, which were last reviewed in October 2016. The policies addressed requirements of the *Judgement Support Framework,* including the following:

- The roles and responsibilities for risk management and the implementation of the risk management policy in the approved centre.
- The process for identification, assessment, treatment, reporting, and monitoring of risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The policies did not detail the following:

- The procedures for managing incidents involving residents, including the roles and responsibilities around incident reporting and the processes for risk-rating, recording, reporting, investigating, reviewing and monitoring, and learning from untoward incidents or adverse events involving residents.
- The process for notifying the Mental Health Commission about incidents involving residents.

Training and Education: Relevant staff were trained in the identification, assessment, and management of risk. Clinical staff were trained in individual risk management, and managerial staff were trained in organisational risk management. All staff had signed the signature log, indicating that they had read and understood the policies. Staff interviewed were able to articulate the risk management processes, as set out in the policies. Not all staff had received training in incident reporting and documentation. All training was documented.

Monitoring: The risk register was audited at least quarterly to determine compliance with the approved centre's risk management policy. All incidents in the approved centre were recorded in an incident book and risk-rated. Analysis of incident reports had been completed to identify opportunities to improve risk management processes.

Evidence of Implementation: The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management.

Risk management procedures did not actively reduce identified risks to the lowest level of risk, as evidenced by the presence of ligature points. Numerous potential ligatures and ligature anchor points had been identified but had not been effectively mitigated, including cables in bedrooms, bannisters, taps, handles and rails in the toilet, and shower rails.

Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Structural risks were not removed or mitigated.

Risk assessments of residents were completed at admission to identify individual risk factors. Each resident's clinical file contained a risk assessment and management plan developed at admission. A risk assessment was also completed prior to a resident's discharge.

The multi-disciplinary team had input into the development, implementation, and review of individual risk management processes, as evidenced by the minutes from their regular meetings. Residents and/or their representatives were involved in the risk management process. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated in a standardised format, and the individual responsible for risk management in the approved centre reviewed incidents for any trends or patterns occurring in the service. Six-monthly summary reports of incidents were forwarded to the Mental Health Commission. The approved centre had an emergency plan that included evacuation procedures.

There was no specialist medical input or adjacent medical facility. A GP assessed the residents and provided medical interventions. The only access to specialist medical assessment and treatment is to be sent as an emergency to an emergency department of a general hospital.

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

a) **The risk management policy was not implemented throughout the approved centre in that numerous ligatures and ligature anchor points had not been mitigated or removed, 32(1).**
b) **The risk management policy did not specify the processes for recording, investigating, and learning from serious or untoward incidents or adverse events involving residents, 32(2)(d).**
c) **The only access to specialist medical assessment and treatment is to be sent as an emergency to an emergency department of a general hospital, which constituted a risk to residents.**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

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 FOCUS

The Code of Practice was inspected, to ascertain whether appropriate actions have been taken to address the risks identified.

INSPECTION FINDINGS

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

Admission: There were a number of policies relating to planned and involuntary admissions: *Roles and Responsibilities of Staff Members in the Assessment, Admission, Transfer and Discharge Process*, dated April 2017*; Referral Pathway and Admission Process,* dated October 2016; *Dealing with Urgent Referrals,* dated October 2016; and *Planned Referral to Approved Centre,* dated October 2016.

Together, the policies addressed planned admission, with reference to pre-admission assessments, eligibility criteria for admission, and referral letters. They included protocols for urgent referrals, self-presenting individuals, and timely communication with primary care teams. The approved centre also had a policy on privacy, confidentiality, and consent.

The policies did not reference the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessments.

Transfer: The approved centre's transfer procedures were addressed in the policy entitled *Responsibilities of Staff Members in the Assessment, Admission, Transfer and Discharge Process*, dated April 2017. It outlined how a transfer was arranged, defined the roles and responsibilities of staff in relation to the transfer of residents, and included provisions for emergency transfer. The policies did not include procedures for the transfer of a resident abroad or for ensuring the safety of residents and staff during transfers.

Discharge: The approved centre's discharge procedures were addressed in the policy entitled *Responsibilities of Staff Members in the Assessment, Admission, Transfer and Discharge Process*, dated April 2017. It addressed the discharge of homeless people, older persons, and people with an intellectual disability and included procedures for managing discharge against medical advice. It did not include a procedure for discharging involuntary patients or reference prescriptions and supply of medication on discharge.

There was also a *Follow Up Care* policy, dated October 2016, which addressed the roles and responsibilities of staff in providing follow-up care and the level of follow-up contact required by residents. The follow-up policy did not reference relapse prevention strategies, crisis management planning, or the following up and management of missed appointments.

Training and Education: Not all staff had signed the signature log, indicating that they had read and understood the policies on admission, transfer, and discharge.

Monitoring: Audits had been completed in February 2017 on the implementation of and adherence to the admission and discharge policies.

Evidence of Implementation: The approved centre did not comply with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

The admissions, transfers, and discharges inspected pertained to the period after the last inspection.

Admission: The clinical files of three residents admitted to the approved centre were examined. These indicated that there was a key worker system in place and the entire multi-disciplinary team record was contained in a single clinical file. Each admission was made on the basis of a mental illness or disorder, and the decision to admit was taken by a registered medical practitioner (RMP). An admission assessment was completed, and details of all assessments and examinations were included in the clinical files.

Admission assessments included a history of presenting problems, the previous psychiatric history, family history, medical history, details of current and past medication, social history, a mental state examination, and a full physical examination. A family/advocate/carer was involved in the admission process in two cases; the third resident did not consent to family involvement.

Transfer: The clinical files of two residents who were transferred to another medical facility for specialised treatment were examined. Both transfers were emergencies.

In one case, while the decision to transfer was made by the RMP, this was not documented. In each case, efforts were made to respect the residents' wishes and obtain consent to the transfers, and this was documented. A family member was involved in one of the transfers; the second resident did not consent to family involvement in the transfer.

A copy of the referral letter was not retained in one resident's file.

Discharge: The clinical files of three residents who had been discharged from the approved centre were examined. In each case, the decision to discharge was made by an RMP. None of the residents had a documented discharge plan in place as part of their individual care plans. In two cases, a discharge meeting involving the resident, key worker, relevant members of the MDT, and a family member/carer/advocate did not take place.

There was no documentary evidence that a comprehensive assessment of the residents took place prior to discharge. In one of the files examined, there was no evidence that the discharge was coordinated by the key worker. In one file, there was no evidence of family/carer/advocate involvement in the discharge process.

There was no documentary evidence that efforts were made to inform the primary care/community mental health care team of the discharge within 24 hours. In three cases, there was no record that a preliminary discharge summary was sent to the primary care/community mental health team within three days or was followed by a comprehensive discharge summary within two weeks. One summary was not sent until 41 days after a discharge against medical advice, while two other summaries were not dated. None of the discharge summaries referenced prognosis, follow-up arrangements, contact information for key people for follow-up, or risk issues. One discharge summary did not record the resident's medication, and one did not address the resident's outstanding health or social issues.

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

a) **The policy in relation to admission did not address the roles and responsibilities of the MDT in relation to post-admission assessment, 4.7.**
b) **The policy in relation to transfer did not address the following:**
   - **The discharge of involuntary patients, 4.2.**
   - **Prescriptions and supply of medication on discharge, 4.10.**
   - **Transfer abroad or the safety of residents and staff during a transfer, 4.13.**
c) **The post-discharge follow-up policy did not reference relapse prevention strategies, crisis management plans, or a way of following up and managing missed appointments, 4.14.**
d) **There was no documented evidence to indicate that all staff had read and understood the policies in relation to admission, transfer, and discharge, 9.1.**
e) **In one file examined in relation to transfer, the decision to transfer was not documented by the RMP, 26.1.**
f) **A copy of the referral letter was not retained in one resident's clinical file following a transfer, 31.2.**
g) **Residents did not have a discharge plan in place as part of their individual care plans, 34.1, 34.2, and 42.1.**
h) **In two files examined in relation to discharge, a discharge meeting attended by the resident, key worker, relevant members of the MDT, and a family member/carer/advocate was not held, 34.4 and 42.1.**
i) **There was no documentary evidence that residents received a comprehensive assessment prior to discharge, 35.1.**
j) **In one case, there was no evidence that the discharge was coordinated by the relevant key worker, 37.1.**
k) **There was no documentary evidence that efforts were made to inform the primary care/community mental health care team of the discharge within 24 hours, 38.2.**
l) **There was no record that a preliminary discharge summary was sent to the primary care/community mental health team within three days or was followed by a comprehensive discharge summary within two weeks, 38.3.**
m) **None of the discharge summaries referenced prognosis, follow-up arrangements, contact information for key people for follow-up, or risk issues, 38.4.**
n) **One discharge summary did not record the resident's medication, and one did not address the resident's outstanding health or social issues, 38.4.**
o) **In one file, there was no evidence of family/carer/advocate involvement in the discharge process, 39.1**.
p) **The approved centre did not comply with Regulation 32: Risk Management Procedures, which is related to this code of practice, 7.1.**