Elm Mount Unit, St Vincent's University Hospital

ID Number: AC0004

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Elm Mount Unit, St Vincent's University Hospital
Elm Park
Dublin 4

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Other: Eating Disorder Unit

Most Recent Registration Date:
1 March 2017

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Martina Behan, General Manager, CHO East Mental Health Services

Inspection Team:
Noeleen Byrne, Lead Inspector
Leon Donovan
Martin McMenamin
Aisling Nestor
Elaine Healy

Inspection Date:
10 - 13 July 2018

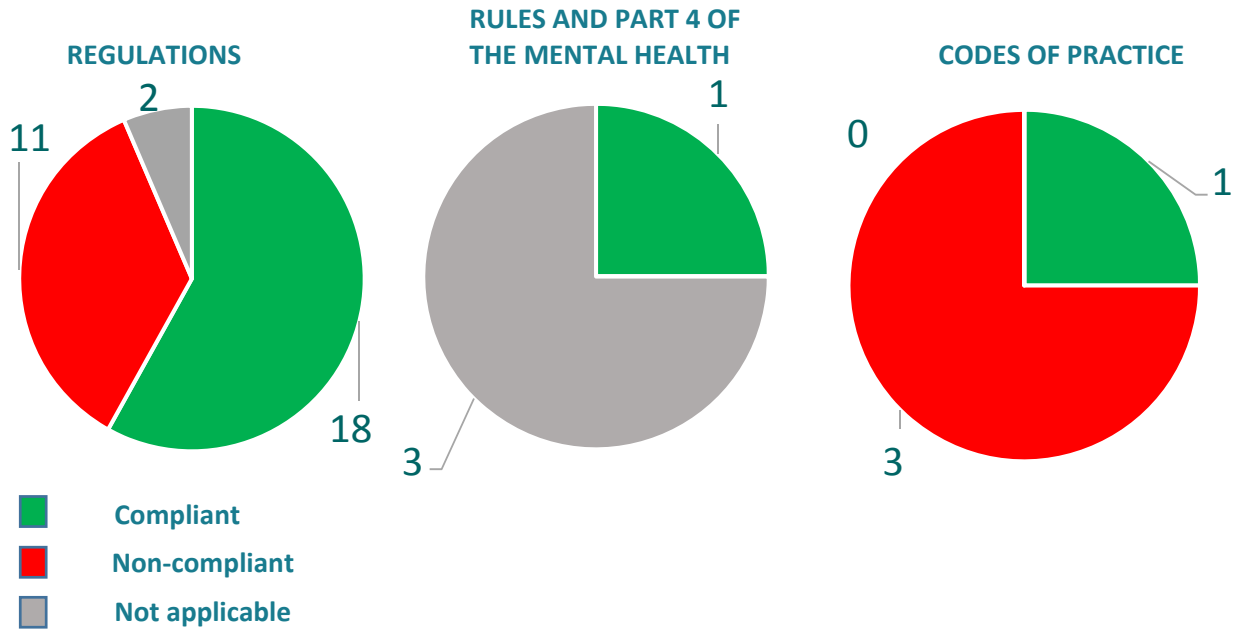
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
25 – 28 April 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
7 February 2019

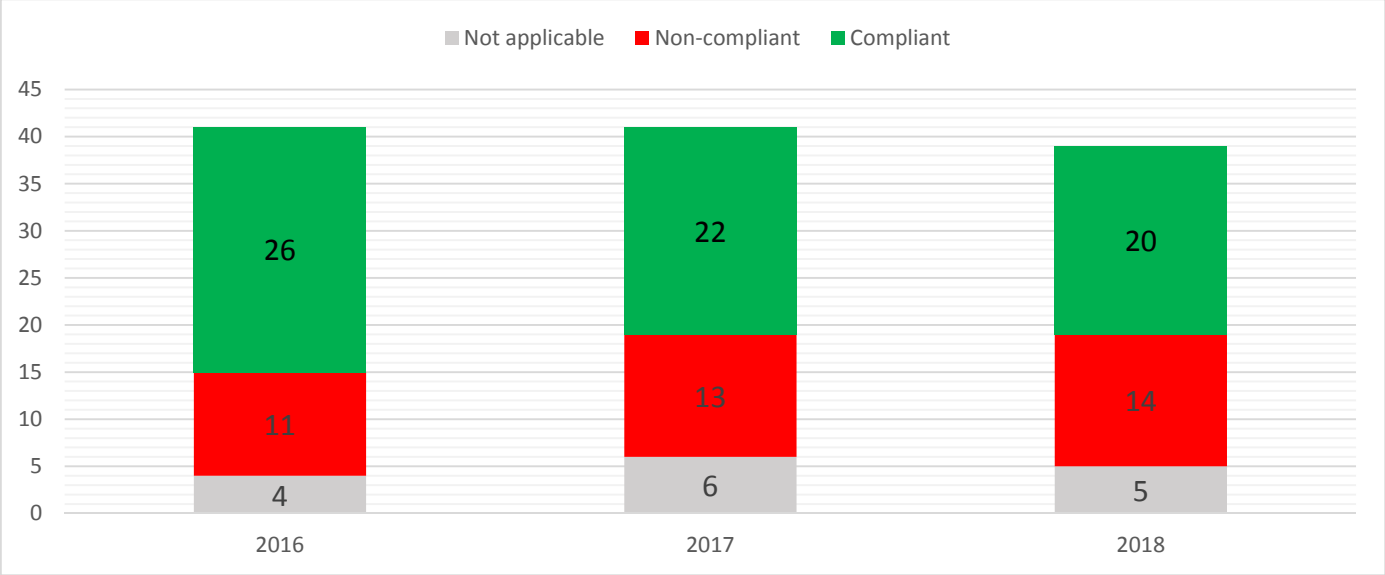
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

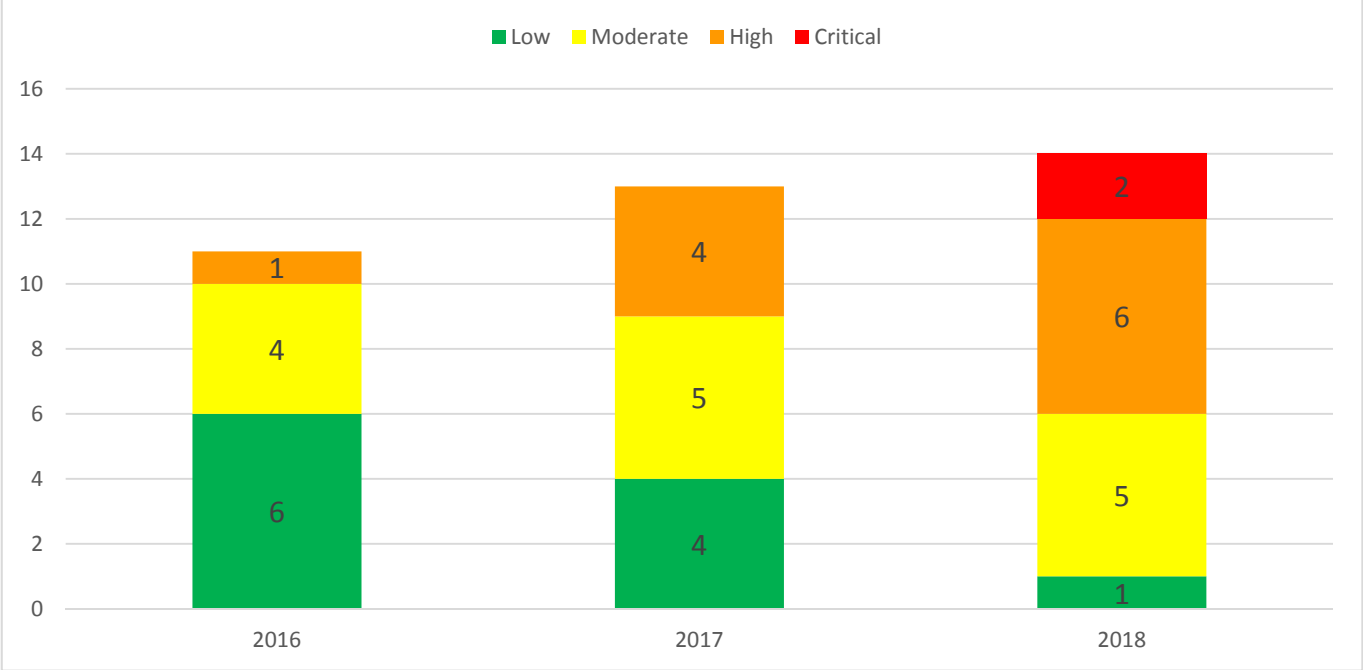
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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 2016 – 2018



Contents

1.0 Introduction to the Inspection Process 5
2.0 Inspector of Mental Health Services – Review of Findings 6
Responsiveness to residents' needs 9
3.0 Quality Initiatives 9
4.0 Overview of the Approved Centre 11
4.1 Description of approved centre 11
4.2 Conditions to registration 11
4.3 Reporting on the National Clinical Guidelines 12
4.4 Governance 12
4.5 Use of restrictive practices 13
5.0 Compliance 14
5.1 Non-compliant areas on this inspection 14
5.2 Areas of compliance rated "excellent" on this inspection 14
5.3 Areas that were not applicable on this inspection 15
6.0 Service-user Experience 16
7.0 Feedback Meeting 17
8.0 Inspection Findings – Regulations 18
9.0 Inspection Findings – Rules 60
10.0 Inspection Findings – Mental Health Act 2001 63
11.0 Inspection Findings – Codes of Practice 64
Appendix 1: Corrective and Preventative Action Plan 71

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".

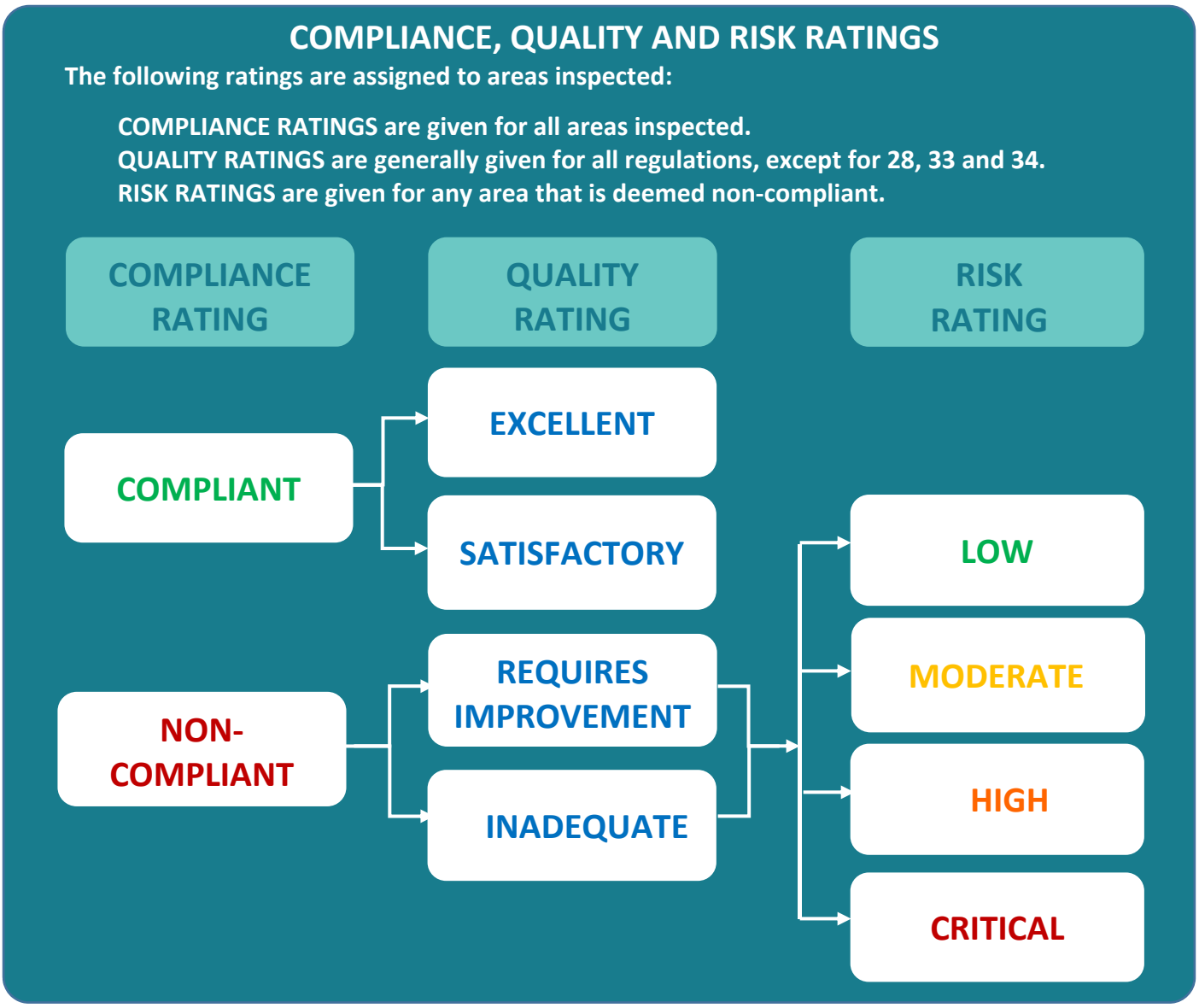
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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.

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.

The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

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, risk ratings and quality assessments, 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.



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.

2.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated Judgement Support Framework, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

In brief

Elm Mount was a 36-bed approved centre operating in of St. Vincent's University Hospital, Elm Park, Dublin 4. It was a partnership venture between the HSE and the St. Vincent's Healthcare Group and had opened in 2005. The approved centre provided mental health in-patient treatment and care to people living in the Community Healthcare Organisation (CHO) 6, namely the Dublin South East area. It was divided into upper and lower units and included a specialist Psychiatry of Old Age (POA) unit which accommodated up to six residents. There were three in-patient beds available to residents with Eating Disorders, based in Elm Mount Lower.

There had been some deterioration in compliance with regulations, rules and codes of practice; from 63% compliance in 2017 to 59% in 2018. In addition, there were two non-compliances rated as critical risk; Regulation 15 Individual Care Plans and the Code of Practice on Physical Restraint.

There were no conditions to registration.

Safety in the approved centre

Not all staff had up to date training in fire safety, Basic Life Support, the Mental Health Act 2001 and management of violence and aggression. There were numerous errors in the prescribing, storage and administration of medication, which had the potential to lead to more serious medication errors. Food safety audits were carried out regularly and the kitchen areas were clean.

Individual clinical risk assessments were completed on admission; however, there was little evidence that they were repeated during the residents' stay in the approved centre. It was unclear who was involved in the development, implementation and review of individual risk management processes. There were incomplete risk management plans for some residents. Individual care plans did document risk; however, they did not address the risk as identified in the individual overall risk assessments.

There was an emergency plan that specified responses by staff to possible emergencies, including evacuation procedures.

Appropriate care and treatment of residents

There were seven reasons for non-compliance with the Code of Practice on Admission, Transfer and Discharge, including omission of assessments and documentation. There were serious deficits in care planning for residents. Many residents did not have initial care plans, which should have been formulated on admission. Not all residents had an individual care plan (ICP) developed by the multi-disciplinary team (MDT), and one ICP was only developed by a consultant and nursing staff. Some residents did not attend MDT meetings or discuss their care plans with their team. Several sections were not completed in some admission assessments including: medical, educational, occupational, and vocational history, and historical and current medication. Not all ICPs identified the resident's assessed needs, appropriate goals, the care and treatment required to meet the goals identified (including the frequency and responsibilities for implementation), individual risk management plans, or a discharge plan. A key worker was not identified in the ICP to ensure continuity in implementation. This is the third year in a row that the approved centre was found to be non-compliant with this regulation.

There was insufficient social work and psychology staff dedicated to the unit. As a result of the shortage of staff, the MDT was not functioning effectively as the treating team. Residents were being referred for therapeutic services outside the approved centre. Some MDT meetings, including the POA meetings, were held in another building and the residents did not attend.

The upper and lower units of the approved centre had therapeutic services and programmes, whereas the Psychiatry of Old Age (POA) unit did not have a therapeutic programme. Where a resident required a therapeutic service that was not provided internally, the approved centre arranged for the service to be provided externally by an appropriate health professional, but this did not happen in the POA unit. No dedicated facilities or therapy rooms were available in the POA unit. The POA unit did have access to a community occupational therapist for assessments and limited follow-up. The lack of an occupational therapist and programmes was highlighted in the complaints log a number of times.

All residents had physical assessments on admission and thereafter as necessary. Not all records were maintained in a manner so as to ensure completeness, the time of the entry was not recorded, student nurse entries were not always countersigned and errors were not corrected in line with best practice.

Respect for residents' privacy, dignity and autonomy

On admission, all residents were restricted from wearing day clothes until reviewed by the consultant psychiatrist, even though a risk assessment had been completed. This was a blanket restriction that impacted on residents' choice and dignity. There were private visiting areas. Searches were carried out in a manner that respected the resident's privacy; however, the approved centre did not ensure that residents and staff were aware of the policy and procedures on searching and there was no evidence that resident was informed of what was happening during the search and the reason for it. The premises was conducive to residents' privacy.

This year was the fourth consecutive year that the approved centre was not compliant with the Code of Practice on the use of Physical Restraint. There were eight elements of non-compliance found in this inspection.

Responsiveness to residents' needs

Some residents were permitted to access the internet via the occupational therapy suite. Residents in the POA area were not able to access this as they did not go downstairs. There was a choice of food at mealtimes although some residents thought the portions should be bigger and more vegetables should be made available. There were adequate recreational activities available. However, some residents said there was not enough physical activity as there was no gym or outside area to walk in.

The provision of essential information to residents was unsatisfactory. While an information booklet was provided, it did not include information on resident rights and some of it was out of date. Interviews indicated that residents must ask for the information, rather than it being proactively provided. Some staff interviewed were unsure of where to find appropriate information. Residents were provided with written and verbal information on diagnosis but there was no evidence that information on indications for use of all medication, including any possible side effects, was provided to residents. All complaints were investigated promptly and handled appropriately and sensitively. Complainants were informed promptly of the outcome and details of the appeals process. The complaints officer maintained a log for complaints they dealt with, including complete details of the complaint, investigation, outcomes, and the complainant's view of the outcome.

The premises was clean and well maintained throughout, although the ECT suite required improved ventilation.

Governance of the approved centre

There was shared governance between the HSE Community Healthcare East and St. Vincent's Healthcare Group. The senior management teams of St Vincent's Healthcare Group and HSE Community Healthcare East formed the St Vincent's mental health forum. This group met four times a year to manage the Elm Mount approved centre. For the greater part, clinical governance was under the management of the HSE Community Healthcare East.

There was an organisational chart; however, it did not clearly outline lines of accountability and reporting structures. The HSE Community Healthcare East Occupational Therapy (OT) Manager managed two units; Elm Mount Upper and Elm Mount Lower. The OT line management for the POA was through the St Vincent's University Hospital OT Manager who did not have direct input into mental health or attend any management meetings. There was no dedicated psychologist or social worker for the approved centre.

Mental health management meetings took place monthly. A risk register for the approved centre was introduced in recent months and quality indicators were drawn up to monitor performance. Incidents were recorded and risk-rated in a standardised format. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. All clinical incidents were reviewed by the MDT at their regular meeting. A record was maintained of this review and recommended actions.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A comprehensive staff training needs analysis had been completed.
2. Five staff members had been trained as quality champions.
3. A service user feedback survey had been introduced.
4. An audit programme had been implemented in the approved centre.
5. A new information pack was prepared for residents that included details of the admission process and the care and services provided.
6. An information pack had been prepared for the residents on the discharge process.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Elm Mount Unit was an approved centre operating within the confines of St. Vincent's University Hospital, Elm Park, Dublin 4. The unit was a partnership venture between the HSE and the St. Vincent's Healthcare Group. The unit, which opened in 2005, provided mental health in-patient treatment and care to people living in the Community Healthcare Organisation (CHO) 6, namely the Dublin South East area. Elm Mount Unit was a 36-bed unit divided into three distinct areas.

Elm Mount Upper, located on the ground floor level, accommodated up to 20 residents. It was an acute admission unit that comprised dormitory accommodation and six single rooms. The dormitories were three- and four-bed rooms for both male and female residents. A specialist Psychiatry of Old Age (POA) unit was located adjacent to Elm Mount Upper and accommodated up to six residents. Accommodation comprised two single and two double bedrooms. There was an affiliation with Carew House located in the grounds of St. Vincent's University Hospital and the headquarters for the POA team. Residents often attended Carew House Day Hospital located a short distance away as part of their assessment, care, and treatment while in the approved centre.

Elm Mount Lower was located in the lower ground floor and accommodated up to 13 residents. It was a sub-acute admission unit and comprised two five-bed dormitory rooms and three single rooms. There were three in-patient beds in Elm Mount Lower, available to residents with eating disorders from the Community Healthcare East area.

The occupational therapy department was located on the lower ground floor. It comprised group rooms, an activities kitchen, and offices. There were consulting rooms and an outpatient facility in this area, which was located around a central glass atrium with planting and seating areas suitable for visits. This could be viewed from the ground floor reception area of Elm Mount Upper.

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

Resident Profile	
Number of registered beds	***36***
Total number of residents	**29**
Number of detained patients	9
Number of wards of court	0
Number of children	0
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

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

There was shared governance between the HSE Community Healthcare East and St. Vincent's Healthcare Group. The senior management teams of St Vincent's Healthcare Group and HSE Community Healthcare East formed the St Vincent's mental health forum. This group met four times a year to manage the Elm Mount approved centre. For the greater part, clinical governance was under the management of the HSE Community Healthcare East.

There was an organisational chart; however, it did not clearly outline lines of accountability and reporting structures. The HSE Community Healthcare East Occupational Therapy (OT) Manager managed two units; Elm Mount Upper and Elm Mount Lower. The OT line management for the POA was through the St Vincent's University Hospital OT Manager who did not have direct input into mental health or attend any management meetings. There was no dedicated psychologist or social worker for the approved centre and a business case was being prepared to include in the upcoming budget estimates.

Mental health management meetings took place monthly. The minutes were reviewed and relevant issues were discussed by the senior management who documented actions and outcomes. Capital had been secured to fund the replacement of windows to mitigate ligature points. A quality and safety committee had been set up in January 2018 and minutes were provided of meetings held since it commenced. A risk register for the approved centre was introduced in recent months and quality indicators were drawn up to gauge performance.

The policy review group incorporated the HSE and Judgement Support Framework into updated policies to ensure procedures meet best practice.

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following individuals:

- Clinical Director
- Area Director of Nursing
- Principal Psychologist
- Occupational Therapy Manager Community Healthcare East
- Occupational Therapy Manager St Vincent's University Hospital

The Principal Social Worker was on leave at the time of the inspection so the senior social worker was interviewed. The area lead for mental health engagement was on annual leave. All heads of discipline provided a clear overview of the governance within their respective departments. The clinical director was

based on site and the area director of nursing attended at least twice a week. All Community Healthcare East heads of discipline attended monthly meetings. Medical staff stated that some meeting time, during the summer months, was scheduled for staff training to ensure mandatory training was brought up to date. An operational risk for social work and psychology departments included not having sufficient staff dedicated to the unit. There was a psychologist dedicated to the three bed Eating Disorder Service. As a result of the shortage of staff, the multi-disciplinary team (MDT) was not functioning correctly as the treating team. Some residents, as part of their discharge plan, were being referred for therapeutic services outside the approved centre. Some MDT meetings, including the POA meetings were held in Carew House and residents did not attend. A service user forum had been set up in recent months.

4.5 Use of restrictive practices

The Elm Mount unit maintained an open door policy, however the door to the psychiatry of older age (POA) unit was locked to ensure the safety of residents. Residents in the POA unit were not permitted to attend therapeutic programmes in the occupational therapy room.

On admission, all residents were restricted from wearing day clothes until reviewed by the Consultant Psychiatrist, even though a risk assessment had been completed.

5.0 Compliance

5.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2017 and 2016 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 7: Clothing	✗	Low	✓		✗	Moderate
Regulation 12: Communication	✓		✓		✗	Moderate
Regulation 13: Searches	✗	Low	✗	Low	✗	High
Regulation 15: Individual Care Plan	✗	Low	✗	High	✗	Critical
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	High
Regulation 20: Provision of Information to Residents	✓		✓		✗	Low
Regulation 22: Premises	✓		✗	High	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✗	Moderate	✗	High
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	High
Regulation 27: Maintenance of Records	✓		✗	Moderate	✗	Moderate
Regulation 32: Risk Management Procedures	✗	Moderate	✗	High	✗	High
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Moderate	✗	High	✗	Critical
Code of Practice relating to the Admission of Children under the Mental Health Act 2001	✗	High		Not applicable	✗	Moderate
Code of Practice: Admission, Transfer and Discharge	✗	Low	✗	Low	✗	High

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

5.2 Areas of compliance rated "excellent" on this inspection

One regulation was excellent on this inspection:

Regulation
Regulation 10: Religion

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation 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 no resident had been mechanically restrained since the last inspection, 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.

6.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engaged 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.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.

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 inspection team met with eight residents. They were generally very complimentary of the staff and the care they received. Some residents praised the food where others, particularly those in Elm Mount Lower, thought the portions should be bigger and more vegetables should be made available. Of concern to residents was the lack of recreational activities with some saying there was not enough physical activity. There was no gym or outside area to walk in. There was a therapeutic programme available but two residents said there was little on it of interest. One said he thought it was for other people.

Residents did not attend multi-disciplinary team meetings or discuss their care plans with their team. A doctor or doctors met the resident usually once a week and a nurse would discuss the care plan with the resident. Residents did have an opportunity to bring up points if they felt it was necessary. They would also meet other members of the team separately.

Fourteen completed resident questionnaires were returned to the inspection team. As with the formal interviews there were positive comments about staff and residents' experiences of care and treatment. Comments included not having enough to do and not having access to the internet. Residents all had a key worker and understood they could discuss issues or concerns with them. On a scale of 1-10 with 1 being poor and 10 being excellent residents rated 8, 9 or 10 for their overall experience of care and treatment.

7.0 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
- Head of Service for Mental Health
- Occupational Therapy Manager for Elm Mount Upper and Lower
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager grade 3
- Clinical Nurse Manager grade 2 x 3
- Clinical Nurse Manager 1
- Nurse Practice Development coordinator
- Mental Health Administration

Apologies were received from the Principal Psychologist and the Principal Social Worker.

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. A discussion took place around whether residents from psychiatry of older age could attend therapeutic activities in the dedicated occupational therapy room and whether they had access to the internet. The head of service undertook to clarify these matters. It was confirmed that quotes had been sought for the installation of air conditioning in the electroconvulsive therapy suite as there was no ventilation there.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: There was a minimum of two resident identifiers, appropriate to the resident profile group and individual resident's needs. Two appropriate resident identifiers were used when administering medications, undertaking medical investigations, and providing other health care services. This included Medical Registration Number, name, and date of birth. An appropriate identifier was used prior to provision of therapeutic services.

The identifiers were person-specific and detailed within the residents' clinical files. Identifiers were appropriate to the residents' communication abilities. The service had an alert sticker process to identify residents with the same or similar name.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education implementation pillar.

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had read the policy; the catering staff had not signed the signature log or read the policy. Catering staff interviewed were not able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Catering staff also used an electronic system called *Dish the Info* to help ensure each dish had the appropriate nutritional value, as recommended by a dietitian. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Approved centre menus were approved by a dietitian to ensure nutritional adequacy. Residents were provided with a variety of wholesome and nutritious food that was presented in a manner that was attractive and appealing. Residents had at least two choices for meals, with hot meals provided on a daily basis. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations, and hot and cold drinks were offered to residents regularly.

For residents with special dietary requirements, residents and their representatives were educated about residents' diets. Nutritional and dietary needs for residents with special dietary needs were generally assessed and addressed in every residents' individual care plans. The needs of the residents were reviewed once or twice a week. However, the dietitian did not always have input into the weekly ICPs of residents with eating disorders. An evidence-based nutrition assessment tool was not used by nurses, though residents were referred to a dietitian if necessary.

There were inconsistencies with the completion of weight charts. There were two weight chart forms for residents with eating disorders; however only one form was filled in, and it was unclear which form was intended to be in use. Intake charts were intended to be monitored on a daily basis, however each day was not documented.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring and evidence of implementation pillars.

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes. Food safety measures included monthly contamination testing of sample food, and having an independent food safety expert randomly tested foods for contamination.

Evidence of Implementation: Food was prepared in a manner that reduced risk of contamination, spoilage, and infection. Appropriate protective equipment was used during the catering process. There was suitable and sufficient catering equipment, crockery, and cutlery within the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food.

Hygiene was maintained to support food safety requirements. Appropriate hand-washing areas were provided for catering services. Catering areas, associated catering, and food safety equipment were appropriately cleaned.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met all criteria of the *Judgement Support Framework* under the training and education pillar.

Regulation 7: Clothing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' clothing, which was last reviewed in April 2017. The policy addressed all the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. A record of residents wearing nightclothes during the day was maintained and monitored.

Evidence of Implementation: On admission, all residents were restricted from wearing day clothes until reviewed by the Consultant Psychiatrist, even though a risk assessment had been completed. On completion of admission, residents were supported to keep and use personal clothing, and had an adequate supply of individualised clothing. Residents' clothing was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, religious, and cultural practices. Residents generally changed out of nightclothes during daytime hours except when they chose to remain in them.

The approved centre was non-compliant with this regulation because all residents had to remain in night clothes until reviewed by the Consultant Psychiatrist, 7 (2).

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Residents were entitled to bring personal possessions, but were advised to leave valuables at home for safekeeping. Residents were supported to manage their own property, unless this posed a danger to the resident or others.

On admission, the approved centre compiled a detailed property checklist with each resident. A personal property log was maintained, including details of valuables, cards, and money under €50. The log was signed by two nurses and updated as required. The property checklists were kept separately from individual care plans and were available to residents.

Access to, and use of, resident money was overseen by two members of staff and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained. Where possible this was counter-signed by the resident or their representative.

Residents' personal property were safeguarded in secure facilities when the approved centre assumed responsibility for them. Each resident had a wardrobe and locker, which were not locked, but had a locker

in a locked store room that could be accessed by asking a staff member. Any money over €50 was put in the main hospital safe, which could be accessed Monday to Friday, 9–5 pm.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education and monitoring implementation pillars.

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in April 2017. The policy included all the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake and attendance. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. Activities were nurse led and differed depending on what unit a resident was in. Activities included word wheels, TV, crosswords, walks to the shopping centre, and newspapers. Indoor and outdoor exercise and physical activity opportunities were provided. Recreational activities were scheduled for weekdays and the weekend.

Information containing the types and frequency of activities was provided in an appropriate and accessible format. Where applicable, individual risk assessments were completed to help select activities. Residents were free to choose whether to participate and their decisions were respected and documented. Logs of participation were maintained for recreational activities.

Recreational activities were appropriately resourced. Communal areas were suitable for recreational activities. Nursing staff and an occupational therapist had input into activities. Recreational activities programmes were developed, implemented, and maintained for residents, with significant resident involvement.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education and monitoring implementation pillars.

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy to support residents' religious practices was reviewed to ensure that it reflected the identified needs of residents. This was documented.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. Facilities were provided for residents' religious practices, including a church and oratory on the adjacent St. Vincent's University Hospital. A chaplaincy service was provided via the Hospital and chaplains visit at least weekly.

Residents had access to multi-faith chaplains, with leaflets provided to support access to religious services including multi-faith hospital prayers, chaplaincy services, and hospital prayers. Residents had access to local religious services in the locality and were supported to attend, and visits from the residents' own Minister were facilitated. Residents were facilitated to observe or abstain from religious practice in line with their wishes.

The approved centre's care and services were respectful of the residents' religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment were documented in each resident's clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which were last reviewed in April 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate, reasonable, and publicly displayed, and restrictions on visiting at protected meal times were noted. Restrictions on visiting a resident were justified and documented in the resident's clinical file. The clinical file also documented names of visitors a resident did not wish to see or who posed a risk to the resident.

Visiting areas were provided throughout and directly outside the approved centre. While there was not an identified visitor's room, staff noted rooms would be provided if requested, or if a child was visiting. Access to appropriate child-friendly facilities could be facilitated. Children visiting were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 12: Communication

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to resident communication, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: There was no signature sheet for this regulation in the signature book. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policies.

Monitoring: Resident communication needs and restrictions on communication were monitored at admission and during multi-disciplinary team meetings. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents were permitted to access the internet via the occupational therapy suite. Residents in the psychiatry for older age (POA) area were not able to access this as they did not go downstairs. Residents were allowed mobile phones, unless this posed a risk to the resident's or other residents' well-being.

The approved centre was non-compliant with this regulation because all residents did not have access to the internet including email and so were not free to communicate at all times, 12 (4).

Regulation 13: Searches

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in April 2017. It covered requirements of the *Judgement Support Framework,* including details of the following:

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

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. A risk assessment was undertaken prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. A checklist indicated that residents' consent was sought prior to all searches. There was not, however, evidence that written consent was obtained. A written record was kept of all environmental searches.

There was no documented evidence that the search policy was explained to residents. The information booklet contained no information on the search policy, and no clear records existed to indicate if it was explained either on admission or before a search. During the inspection, an information booklet was amended to provide this information. There was also no evidence that residents were informed by those implementing the search of what was happening during a search and why.

A minimum of two clinical staff were in attendance at all times when searches were being conducted. The search log included a written record of every search undertaken, the reason for the search, and every search had two signatures of staff members. However, neither the progress notes nor the search log indicated who was present. Policy requirements were implemented when illicit substances were found as a result of a search.

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

a) **The approved centre did not ensure that residents and staff were aware of the policy and procedures on searching, 13 (5).**
b) **No evidence that resident was informed of what was happening during the search and why, 13 (8).**

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policies and protocols in relation to care of the dying, which were last review in April 2017. The policies addressed requirements of the *Judgement Support Framework*, except that they did not outline a process for ensuring that the approved centre was informed in the event of the death of a resident who has been transferred elsewhere.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policies.

As there were no deaths since the last inspection, the monitoring and evidence and implementation pillars could not be assessed against.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating CRITICAL

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy, with no medics having signed the log. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Residents' ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Thirteen ICPs were reviewed on inspection. The ICPs were a composite set of documents, which were identifiable and uninterrupted, stored within clinical files, and not amalgamated with progress notes. The ICPs had allocated space for goals, treatment, care, and resources required.

Many residents did not have initial care plans, which should have been formulated on admission. Not all residents had an ICP developed by the MDT following a comprehensive assessment within seven days of admission, and one ICP was only developed by a consultant and nursing staff. Residents did not attend multi-disciplinary team meetings or discuss their care plans with their team. Whilst there was evidence that ICPs were discussed with the residents, there was no evidence of family involvement. Evidence-based assessments were used where possible.

The admission assessment form included relevant information and assessments. However, several sections of the assessments were not completed including: medical, educational, occupational, and vocational history, and historical and current medication. Not all ICPs identified the resident's assessed needs, appropriate goals, the care and treatment required to meet the goals identified (including the frequency and responsibilities for implementation), individual risk management plans, or a discharge plan. A key worker was not identified in the ICP to ensure continuity in implementation, although the key worker was identified on notice boards in the units.

The ICPs were reviewed and updated by the MDT in consultation with the resident on a weekly basis. Residents had access to the ICP and was kept informed of any changes. In some cases, ICPs did not record whether a copy of the ICP, including any reviews, was offered to a resident. Some ICPs did not indicate whether a resident declined a copy of their ICP or why the declined.

This is the third year in a row the approved centre was found to be non-compliant with this regulation.

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

a) **Four ICPs did not identify clear goals.**
b) **Five ICPs did not identify treatment and care required.**
c) **Four ICPs did not identify necessary resources.**
d) **Two ICPs were not developed by an MDT. One had medical and nursing input only and the other medical only.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy, as no medics had signed the log. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis. Service user evaluations were used and timetables were regularly amended. Documented analysis to identify opportunities for improving the processes relating to therapeutic services and programmes was not available for each area of the approved centre. An audit had been undertaken for the Elm Mount upper and lower units, but not for the psychiatry for older age unit (POA).

Evidence of Implementation: The upper and lower units had therapeutic services and programmes, whereas the POA unit only had access to therapeutic services. In the upper and lower units, the therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. However, the POA did not have a therapeutic programme.

A list of the occupational therapy programme was provided to residents, weekly, in the upper and lower units. There were no programmes available in the POA unit, so no list could be provided. There was no input from social workers or psychologists to the weekly programme. Where a resident required a therapeutic service that was not provided internally, the approved centre arranged for the service to be provided externally by an appropriate health professional. This happened for therapeutic programmes in the upper and lower units, but not in the POA unit.

The therapeutic services and programmes provided were evidence-based. The occupational therapist conducted regular surveys to further build the evidence base. A record was maintained of participation and engagement in, and outcomes achieved, in therapeutic services or programmes in residents' individual care plans or clinical files.

In the upper and lower units, there were adequate and appropriate resources and facilities available to provide the occupational therapy programme. In the upper and lower units, occupational therapy services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. No dedicated facilities or therapy rooms were available in the POA unit. Local occupational therapists were available to the residents in the upper and lower units, but not in the POA unit. The POA unit did have access to a community occupational therapist for assessments and limited

follow-up. The lack of an occupational therapist and programmes was highlighted in the complaints log a number of times.

The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of all residents, as documented in their individual care plans. Documented evidence indicated that one patient was not having their assessed needs met by the therapeutic services and programmes. Further, neither psychologists nor social workers had input into programmes, though referrals made to a psychologist or social worker were being addressed. The occupational therapist worked with the POA unit on a referral basis, and was working with a number of residents. The occupational therapist was aware of the lack of programmes available to POA residents. If the occupational therapist considered that a resident would benefit from a specific programme, they wrote it in the progress notes. Where a programme was not available to the resident, the occupational therapist wrote it in a way so that it could be addressed locally by nurses.

The approved centre was non-compliant with this regulation due to a lack of therapeutic programmes, resident did not have access to an appropriate range of therapeutic programmes in accordance with their assessed needs, 16 (1).

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents, which was last reviewed in October 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: An assessment was completed and documented prior to transfers, including an individual risk assessment. Verbal communication and liaison took place between the approved centre and the receiving facility prior to transfers. Full and complete written information was sent in advance and accompanied the resident upon transfer, to a named individual. Information included a letter of referral, medication requirements, and a transfer form. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred.

Copies of all records relevant to the resident transfer were retained in the resident's clinical file. Documented consent of resident to transfer was available, or justification as to why consent was not received. Communication records with receiving facility were documented and available on inspection.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in April 2017. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. Not all clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents' take-up of national screening programmes was recorded and monitored, where applicable. No resident was in the approved centre for more than six months, so the approved centre was not assessed against the other requirements of the monitoring pillar.

Evidence of Implementation: Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as indicated by the residents' needs. Residents received appropriate general health care interventions in line with their individual care plans. Residents had information on, and could access, appropriate national screening programmes, including breast checks, cervical screening, retina checks, and bowel screening. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator. Both were checked daily.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.

Regulation 20: Provision of Information to Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policies and procedures in relation to the provision of information to residents, which was last reviewed in April 2017. The policies included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policies.

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: An information booklet was provided to residents and their representatives at admission in the required format. The booklet was clearly and simply written, and outlined the required information on care, services, and housekeeping practices, including arrangements for personal property, mealtimes, visiting times, and visiting arrangements. However, it did not include information on resident rights. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis, unless the information would be detrimental to a resident's health and well-being. There was no evidence that information on indications for use of all medication, including any possible side effects was provided to residents.

Information provided to residents was evidence-based. There was little information available, some of which was out of date. Interviews indicated that residents must ask for the information, rather than it being proactively provided. Some staff interviewed were unsure of where to find appropriate information. The information booklet provided little guidance on where to access information or that residents have a right to the information. The information booklet was updated during the inspection to include the Choice and Medication website, which included information on diagnoses and medications. Residents had access to interpretation and translation services as required.

The approved centre was non-compliant with this regulation because there was no evidence that information on indications for use of all medications to be administered to the resident, including any possible side-effects was provided to residents, 20 (1)(e).

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Staff had an appropriate demeanour and dressed appropriately. Staff communicated with residents appropriately, used discretion when discussing medical conditions or treatment, and used residents' preferred names.

Staff sought the resident's permission before entering their room. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms that were overlooked by public areas had opaque glass. Noticeboards did not display resident names or other identifiable information.

All residents were wearing clothes that respected their privacy and dignity. Residents were facilitated to make private phone calls and could use a portable ward phone in their bedrooms.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in December 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had not completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space through bedrooms, which were appropriately sized to address the resident needs. Where rooms had multiple beds, attempts were made to reduce the number of residents in the room, for example, a five bedded room only had three residents. The bedrooms were not lockable.

Residents had appropriately sized communal rooms and access to internal and external gardens. The approved centre had a sluice room, cleaning, laundry room, and a medium-sized lift. The approved centre was well heated, though the temperate is controlled centrally so residents could not control the temperate in their rooms. Rooms were well ventilated, though the electro-convulsive therapy (ECT) suite lacked ventilation, had no windows. The doors adjacent to the ECT suite were wedged open with equipment in an attempt to ventilate the room. These doors could not be left open when ECT was in progress. There was no excessive noise noted, the approved centre was well lit, signage and sensory aids were appropriate, and hazards were minimised. Remaining ligatures were being managed through an appropriate risk management process. Funding had been secured to replace the approved centre's windows.

The approved centre provided suitable furnishings and assisted devices to support resident need, independence, and comfort. The psychiatry for older age unit did not have a dedicated therapy or examination room. There was a sufficient number of accessible, appropriately placed, and well signposted toilets and showers in the approved centre. There was also one assisted toilet and shower per floor. There were ceiling hoists in some toilets and mobile lifting hoists were available.

The approved centre was kept in a good state of repair externally and internally. Routine maintenance was carried out by St. Vincent's University Hospital and, although there was no maintenance plan, maintenance requests were communicated and dealt with efficiently. There was also a daily schedule for cleaning and weekly schedule for deep cleaning. The approved centre had two rooms that were malodorous.

Current national infection control guidelines were followed. Back-up power was available through St. Vincent's systems. Remote or isolated areas of the approved centre were monitored, with adequate sight lines for observation.

The approved centre was non-compliant with this regulation because the ECT suite did not have adequate ventilation 22.1 (b).

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 FINDINGS

Processes: The approved centre had a written policies and procedures in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in April 2017. The policies addressed requirements of the *Judgement Support Framework*, except that it did not outline processes for:

- Medication management at admission, transfer, and discharge.
- Medication reconciliation.
- Reviewing resident medication.

Training and Education: Not all nursing or medical, had signed the signature log to indicate that they had read and understood the policies. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medication, as set out in the policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Not all nursing, medical, and pharmacy 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) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten MPARs were reviewed during inspection. MPARs had dedicated space for routine, once off, and as required medication. All MPARS recorded the frequency of administration. All MPAR entries were written in black, indelible ink, but two MPARs had illegible entries. Each MPAR used two appropriate identifiers.

However, the MPARs contained numerous gaps in information. For each of the following requirements:

- One MPAR did not record: the date of initiation or the generic name of the medication, a record of medication withheld or refused by the resident, or micrograms written in full.
- Two MPARs did not record: allergy status, the administration route, the Medical Council Registration Number of the administering medical practitioner, or the correct dose/amount of medication.
- Three MPARs did not record a discontinuation date, or had unidentified gaps in the record of medications administered to residents.

Where a prescription required alteration, the medical practitioner rewrote the prescription. There was no evidence that a risk assessment was completed for resident self-administration of medication. Medications for self-administration were also not clearly labelled.

All medicines were administered by an appropriate health professional. Good hand-hygiene techniques were implemented during the dispensing of medications. The expiration date of the medication was checked prior to administration; expired medications were not administered. However, a box of medication had no expiry date on it. Two staff members checked schedule two controlled drugs against the delivery form, and completed a logbook following administration.

Medication was stored in an appropriate environment. Medication storage areas were incorporated in the cleaning and housekeeping schedules. However, a fridge used for storing medication was dirty. Food and drinks were also stored in one medication fridge. A log noting the temperature of the refrigeration storage unit was not taken daily. Medication dispensed or supplied to residents was stored securely in a locked storage unit or fridge. The medication trolley and medication administration cupboard remained locked at all times and secured in a locked room. Scheduled two and three controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

Pharmacy staff carried out weekly medication inventories, which checked the name, dose, and quantity of medication, but not expiry dates. A system of stock rotation was implemented to avoid accumulation of old stock. Medication that was no longer required was not returned to the pharmacy for disposal as soon as possible.

The approved centre was non-compliant with this regulation as there were not appropriate and suitable practices to the ordering, prescribing, storing and administration of medication to residents, specifically:

a) **The Medical Council Registration Number not documented on two Medication Prescription and Administration Records (MPAR), 23 (1).**
b) **There were gaps in the documentation of administration of medication, 23 (1)**
c) **Medication for self-administration was not correctly labelled, 23 (1).**
d) **The allergy section was not completed in two MPARs, 23 (1).**
e) **Generic name not used in one MPAR, 23 (1).**
f) **Two entries were not legible, 23 (1).**
g) **A fridge used for storing medication was dirty, 23 (1).**
h) **Food and drinks were stored in one medication fridge, 23 (1).**
i) **A log noting the temperature of the refrigeration storage unit was not taken daily, 23 (1).**

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes:
The approved centre had a written operational policy in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in December 2017. The policy addressed requirements of the *Judgement Support Framework*, except there were no references to:

- Response to sharps or needle stick injuries.
- Availability of staff vaccinations and immunisations.
- Support provided to staff following exposure to infectious diseases.
- First aid response requirements.
- Falls prevention initiatives.
- The staff training requirements in relation to health and safety.
- The monitoring and continuous improvement requirements implemented for the health and safety processes.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

Monitoring: The health and safety policy was monitored pursuant to Regulation 29: Operational Policies and Procedures.

Evidence of Implementation: Regulation 24 was only assessed against the approved centre's written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Inadequate

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policies and procedures in relation to its staffing requirements, which was last reviewed in April 2017. The policy addressed the requirements of the *Judgement Support Framework*, including the following:

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

The policy did not address the process for transferring responsibility from one staff member to another or the required qualifications of training personnel.

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had not been reviewed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: Staff were recruited, selected, and vetted in accordance with the approved centre's policy. A comprehensive contract between the approved centre and registered/licensed staffing agency was used for agency staff. The contract set out the agency's responsibilities relating to assessing potential staff. Staff had the appropriate qualifications to do their job.

There was an organisational chart, which identified the management structure and the lines of accountability. There was no written staffing plan for the approved centre, except for nursing staff. The numbers and skill mix of staffing were not sufficient to meet resident needs, as there were too few occupational therapists, social workers, and psychologists. A planned and actual staff rota was maintained. An appropriately qualified staff member was on duty and in charge at all times, which was

documented. The required number of staff were on duty at night to ensure safety of residents in the event of emergency.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Opportunities were made available and communicated to staff for further education. Staff were appropriately supported to take these opportunities. In-service training was completed by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training.

Orientation training was completed for staff, alongside a comprehensive employee resource pack that included induction guidelines. All staff were trained in Children First, manual handling, risk management, incident reporting, and protection of children and vulnerable adults. Not all health care professionals were trained in fire safety, Basic Life Support, Management of Violence and Aggression, or the Mental Health Act 2001. There was evidence of training for manual handling, risk management, incident reporting, and protection of vulnerable adults. Not all staff training was documented, and staff training logs were not maintained.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Elm Mount Upper	CNM2 CNM1 RPN Occupational Therapist Social Worker Psychologist	1 1 4 1 By referral By referral	3

Ward or Unit	*Staff Grade*	*Day*	*Night*
Elm Mount Lower	CNM2 CNM1 RPN Occupational Therapist Social Worker Psychologist	1 1 1 1 By referral By referral and 0.5 for eating disorder programme	2

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

a) **The numbers and skill mix of staffing were insufficient to meet resident needs, 26 (2).**
b) **Not all staff had up to date training in fire safety, basic life support, the Mental Health Act 2001 and management of violence and aggression, 26 (4).**

Ward or Unit	Staff Grade	Day	Night
Psychiatry of Old Age	CNM2	1	
	RPN	2	1
	HCA	0	1
	Occupational Therapist	By referral	
	Social Worker	By referral	
	Psychologist	By referral	

There was one Clinical Nurse Manager III working full time in the approved centre

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

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in December 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents' records.
- Record retention periods.
- The destruction of records.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. However, this was only referenced at the back of the policy, and not linked directly, making it difficult to access for staff members. Not all clinical staff had been trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were not included in the review process. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Five clinical files were reviewed on inspection. Residents' records were secure, up to date, in good order, and were constructed, maintained, and used in line with national guidelines and legislative requirements. All resident records were physically stored together. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

A record was initiated for every resident assessed or provided with care and services by the approved centre. Resident records were reflective of the residents' current status, care, and treatment. Resident records were maintained using a unique identifier, and two appropriate identifiers were recorded on all

documentation. Resident records were written legibly in black, indelible ink, were readable when photocopied, and were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases.

Each entry included the date. However, the time was missing in all entries made by doctors and social workers in clinical files reviewed. Each entry was followed by a signature. The approved centre did not maintain a record of all signatures used in the resident record. Entries made by student nurses or clinical training staff were not always countersigned by a registered nurse or clinical supervisor. Where errors were made, the correction did not follow best practice in two files. Where a member of staff made a referral to, or consults with another member of the health care team, this person was clearly identified by their full name and title. Where information or advice was given over the phone, this was properly documented.

Resident records were accessible and amendable to authorised staff only. Staff had access to the information needed to carry out their responsibilities. Residents' access to their records was managed in accordance to the data protection legislation.

The approved centre was non-compliant with this regulation because all records were not maintained in a manner so as to ensure completeness, the time of the entry was not recorded, student nurse entries were not always countersigned and errors were not corrected in line with best practice. 27(1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in April 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had not been undertaken to determine compliance with review timeframes. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately formatted, approved, and communicated to all relevant staff. Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained but removed from access by staff.

Generic policies were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre has a written statement to this effect (adopting the generic policy).

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met all criteria of the *Judgement Support Framework* under the training and education and monitoring pillars.

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

(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.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals, which was last reviewed in August 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the management of complaints, which was last reviewed in December 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. Not all 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 making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was not analysed. Required actions had not been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: Residents and their representatives were provided with information on the complaints process, with information being well publicised and accessible. Residents and their representatives were assisted to make complaints using appropriate methods and facilitated to access an advocate. This was done verbally and in writing through an information leaflet. There was a nominated complaints officer who was responsible for dealing with complaints, who was clearly identified. There was also a method for addressing minor complaints. The complaints officer dealt with minor complaints that could not be addressed locally.

All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and informed promptly of the outcome and details of the appeals process. The complaints officer maintained a log for complaints they dealt with, including complete details of the complaint, investigation, outcomes,

and the complainant's view of the outcome. This was kept separate from the resident's individual care plan.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected because of the complaint being made. All information obtained in the complaints process was treated confidentially, consistent with relevant legislation.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education and monitoring pillars.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in April 2017. The policy addressed all of the requirements/requirements of the *Judgement Support Framework*, including the following:

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

The policy did not address the following:

- The person responsible for the completion of six-monthly incident summary reports.
- The process for identification, assessment, treatment, reporting, and monitoring of organisational, structural, health and safety and capacity risks throughout the approved centre.

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. Not all staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.

Monitoring: The risk register was not reviewed at least quarterly to determine compliance with the approved centre's risk management policy as it was only introduced in recent months. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The risk management procedures actively reduced identified risks to the lowest practicable level. Structural risks, including ligature points, were removed or effectively mitigated. The approved centre implemented a plan to reduce risks to residents while works to the premises were ongoing. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. Clinical, health and safety, and corporate risks were identified, assessed, treated, reported, and monitored. A risk register had recently been established, where these risks were documented. Clinical risk assessments were completed on admission, however there was little evidence that they were repeated. There was an emergency plan that specified responses by staff to possible emergencies, including evacuation procedures.

Individual risk assessments considered physical restraint, specialised treatments, and individual risk factors, amongst others. However, resident discharge was not addressed during this assessment. Residents and their representatives, but not multi-disciplinary teams, were involved in the development, implementation, and review of individual risk management processes. It was unclear who was involved in the development, implementation and review of individual risk management processes. There were incomplete risk management plans for some residents. Individual care plans documented a risk however, they did not address the risk as identified in the risk assessments.

Incidents were recorded and risk-rated in a standardised format. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The approved centre provided six-monthly summary reports of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymised at resident level.

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

a) **The registered proprietor did not ensure that a comprehensive written risk management policy was in place and that it is implemented throughout the approved centre, 32 (1).**
b) **The registered proprietor did not ensure that the risk management policy was implemented as there were incomplete risk management plans some of which did not address the risks identified on assessment. 32 (1)**
c) **The risk management policy did not include the identification and assessment of risks throughout the approved centre 32 (2a).**
d) **The risk management policy did not include the precautions in place to control the risks identified; 32 (2 b)**.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with no conditions to registration attached. The certificate was displayed prominently.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

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.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated May 2018. It contained protocols that were developed in line with best international practice, including:

- Storing initial and subsequent doses of Dantrolene in a stored, locked cupboard.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated suite for the delivery of ECT, including a private waiting room and adequately equipped treatment and recovery rooms. This area was shared with the Clozaril nurse, who was also an ECT nurse. Storage was a problem, with Clozaril files stored in the ECT and recovery rooms, which was inappropriate. The ECT suite lacked ventilation, had no windows, and the temperate exceeded 29 degrees. The doors adjacent to the ECT suite were wedged open with equipment in an attempt to ventilate the room. These doors could not be left open when ECT was in progress. High-risk patients received ECT in the main theatre where more staff were on standby.

A named consultant psychiatrist and anaesthetist had overall responsibility for ECT management and anaesthesia respectively. There were at least two registered nurses in the ECT suite at all times, one of whom was a designated ECT nurse.

Materials and equipment in the ECT suite were in line with best international practice. Up-to-date protocols for management of cardiac arrest, anaphylaxis, and malignant hyperthermia, were prominently displayed. There was a facility for monitoring EEG on two channels. ECT machines regularly maintained and serviced, with a new ECT machine and monitor awaiting to be installed. An online record of maintenance was kept.

One resident had received a programme of ECT and all clinical forms were complete. The patient was assessed as not having the capacity to consent to treatment. The anaesthesia and ECT were prescribed, administered, and recorded appropriately. A patient's clinical and cognitive status was assessed before,

during, and after each ECT session and programme. The continued use of ECT was reviewed by the consultant psychiatrist in consultation with the patient.

The approved centre was compliant with this rule.

10.0 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: Consent to Treatment was not applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating **CRITICAL**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated April 2018. It addressed the following:

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

Training and Education: There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: The clinical files of three episodes involving two residents were examined in relation to the use of physical restraint. The files indicated that physical restraint was used to prevent immediate and serious harm and in rare and exceptional circumstances. Physical restraint was initiated after considering alternatives and following a risk assessment, and cultural awareness and gender sensitivity were demonstrated. Physical restraint was initiated and staffed in line with the policy on physical restraint. The inspection team noted that one resident had special requirements and needs in relation to the use of physical restraint. This had not been documented in this residents individual care plan. In no case did the order for physical restraint last for more than 30 minutes.

A clinical practice form was completed, signed, filed, and was reviewed following an episode. However, a medical examination of the resident (physical examination) was not completed within three hours of the episode. In one case, the episode was not recorded in the clinical file. In another case, a resident did not have an opportunity to discuss the episode with members of the multi-disciplinary team involved in their care.

If consent was given, or the resident could not consent, the resident's next of kin or representative were not always informed. In one episode the justification for not informing the resident's next of kin or representative' was not recorded and in another, the reason for a resident not consenting to informing their representative was not recorded.

There was one case of a child being physically restrained. The parent/guardian was informed as soon as possible, child protection policies were in place, but the policies did not address appropriate training for staff in relation to child protection.

This was the fourth year in a row that the approved centre were non-compliant with the code.

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

a) **There was not a written record that all staff involved in physical restraint had read and understood the policy, 9.2 (b).**
b) **A registered medical professional did not complete a medical examination of resident (physical examination) within three hours of the start of an episode of physical restraint, 5.4.**
c) **As soon as practicable and with resident's consent, or where resident lacks capacity and cannot consent, the resident's next of kin or representative was not informed of the use of physical restraint, 5.9(a).**
d) **Where the next of kin or representative was not informed, a justification was not recorded in the clinical file, 5.9 (a).**
e) **Where a resident had capacity and did not consent to informing next of kin or representative, this was not documented in clinical file, 5.9 (b)**
f) **Staff were not aware of relevant considerations in individual care plan pertaining to resident's requirements/needs in relation to the use of physical restraint, 6.1.**
g) **Residents were not always afforded an opportunity to discuss the episode with members of the multi-disciplinary team involved in their care as soon as is practicable, 7.2.**
h) **Policies and procedures were not in place to address appropriate training for staff in relation to child protection, 11.3.**

Admission of Children

NON-COMPLIANT

Risk Rating MODERATE

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.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in April 2017. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had not received training in relation to the care of children.

Evidence of Implementation: One child had been admitted to the approved centre for seven days, pursuant to a court order, whilst awaiting CAMHS bed. This was an adult ward and did not have suitable facilities for children admitted. Appropriate provisions were made for accommodation, safety, the child's needs, and to ensure the right of the child to have their views heard through a Court appointed Guardian Ad Litum.

The child had their rights explained and information provided in an accessible way, and the clinical file recorded the child's understanding of the explanation. The child was seen by the Child and Adolescent Psychiatrist and a case conference was held with National CAMHS team. Consent for treatment was obtained from the Guardian and also the resident's family. Observation arrangements were provided as considered clinically appropriate through special nursing observation. Staff observation acknowledged gender sensitivity. Appropriate visiting arrangements were made available for family.

Staff in contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. The Mental Health Commission was notified within 72 hours of admission.

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

a) **Staff had not training relating to the care of children, 2.5 (e).**
b) **Age appropriate facilities appropriate to age and ability were not provided, 2.5 (b).**

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

COMPLIANT

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.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated May 2018. It contained protocols that were developed in line with best international practice, including

- How and where the initial and subsequent doses of Dantrolene are stored; which was stored in a locked medication press in the ECT suite.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had: a dedicated ECT suite, a rapid intervention area, appropriate materials, equipment, and protocols, well maintained machines, appropriate staffing, and appropriately monitoring.

The consultant psychiatrist provided accessible and appropriate information on ECT to enable resident to make a decision on consent, with an interpreter available. Resident questions were answered and documented and residents were informed of right to access advocate. Subject to urgency of clinical circumstances, residents were given 24 hours to reflect on the information if they wished.

ECT was only administered with resident's written consent to each ECT session. A clinical psychiatrist assessed the residents' capacity for consent, which ensured that the resident could understand the information provided to them, make a free choice, and communicate that choice. This was documented.

The approved centre was compliant with this code of practice.

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 FINDINGS

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

Admission: The admission policy, which was last reviewed in January 2018, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in October 2017, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in October 2017, included the policy-related criteria for this code of practice, except that it did not address procedures for managing discharge against medical advice.

Training and Education: There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission and transfer policies, but not for the discharge policy.

Evidence of Implementation:

Admission: All admissions were on the basis of mental illness or mental disorder. Admission assessments were completed and included the presenting problem, past psychiatric history, a risk assessment, and a current mental health state. However, assessments did not include family, medical, and medication history. A key worker system was in place.

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

Discharge: Discharge plans included the estimated date of discharge and a follow-up plan, but did not include documented communication with the relevant health professionals or a reference to early warning signs of relapse and risks. There was no evidence of discharge assessments in resident files. Discharge meetings were attended by residents, representatives, and appropriate health professionals. A key worker coordinated the discharge.

A comprehensive discharge summary was issued to the resident's GP within 14 days. Summaries included diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, and follow-up arrangements. However, they did not include names and contact details of key people for follow-up and risk issues, such as sign of relapse. A family member, carer, or advocate was involved in discharge process, where appropriate.

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

a) **There was no documentary evidence that all relevant staff have read and understood the admission, transfer, and discharge policies, 9.1.**
b) **Admission assessments did not include family history, medical history, and current and historic medication, 15.3.**
c) **The written policy for discharge did not describe procedures for managing discharge against medical advice, 4.15.**
d) **No audit of the implementation of and adherence to the discharge policy was undertaken, 4.19.**
e) **Discharge plans did not include documented communication with the relevant general practitioner/primary care team and/or Community Mental Health team or a reference to early warning signs of relapse and risks, 34.2.**
f) **There was no evidence of discharge assessments, 34.4.**
g) **Discharge summaries did not include names and contact details of key people for follow-up or risk issues such as signs of relapse, 38.4.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 7: Clothing

Report reference: Page 22

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. All residents had to remain in night clothes until reviewed by the Consultant Psychiatrist, 7 (2).	New	Corrective Action(s): Night clothes are not worn by residents during the day, unless specified in a resident's individual care plan and based on their individual clinical risk assessment. Post-Holder(s) responsible: Admitting clinician / treating consultant / Key worker	Audit completed	Action Completed - Achieved	10/12/2018
		Preventative Action(s): A record of residents wearing night clothes during the day, is documented in the ICP and monitored. Post-Holder(s) responsible: Admitting clinician / treating consultant / Key worker	Ongoing analysis	Achieved	10/12/2018

[1] Area of non-compliance reoccurring from 2017
[2] Area of non-compliance not reoccurring from 2017

Regulation 12: Communication

Report reference: Page 28

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
2. All residents did not have access to the internet including email and so were not free to communicate at all times, 12 (4).	New	Corrective Action(s): All resident have access to free Wi-Fi facility within the approved centre, based on their individual risk assessment and treatment plan. Post-Holder(s) responsible: Treating Consultant, Key worker and CNM 2	Analysis	Action completed. Achieved.	Dec 2018.
		Preventative Action(s): Resident communication needs and restrictions on communication are monitored on an regular basis and this is documented in resident clinical file and ICP. Post-Holder(s) responsible: Treating Consultant, Key worker and members of MDTs	Healthcare record and ICP audit	Achievable	Audit scheduled Jan 2019.

Regulation 13: Searches

Report reference: Pages 29 & 30

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
3. The approved centre did not ensure that residents and staff were aware of the policy and procedures on searching, 13 (5).	New	Corrective Action(s): Resident information booklet updated to include information on searching process. The operating policies and procedures on searching are communicated to all relevant staff. Implemented PPPG signature log register for staff who have read and understand the policy. Post-Holder(s) responsible: Heads of discipline / CNM 2	Review of resident information booklet Analysis to be undertaken to determine compliance with policy dissemination process.	Action completed-achieved. Achievable	25th July 2018 1st Feb 2019.
		Preventative Action(s): Heads of Discipline and Mental Health Services Management to ensure staff have read and understand the policies. Post-Holder(s) responsible: Heads of Discipline	Audit	Achievable	1st Feb 2019
4. No evidence that resident was informed of what was happening during the search and why, 13 (8).	New	Corrective Action(s): At present Residents are informed by those implementing the search of what is happening during a search and why. Staff will now document in resident clinical file and in search logbook Post-Holder(s) responsible:	Analysis of search log and clinical file	Achievable	1st Jan 2019

		Keyworker			
		Preventative Action(s): Each search record is systematically reviewed to ensure the requirements of the regulation have been complied with. Post-Holder(s) responsible: Audit Group	Analysis of search record and clinical file	Achievable	1st Jan 2019

Regulation 15: Individual Care Plan

Report reference: Page 32 & 33

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
5. Four ICPs did not identify clear goals.	Reoccurring	Corrective Action(s): MDT ICP Working group was established on 12th August 2018 and has now initiated a trial period for introduction of new ICP template. All ICP's have been reviewed and updated with appropriate goals for the resident. This is documented in the individual ICP's Post-Holder(s) responsible: Members of the MDT.	Monthly ICP audit	Achievable	28th March 2019
		Preventative Action(s): Resident's ICP's are reviewed and updated on a weekly basis by MDT. This is documented Post-Holder(s) responsible: Members of MDTs and Keyworker.	Regular analysis to identify opportunities to improve the individual care planning process	Achievable	28th March 2019
6. Five ICPs did not identify treatment and care required.	Reoccurring	Corrective Action(s): All ICP's have been reviewed and determined the necessary care and treatment to meet the goals identified. This is documented in the individual ICP's. Post-Holder(s) responsible: Members of the MDT.	Monthly ICP audit	Completed	12th December 2018
		Preventative Action(s):	Monthly ICP audit	Achievable	January 2019

		Ongoing review of resident's ICP's on a weekly basis by MDT. This is documented. There will be a monthly audit of same. Post-Holder(s) responsible: Members of MDTs and Keyworker.			
7. Four ICPs did not identify necessary resources.	Reoccurring	Corrective Action(s): Resident individual care plan have been updated and named the resources required to provide the care and treatment identified. Post-Holder(s) responsible: Members of the MDT and keyworker	Monthly ICP audit	Completed	12th December 2018
		Preventative Action(s): Residents ICP's are reviewed and updated on a weekly basis as required by MDT. This is recorded. Post-Holder(s) responsible: Members of MDT and keyworker	Regular analysis and this is documented.	Achievable	January 2019
8. Two ICPs were not developed by an MDT. One had medical and nursing input only and the other medical only.	New	Corrective Action(s): Available MDT members are involved in the review and updating of ICP's on a weekly basis. Residents are encouraged to participate in a weekly Pre MDT review meeting and the MDT Care Plan meeting. Resident's involvement or choice not to attend either meeting is documented. Post-Holder(s) responsible: Members of MDT	Monthly ICP audit	Complete	12th December 2018
		Preventative Action(s): All MDT members attend weekly ICP Review meetings. This is documented in ICP.	On going analysis	Achievable	January 2019

		Regular feedback to MDTs on recommendations from monthly ICP audit via Heads of Discipline. Post-Holder(s) responsible: Treating consultant & Members of MDTs/ HODs.			

Regulation 16: Therapeutic Services and Programmes

Report reference: Pages 34 & 35

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
9. Residents did not have access to an appropriate range of therapeutic programmes in accordance with their assessed needs, 16 (1).	New	Corrective Action(s): Access to therapeutic services for POA residents on an individual basis in place. Therapeutic progamme for POA residents available on campus in Carew House POA Day hospital. Post-Holder(s) responsible: MDT members	Process anaylsis	Achievable	March 2019
		Preventative Action(s): Needs analysis will be completed for Occupational Therapy services for POA residents and resources identified. Post-Holder(s) responsible: OT Manager	Feedback from residents, anaylsis of ICP's and review of previous OT input	Achievable	March 2019

Regulation 20: Provision of Information to Residents

Report reference: Page 38 & 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
10. There was no evidence that information on indications for use of all medications to be administered to the resident, including any possible side-effects was provided to residents, 20 (1)(e).	New	Corrective Action(s): Patient information booklet updated to include information on indications for use of all medications. The Treating consultant / Key worker will provide medication information sheets, including any possible side-effects, in a format that is appropriate to resident needs as required. This is documented in the clinical file. Post-Holder(s) responsible: Treating consultant, Keyworker.	Regular monitoring and analysis	Achieved	10th August 2018
		Preventative Action(s): The provision of information to residents is monitored on an ongoing basis to ensure the information is appropriate and accurate. Post-Holder(s) responsible: Treating consultant, Keyworker.	Audit	Achievable	15th Jan 2019

Regulation 22: Premises

Report reference: Pages 41 & 42

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
11. The ECT suite did not have adequate ventilation 22.1 (b)	New	Corrective Action(s): Funding secured to address ventilation issue Post-Holder(s) responsible: General Manager in consultation with HSE Estates	Visual inspection	Achievable	March 2019
		Preventative Action(s): Daily Temperature log in place Post-Holder(s) responsible: CNM3 ECT	Premises audit	Achievable	March 2019

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

Report reference: Pages 43 & 44

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
12. The Medical Council Registration Number was not documented on two Medication Prescription and Administration Records (MPAR), 23 (1).	Reoccurring	Corrective Action(s): MPAR reviewed and MCRN of every medical practitioner prescribing medication is present within the resident's MPAR. Post-Holder(s) responsible: Consultant & medical staff	MPAR Audit completed	Achieved	10th and 11th Dec 2018
		Preventative Action(s): Analysis to be completed to identify opportunities for improvement of medication management processes. Post-Holder(s) responsible: Audit Review Group	Audit	Achievable	15th March 2019
13. There were gaps in the documentation of administration of medication, 23 (1)	New	Corrective Action(s): MPAR reviewed and gaps in documentation addressed. Post-Holder(s) responsible: Consultant & Clinical and Nursing staff	Audit	Achieved	10th & 11th December 2018
		Preventative Action(s): All nursing staff to complete HSELand online training on medication management	Training log / data base Audits of Medication Prescription and Administration Records	Achievable	15th March 2019

		Post-Holder(s) responsible: Audit Review Group			
14. Medication for self-administration was not correctly labelled, 23 (1).	New	Corrective Action(s): Medications for self-administration will be labeled individually by a Pharmacist with the resident name, MRN and appropriate directions for use, and stored appropriately for use only by that resident. Post-Holder(s) responsible: Consultant, medical and nursing staff and pharmacist.	Measureable	Achievable	1st Jan 2019
		Preventative Action(s): Analysis to be completed to identify opportunities for improvement of medication management processes. Post-Holder(s) responsible: Audit Review Group	Audit of Medication Prescription and Administration Records	Achievable	15th March 2019
15. The allergy section was not completed in two MPARs, 23 (1). 16. Generic name not used in one MPAR, 23 (1). 17. Two entries were not legible, 23 (1).	Reoccurring	Corrective Action(s): All MPAR reviewed • All entries on the MPAR are legible • All MPAR includes record of any allergies or sensitivities to any medications. • The generic name of the medication are recorded on the MPAR Post-Holder(s) responsible: Consultant & medical staff and pharmacist	MPAR Audit completed	Achieved	10th and 11th Dec 2018

		Preventative Action(s): Analysis to be completed to identify opportunities for improvement of medication management processes. Post-Holder(s) responsible: Audit Review Group	Audits of Medication Prescription and Administration Records	Achievable	15th March 2019
18. A fridge used for storing medication was dirty, 23 (1). 19. Food and drinks were stored in one medication fridge, 23 (1).	New	Corrective Action(s): Medication storage areas are free from litter and dust. Food and drink is not stored in areas used for the storage of medication. Post-Holder(s) responsible: CNM2	Daily checks of storage of medication is carried out by the PIC and this is documented	Achieved	10th and 11th Dec 2018
		Preventative Action(s): Medication storage / press should be tidy and clean after each use. This is informed to all relevant staff. "Medication Only" notice placed on fridge. Post-Holder(s) responsible: All Nursing Staff	Audit	Achievable	15th March 2019
20. A log noting the temperature of the refrigeration storage unit was not taken daily, 23 (1).	New	Corrective Action(s): A temperature log of the refrigeration storage unit is maintained and updated daily. Post-Holder(s) responsible: PIC	Temperature log register inspection	Achieved	10th and 11th Dec 2018
		Preventative Action(s):	Audit of Medication Prescription and Administration Records	Achievable	15th March 2019

		Ongoing analysis to be completed to identify opportunities for improvement of medication management processes. Post-Holder(s) responsible: CNM2 & Audit Group.			

Regulation 26: Staffing

Report reference: Page 46 - 48

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
21. The numbers and skill mix of staffing were insufficient to meet resident needs, 26 (2).	New	Corrective Action(s): Continue to recruit as vacancies arise. Outline of skill mix and staffing numbers provided directly following inspection. Post-Holder(s) responsible: All Heads of Discipline	Monitor through central vacancy tracking system held at the office of the Head of Service. Human Resources/staffing is a standing item on Executive Management Team agenda.	Achievable	Ongoing
		Preventative Action(s): Community Mental Health Team OTs, Social Workers and Psychologists provide services throughout the patients continuum of care, during their inpatient stay and post-discharge in the community. Post-Holder(s) responsible: All Heads of Discipline	Through ICP review	Achievable	Ongoing
22. Not all staff had up to date training in fire safety, basic life support, the Mental Health Act 2001 and management of	Reoccurring	Corrective Action(s): Staff training log register /database in place. Training needs analysis completed and schedule for training identified and circulated. Post-Holder(s) responsible: All Heads of Discipline	Training needs analysis is completed	Achieved	19th December 2019
		Preventative Action(s):	Auditing via training log statistics	Achievable	30th June 2019

violence and aggression, 26 (4).		Senior management team will ensure that all HODs facilitate staff training for their areas of responsibility and maintain a training log for all MDT members Post-Holder(s) responsible: All MDT, Heads of Discipline and CNM's in units			

Regulation 27: Maintenance of Records

Report reference: Page 49 & 50

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
23. All records were not maintained in a manner so as to ensure completeness, the time of the entry was not recorded, student nurse entries were not always countersigned and errors were not corrected in line with best practice. 27(1).	Reoccurring	Corrective Action(s): Resident clinical records reviewed and corrected Post-Holder(s) responsible: Members of MDT	Audit	Completed	July 2018
		Preventative Action(s): All clinical staff advised to complete HSELand online training on Healthcare Records Management. This is recorded in staff training log register. Monthly monitoring of resident clinical file to ensure completeness and accuracy. Post-Holder(s) responsible: Members of MDTs and Audit Group	Review Training register Analysis	Achievable	March 2019

Regulation 32: Risk Management Procedures

Report reference: Pages 56 & 57

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
24. The registered proprietor did not ensure that a comprehensive written risk management policy was in place and that it is implemented throughout the approved centre, 32 (1). 25. The risk management policy did not include the identification and assessment of risks throughout the approved centre 32 (2a). 26. The risk management policy did not include the precautions in place to control the risks identified; 32 (2 b).	Reoccurring	Corrective Action(s): The existing risk management policy will be updated to include: • the identification and assessment of risks throughout the approved centre. • precautions in place to control the risks identified Post-Holder(s) responsible: Policy Review Group	Processes agreed by Policy working group.	Achievable	Next policy review meeting scheduled on 29th Jan 2019.
		Preventative Action(s): Policy update every three years unless indicated by either legislation, change in practices or recommendations from the Mental Health Commission Inspectorate Post-Holder(s) responsible: Policy review Group	Analysis	Achievable	March 2019
27. The registered proprietor did not ensure that the risk management policy was implemented as there were incomplete risk management plans some of which did not address	Reoccurring	Corrective Action(s): A comprehensive and ongoing risk assessment and management plan is developed as a component of the Individual Care Plan. This is communicated to all relevant clinical staff. Post-Holder(s) responsible:	ICP audit	Achievable	March 2019

the risks identified on assessment. 32 (1)		Admitting clinician , consultant and key worker.			
		Preventative Action(s): Monthly ICP audit and feedback Post-Holder(s) responsible: Members of MDTs and Audit Group	ICP Audit	Achievable	March 2019.

Code of Practice: Use of Physical Restraint

Report reference: Pages 65 & 66

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
28. There was not a written record that all staff involved in physical restraint had read and understood the policy, 9.2 (b).	Reoccurring	Corrective Action(s): Policy dessimination session on physical restaints and code of practice will be held early 2019. Implemented PPPG signature log register for staff who read and understood policy and COP. Post-Holder(s) responsible: HODs/ PIC.	Monthly audit on Physical Restraint Process	Achievable	March 2019
		Preventative Action(s): Review and monitored the PPPG signature sheet. Post-Holder(s) responsible: Audit Group	Analysis	Achievable	March 2019
29. A registered medical professional did not complete a medical examination of resident (physical examination) within three hours of the start of an episode of physical restraint, 5.4.	Reoccurring	Corrective Action(s): Algorithm has been developed and implemented to ensure compliance with Code of Practice on physical restraints. Post-Holder(s) responsible: Keyworker and NCHD	Monthly Audit	Achievable	January 2019
		Preventative Action(s): Audit and feedback Post-Holder(s) responsible:Audit Group	Monthly audit	Achievable	Jan 2019
	Reoccurring	Corrective Action(s):	Audit	Achievable	Jan 2019

30. As soon as practicable and with resident's consent, or where resident lacks capacity and cannot consent, the resident's next of kin or representative was not informed of the use of physical restraint, 5.9(a). 31. Where a resident had capacity and did not consent to informing next of kin or representative, this was not documented in clinical file, 5.9 (b)		Algorithm has been developed and implemented to ensure compliance with Code of Practice physical restraints. Post-Holder(s) responsible: Key worker / PIC			
		Preventative Action(s): Audit and feedback Post-Holder(s) responsible:Audit Group and CNM 2	Audit	Achievable	Jan 2019
32. Staff were not aware of relevant considerations in individual care plan pertaining to resident's requirements/needs in relation to the use of physical restraint, 6.1.	New	Corrective Action(s): Incorporate individual residents special requirements and needs in residents ICP and Key worker will ensure that all staff are aware of relevant consideration during restraints process. Post-Holder(s) responsible: Members of MDT and Key worker.	Audit	Achievable	Jan 2019
		Preventative Action(s): Audit and Feedback to MDTs Post-Holder(s) responsible: Audit Group	Audit	Achievable	Jan 2019
33. Residents were not always afforded an opportunity to discuss the episode with members of the multi-disciplinary team involved in	New	Corrective Action(s): Following physical restraints, key worker will ensure that residents afforded opportunity to discuss the episode with relevant MDT members and this is documented in residents clinical notes.	Monthly audit	Achievable	Jan 2019

their care as soon as is practicable, 7.2.		Post-Holder(s) responsible: Key worker			
		Preventative Action(s): Algorithm will be developed and implemented to ensure compliance with Code of Practice on physical restraints. Post-Holder(s) responsible: CNM 3	Regular analysis	Achievable	Jan 2019
34. Policies and procedures were not in place to address appropriate training for staff in relation to child protection, 11.3.	Reoccurring	Corrective Action(s): The existing policy for staffing will be updated to include training for staff in relation to child protection. Post-Holder(s) responsible: Policy review Group	Audit	Achievable	Jan 2019
		Preventative Action(s): Policy updated annually unless indicated by either legislation, change in practices or recommendations from the Mental Health Commission Inspectorate Post-Holder(s) responsible: Policy review group	Analysis	Achievable	March 2019

Code of Practice: Admission of Children

Report reference: Page 67

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
35. Not all staff had training relating to the care of children, 2.5 (e).	New	Corrective Action(s): All Staff to complete HSELand online introduction to Children first training Post-Holder(s) responsible: Head of Discipline	Training Need analysis Training log register	Achievable	31st Jan 2019
		Preventative Action(s): Senior management team will ensure that all Heads of Discipline facilitate staff training for their areas of responsibility and maintain a training log for all MDT members Post-Holder(s) responsible: Heads of Discipline	Auditing via training log statistics	Achievable	31st Jan 2019 and ongoing
36. Age appropriate facilities appropriate to age and ability were not provided, 2.5 (b).	New	Corrective Action(s): Area identified within the approved centre that can be adapted for use, depending on the age and ability of the child on admission. This is completed based on individual child need assessment. Approved centre to facilitate access to Headspace toolkit during inpatient stay. Facilities required to be identified through consultation with the Clinical Director Children and Adolescent Mental Health Services. Post-Holder(s) responsible:	Regular analysis	Achieved Achievable	18th Dec 2018 January 2019

		PIC/ Consultant responsible for treatment and care. Clinical Director to contact Clinical Director CAMHS.			
		Preventative Action(s): Individual room allocated as required with continuous observation Post-Holder(s) responsible: ADON and CNM 2	Analysis	Achievable	Depends on child admission

Code of Practice: Admission, Transfer and Discharge

Report reference: Pages 68 & 69

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
37. There was no documentary evidence that all relevant staff have read and understood the admission, transfer, and discharge policies, 9.1.	Reoccurring	Corrective Action(s): Policy dissemination session on admission, transfer, and discharge policies will be held within the approved centre in early 2019. Implemented PPPG signature log register for staff who have read and understood the policy. Post-Holder(s) responsible: Head of Discipline / Members of MDTs.	Review of the PPPG signature log	Achievable	1ST February 2019
		Preventative Action(s): Policy dissemination planner in place for 2019. Post-Holder(s) responsible: CNM3	Analysis of Policy dissemination process	Achievable	January 2019
38. Admission assessments did not include family history, medical history, and current and historic medication, 15.3.	New	Corrective Action(s): Residents are initially assessed on admission followed by a more comprehensive assessment within 7 days of admission. This includes family history, medical history, and current and historic medication. Post-Holder(s) responsible:	Spot check of resident admission assessment completed. Any deficits identified are discussed with the relevant key worker/MDT member.	Achieved. Completed	11th Dec 2019

		Members of the MDT.			
		Preventative Action(s): Plan in place to review the current admission assessment form in early 2019. A annual audit is undertaken to determine compliance to the processes relating to the admission assessment . Post-Holder(s) responsible: Audit Group	Annual audit	Achievable	March 2019
39. The written policy for discharge did not describe procedures for managing discharge against medical advice, 4.15.	New	Corrective Action(s): The existing policy for discharge will be updated to include procedures for managing discharge against medical advice Post-Holder(s) responsible: Policy review Group	Processes agreed by Policy working group.	Achievable	Next policy review meeting scheduled on 29th Jan 2019.
		Preventative Action(s): Policy updated every three years unless indicated by either legislation, change in practices or recommendations from the Mental Health Commission Inspectorate Post-Holder(s) responsible: Policy review Group	Audit is undertaken to determine compliance with review timeframes		March 2019
40. No audit of the implementation of and adherence to the discharge policy was undertaken, 4.19.	Reoccurring	Corrective Action(s): Audit on discharge process completed Post-Holder(s) responsible: Audit Group	Action is completed.	Achieved. Completed	12th October 2018
		Preventative Action(s): 2019 Audit planner in place.	Annual audit	Achievable	March 2019

		Post-Holder(s) responsible: Audit Group			
41. Discharge plans did not include documented communication with the relevant general practitioner/primary care team and/or Community Mental Health team or a reference to early warning signs of relapse and risks, 34.2. 42. There was no evidence of discharge assessments, 34.4. 43. Discharge summaries did not include names and contact details of key people for follow-up or risk issues such as signs of relapse, 38.4.	New	Corrective Action(s): A comprehensive and structured discharge plan is developed as a component of the Individual Care Plan, this includes communication with the relevant general practitioner/primary care team and/or Community Mental Health team and a reference to early warning signs of relapse and risks Amended ICP now includes pre discharge assessment including risk assessment and contact details of key people for follow-up. Post-Holder(s) responsible: CD lead MDT working group	Action is completed.	Achieved. Completed	December 2018
		Preventative Action(s): Regular analysis on discharge process Post-Holder(s) responsible: Audit Group	Annual audit	Achievable	January 2019