Mental Health Commission

Focused Inspection Report

(Mental Health Act 2001)

MENTAL HEALTH SERVICE TYPE	Acute adult mental health care Psychiatry of Later Life Mental health care for people with intellectual disability Mental health rehabilitation
NAME	Department of Psychiatry, Midland Regional Hospital, Portlaoise
IDENTIFICATION NUMBER	AC0030
REGISTERED PROPRIETOR	Health Service Executive
REGISTERED PROPRIETOR NOMINEE	Mr Joseph Ruane
MOST RECENT REGISTRATION DATE	1 March 2014
NUMBER OF RESIDENTS REGISTERED FOR	46
INSPECTION DATE	21, 22, 23 June 2016
PREVIOUS INSPECTION DATE	8, 9, 10 December 2015
CONDITIONS ATTACHED	Yes
LEAD INSPECTOR	Ms Mary Connellan
INSPECTION TEAM	Dr Enda Dooley MCRN 004155 Ms Marianne Griffiths Ms Orla O'Neill Dr Susan Finnerty MCRN 009711
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCRN 009711

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1.0 Mental Health Commission Focused 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.

In addition to the principal function of the Inspector of Mental Health Services under Section 51 of the Mental Health Act 2001 to inspect every approved centre at least once a year (and other mental health services, as appropriate), the inspection may also undertake a focused inspection.

During a focused inspection the Inspector may visit and inspect any premises where mental health services are provided and make a report in writing to the Commission to ascertain whether or not due regard is being had to the Mental Health Act 2001 and its provisions.

2.0 Focused Inspection - Overview

2.1 Overview of the Approved Centre

The approved centre was located within the campus of the Midland Regional Hospital, Portlaoise. The approved centre was registered for 46 beds.

The approved centre consisted of two wards, male and female, which could accommodate up to 24 residents each. At the time of inspection there were 23 beds in each. If either the male or female ward had need to accommodate 24 residents, the other ward would reduce its capacity to 22 residents. Each ward had a high observation bed area where a nurse was present at all times. There were 48 residents in the approved centre, with nine on leave on the first day of the inspection. There were seven detained patients.

Admissions to the unit were coordinated by six community adult mental health teams, one rehabilitation team, one psychiatry of later life team and one intellectual disability team.

At the time of inspection the young adult mental health team had a child resident under their care in the approved centre.

One of the adult mental health teams was the Kildare/West Wicklow team (Naas) who had admitting privileges for up to ten residents. Throughout the inspection there were 11 residents from the Naas service in the approved centre.

The clinical director also had a resident under their care. Therefore, there were eleven teams covering a bed capacity of 46.

2.2 Conditions to Registration

The approved centre currently has a condition attached as follows –

(A) The Mental Health Commission requires full compliance with Article 15 (Individual Care Plan) of S.I. No 551 of 2006; Mental Health Act 2001 (Approved Centres) Regulations 2006.

(B) The Mental Health Commission requires that ongoing clinical audits must be conducted, by appropriately qualified clinical persons external to the approved centre, as a cyclical process to monitor compliance with Article 15 (Individual Care Plan) of S.I. No 551 of 2006; Mental Health Act 2001 (Approved Centres) Regulations 2006 for each in-patient resident of each sector team to ensure improvement has been achieved and sustained. A sectorised report of the results of the ongoing clinical audit, naming each specific sector team, must be submitted to the Commission on 1st April 2014 and on the 1st of each month thereafter.

The report must detail the following: (i) Persons responsible for collecting the data, (ii) Audit criteria (The sample audit tool provided in the MHC Guidance Document on Individual Care Planning may be used), (iii) Outcome of Audit - level of compliance with Article 15, (iv) Quality improvement plan, (v) Implementation dates for the improvement plan, (vi) Dates to repeat the data collection to measure sustainability and/or improvement, and (vii) Methods to communicate the results to key stakeholders.

Review of individual care plans during this inspection indicated that the approved centre remained in breach of this condition.

2.3 Focus of inspection

This was an unannounced focused inspection in which the following areas were inspected against:

Regulation/Rule/Act/Code
Regulation 15 Individual Care Plan
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines
Rules Governing the Use of Seclusion
Part 4 Consent to Treatment
Code of Practice Relating to the Admission of Children under the Mental Health Act 2001

The inspection was undertaken onsite in the approved centre from:

Tuesday 21 June 09:30 to Thursday 23 June 16:00.

2.4 Reason for Focused Inspection

The 2015 inspection report identified areas of concern that included:

Areas of non-compliance in 2015	**Risk rating**	**Findings from inspection 2015**
Breach of a condition of registration with regard to Regulation 15 Individual Care Plan	High	The approved centre was deemed non-compliant with the regulation as the individual care plan (ICP) template structure did not clearly identify the resource or discipline required to deliver an intervention and, in a number of clinical files, the ICP did not reflect the residents' current needs or care. The approved centre was also in breach of a condition requiring full compliance with Regulation 15.
Part 4 of the Mental Health Act 2001	High	The approved centre was in breach of Part 4 of the Act because the consent procedure had not been complied with and the specified form was not completed.
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines	Critical	The approved centre was deemed to be in breach of the requirements of this regulation due to: 1) the inadequacy of policies and practices in relation to medication management, 2) the lack of any audit or oversight mechanism, 3) the inadequacy of the documentation procedure for medication prescription and administration.

Rules Governing the Use of Seclusion	High	The approved centre was deemed to be in breach of the requirements of the rules relating to this section due to: 1) the failure to specify the procedures to be followed should the seclusion of a child be considered necessary 2) the failure to maintain adequate documentary records (the seclusion register was not signed by the responsible consultant) of the monitoring of seclusion, 3) the failure to document policy and procedure for staff training in relation to seclusion. In 16 cases during 2015, the duration of seclusion episodes was in excess of 60 hours.
The Code of Practice Relating to the Admission of Children under the Mental Health Act 2001	High	Since the inspection in June 2014 to December 2015, a total of 21 children had been admitted to the approved centre. The approved centre was not compliant with the code of practice as the facilities were not age-appropriate.

The approved centre was required to provide evidence of the corrective and preventative actions taken to address these areas of non-compliance. Upon review of the evidence provided, the Commission was concerned that these issues had not been addressed. Due to the seriousness of the non-compliant findings a focused inspection was undertaken.

2.5 Summary of Findings from this Inspection

Regulation/Rule/Act/Code	**Compliance**	**Risk rating**
Regulation 15 Individual Care Plan	Non-compliant	Critical
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines	Non-compliant	High
Rules Governing the Use of Seclusion	Non-compliant	Critical
Part 4 Consent to Treatment	Compliant	Not applicable
Code of Practice Relating to the Admission of Children under the Mental Health Act 2001	Non-compliant	Critical

2.6 Initial Meeting with the Senior Management

A meeting was convened with senior managers on the first morning of the focused inspection. All the members of the inspection team were in attendance and a consultant psychiatrist representing the acting executive clinical director, an administrator representing the registered proprietor nominee, the acting area director of nursing, the clinical nurse manager 3 allocated to the approved centre and two assistant directors of nursing, one of whom had specific responsibility for the approved centre (0.5 whole time equivalent) but was based in Lakeview, Naas.

The inspection team set out the parameters of the inspection and sought clarification in related areas. In discussion as to why seclusion rates were high in the approved centre it was suggested by management that the residents who came from the Kildare West Wicklow service may have more acute management and safety needs as there was no high observation unit in their approved centre, Lakeview in Naas. Kildare/West Wicklow had an allocation of ten beds for the approved centre. There was a memorandum of understanding with this service and the bed capacity had increased from six to ten beds since the last inspection.

The inspection team were informed that a multi-disciplinary working group had been convened to develop a new Individual Care Plan template and that this was currently being piloted in the approved centre.

Management confirmed that a pharmacist (0.5 whole time equivalent) had commenced in the service on the week of the inspection.

3.0 Inspection Findings and Required Actions - Regulations

3.15 Regulation 15: Individual Care Plan

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

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

Processes: The approved centre had a policy entitled *Policy and Guideline for Individual Care Planning.* This had been approved December 2014. Roles and responsibilities were set out in the policy with the respective catchment management team referenced as having responsibility 'to ensure individual care planning was in place for all residents in the Department of Psychiatry and that the processes of auditing this are adhered to'. The policy included the provision that a comprehensive assessment should form the basis of the multi-disciplinary team (MDT) care plan. There was provision within the policy for the required content to make up the care plan and this was attached in an appendices. The implementation of the individual care plan (ICP) reviews and updates were included and the policy stated that 'there must be evidence that there is a MDT weekly care plan review being completed'. The policy included the requirement that there was resident involvement in the care plan and that the care plan must be signed by the resident.

The timeframes for assessment planning, implementation and evaluation of the ICP were not included in the policy.

The process for residents' access to their ICP was not described in the policy. However, the policy stated that, if requested, a copy of 'the care plan (Page 1 only)' 'may be given to the resident provided it is copied onto coloured paper other than white, with the names of the healthcare worker involved redacted'. It was unclear why the policy stated that the resident would not have access to the identity of their healthcare worker and, if implemented, it showed a lack of transparency and lack of collaboration with the resident in their care plan.

Training and Education: There was no evidence of a written record indicating that all staff involved in individual care planning had read and understood the policy. A record of attendance at training had been maintained within the approved centre for nursing staff. Records showed that 26 of the 39 nursing staff who worked in the approved centre had completed training in individual care planning. This training was in early 2015 and prior to the introduction of a new care planning template (pilot). Training records for one senior social worker evidenced training in care planning. It was not evident where or when this training had taken place. A Corrective and Preventative Action (CAPA) from the 2015 inspection identified by the service indicated that there was to be ongoing training of all disciplines on ICPs. There was no evidence that this had commenced at the time of the focused inspection.

Monitoring: A CAPA from the 2015 inspection identified by the service was to form a working group to review the ICP template. This was governed by the Inpatient Clinical Governance and Standard Operational Procedures Group. Minutes of meetings presented to the Mental Health Commission (MHC) prior to the inspection and available at the time of the inspection showed that this working group had developed a new ICP template and a new resident weekly expectation form. These were being piloted in the approved centre at the time of the inspection. This working group was multi-disciplinary with representatives from medical, nursing and allied health professionals.

There was evidence that an audit tool was being used to retrospectively audit the processes used for care planning on a monthly basis. The approved centre had a condition attached to its registration that required ongoing clinical audits be conducted by persons external to the approved centre and submitted to the MHC on the first of each month thereafter. This had been achieved.

Evidence of Implementation: A pilot ICP was in use in the approved centre at the time of inspection. The pilot ICP template did not denote goals or resources and was not acceptable as it was not conducive to developing an ICP compliant with this regulation. A new patient experience/expectation form had also been introduced.

There were 48 residents in the approved centre during the focused inspection. All the residents had an initial care plan on admission. The ICPs and clinical files of 32 residents in the approved centre were inspected to include a sample from across the teams and sectors.

Of the 32 ICPs/clinical files inspected, two were compliant with Regulation 15. Three were deemed not applicable as these residents were in the approved centre less than a week and their respective MDT meeting had not been convened. Twenty-seven of the remaining 29 ICPs inspected were non-compliant with Regulation 15.
There was no evidence of MDT input into the development of the ICP for 19 of 29 ICPs. It was unclear the extent of MDT input in two of the ICPs.

Ten residents had not signed their ICP and it was unclear or not evident for 17 residents that they had been involved in their ICP. Ten residents were interviewed during the course of the inspection. One resident was aware of their ICP and had a copy.

Needs were identified in all but two of the ICPs. In two ICPs, the entry on the new template stated ‘see old care plan’ and ‘refer to care plan on admission’.

Twenty-eight of 29 ICPs did not specify resources, i.e. what staff discipline was responsible for intervention. Goals were generally not well framed and were not specified in 13 of the 29 ICPs.
The individual care plan was recorded in one set of documentation for each resident.

Further inspection of the ICPs and clinical files, with reference to the Judgement Support Framework, concluded that overall the ICPs did not provide an overview or strategic account of the care planning requirements, goals and estimated timeframes for discharge for the

residents. Sixteen of 29 ICPs did not address discharge planning. There was no risk assessment in six of the clinical files inspected.

The keyworker role was not evident in practice. It appeared that a key nurse was the person who signed as the keyworker. This named person could change on a daily basis and did not appear to be the coordinator of the care plan. There was no clear evidence that the key worker had discussed the ICP with the resident.

Therefore, it was apparent that not all ICPs gave a picture of current care and treatment needs.

In response to the 2015 inspection, the approved centre had identified CAPAs which have been referenced in both the training and education and monitoring pillars. A further CAPA relating to ICPs was to review team processes in conducting care planning meetings. This was the responsibility of the Inpatient Clinical Governance and Standard Operational Procedures Group. The work of ICP sub-working group was ongoing.

The approved centre was deemed to remain in breach of the requirements of this regulation and remain in breach of the conditions attached to its registration because:

(a) there was no MDT input into the development of 19 ICPs;
(b) not all residents were involved in their ICP;
(c) twenty-eight ICPs did not specify resources; and
(d) resident goals had not been specified in 13 ICPs.

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
			X

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

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

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

Inspection Findings

Processes: There was a policy on Ordering, Prescribing, Storing, and Administration of Medicines. It had been developed by the procedure committee and approved by the senior management team for the Department of Psychiatry, Laois/Offaly, Dublin Mid-Leinster in May 2016.

The revision of the policy had addressed specific anomalies identified in the 2015 inspection and were part of the Corrective and Preventative Action (CAPA) relating to this regulation. This included:

- Administration of controlled drugs
- Administration of medication in crushed form
- Processes for when a resident refuses medication
- Procedures for managing medication errors
- Processes for medication review
- Monitoring procedures

Self-administration of medication was not included in the revised policy. The policy included Administration of Medicines to Involuntary Patients if the resident/patient is either unable or “unwilling” to give such consent. Management were informed by the inspectorate that this needed to be urgently rectified, as there had been an amendment to the Mental Health Act, removing the word “unwilling” from section 59 and 60 of the Act.

Training and Education: Nursing staff had completed in-house training in medication management. There was documented evidence that 27 nursing staff had completed this training since the last inspection. The associated CAPA from the 2015 inspection had stated that this training was to be ongoing. Records at the time of inspection showed that this had been delivered on two dates in December 2015 and 13 nursing staff remained outstanding.

There were no records available to indicate if medical staff had received training in medication management for the approved centre. This had been identified as a corrective action from the 2015 inspection report.

Monitoring: No audits had been completed on any process relating to medication management. The approved centre had recruited a pharmacist since the last inspection. That person had commenced employment in the service on the week of the inspection.

The approved centre had stated that part of the role and responsibility for the pharmacist was to develop audits pertaining to the process regarding medication.

Evidence of Implementation: Medication Prescription and Administration Records (MPARs) had been developed and introduced since the last inspection. This had been a CAPA identified and implemented from the 2015 inspection. This was reported by staff to the inspectors as a welcomed document. It was in a booklet format and contained an addressograph section, photograph section, personal particulars to include status section, drug allergy and food allergy sections and an adverse reaction section. There was a signature log at the back of each booklet. There was a separate box for the Medical Council Registration Number (MCRN) beside the signature for the prescribing doctor.

The MPARs of 45 residents were reviewed by the inspectorate and included all the residents in the approved centre and those on leave that were available to the inspector. Five MPARs did not have the generic name for all the medications prescribed.

All prescriptions were legible and included frequency, dose, route and start and stop date, where applicable. Fourteen of the MPARs did not contain the required MCRN of the prescribing doctor. Twelve did not have the allergy section completed.

The approved centre was deemed to still be in breach of the requirements of this regulation because:

(a) The MCRN had not been recorded in all the prescriptions;
(b) The section in the policy on Administration of Medicines to Involuntary Patients contained the process for giving medication to patients who were in hospital for more than three months if the patient was 'unwilling' to give such consent.

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
		X	

4.0 Inspection Findings and Required Actions - Rules

4.1 Section 69: The Use of Seclusion
Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient".

Inspection Findings

Processes: The approved centre had a policy pertaining to seclusion. It had been reviewed and approved annually, most recently May 2016. The policy included a section which identified who may carry out seclusion, a section which included the provision of information to the patient and a section that detailed how the approved centre attempted to reduce the use of seclusion, where applicable. The policy covered the use of refractory clothing.

There was a section within the policy for staff training in relation to seclusion. This included who was to receive training and the areas to be addressed within the training programme. The policy did not include the frequency of the training or the identification of appropriately qualified person(s) to give the training. The mandatory nature of training for those involved in seclusion was included in the policy. The service had submitted Corrective and Preventative Actions (CAPAs) in relation to updating the policy to include refractory clothing and staff training following the 2015 inspection.

There was a policy regarding the use of Closed Circuit Television (CCTV) in the approved centre.

A policy on seclusion of a child with input from Child and Adolescent Mental Health Services (CAMHS) was to have been prepared as a CAPA following the 2015 inspection. This was outstanding at the time of the focused inspection.

Training and Education: There was no evidence of a written record indicating that all staff involved in the use of seclusion had read and understood the policy. A record of attendance at training had been maintained within the approved centre for nursing staff and non-consultant hospital doctors. Records showed that 17 of the 39 nursing staff who worked in the approved centre had up-to-date training in either Non-violent Crisis Intervention training (CPI) or Prevention and Management of Violence and Aggression (PMVA). The approved centre had adopted the later model for nursing staff going forward. Twelve non-consultant

hospital doctors had received training in Management of Actual or Potential Aggression (MAPA) since the last inspection. One social worker who worked on the psychiatry of later life team had completed CPI training. Training records for all other staff were not available to the inspectorate at the time of the inspection.

Monitoring: No annual audit and analysis of seclusion had been completed by the approved centre. A review of incidents reports was undertaken by the inspection team. Less than 20% of seclusion episodes were reported as incidents within the approved centre. A review of incident reports had also indicated where alternatives to seclusion had been considered and de-escalation had been used effectively.

The Mental Health Commission data collection template, with summary information on the use of seclusion in the approved centre, was available to the inspection team. When this was cross referenced with the clinical practice books and clinical records two names were noted to have not been included with the summary information.

The inspection team requested a copy of the complaints log for the approved centre for the year to date. One complaint concerned a seclusion episode for the complainant among other dissatisfactions. This had been investigated and the complainant informed of findings and appeals process.

Evidence of Implementation: There were three seclusion rooms in the approved centre; two in the male unit and one in the female unit. Bathroom facilities were opposite the seclusion room and staff indicated that they used mobile screens to facilitate residents' privacy and dignity when using the bathroom from seclusion. The seclusion rooms had been adequately cleaned at the time of inspection.

CCTV was used to monitor the three seclusion rooms. This did not replace the provision of Section 5 '*The Monitoring of a Patient During Seclusion'* where patients placed in seclusion were kept under the direct observation by a registered nurse for the first hour following initiation of a seclusion episode, as required by these Rules. There were no facilities to record images and monitoring was by authorised nursing staff within the respective nursing offices.

There had been 52 separate episodes of seclusion since the last inspection on 8-10 December 2015. This pertained to 18 male and nine female residents, 33 and 17 episodes respectively. The registers for all the seclusion orders were inspected. The registers were cross referenced with the clinical files for 15 of the residents.

Seclusion was initiated when the resident posed an immediate threat of serious harm to self or others.

Nine individuals had prolonged episodes in seclusion that were notified to the MHC ranging from 80 hours to 576 hours and 30 minutes. All episodes of seclusion lasting more than 72 hours were notified to the Mental Health Commission.

The general principle in the Rules that seclusion is not prolonged beyond the period which is strictly necessary to prevent immediate and serious harm to the patient or others was not adhered to in all episodes of seclusion. One resident in seclusion was described as "pleasant and engaging" and the treating consultant psychiatrist had recommended the

ending of seclusion and initiation of an alternative management plan. The consultant psychiatrist expressed serious concern in the clinical file that the patient had been in seclusion for this length of time. However, seclusion continued for a further 19 hours. This patient had been in seclusion for more than 240 hours and stated to his consultant psychiatrist that he was in seclusion for 10 days and "even in jail I'd get out for exercise". Another patient continued in seclusion for 12 hours after he was described as "not aggressive or agitated" with no reason as to why seclusion was extended.

It was documented in the clinical file for one patient in seclusion that they "did not express remorse for earlier actions, to remain in seclusion". The next entry, over two hours later, stated that the same patient "expressed remorse for earlier actions. Seclusion discontinued". Other patients were described as "sullen in manner"; "demanding"; "unremorseful"; "continues to show no remorse for her actions"; "refusing to accept responsibility". Expressing remorse for incidents that occurred during a period of severe mental illness must not be a requirement for ending seclusion. To do so is ethically unacceptable and excessively coercive.

One resident, who was interviewed by the inspection team stated that they had spent 12 days in seclusion. They stated that they did not come out of seclusion in that time, did not have a shower and that visitors were not allowed. They said the window blinds were never opened and they cried themselves to sleep.

Three renewal of seclusion orders had not been dated by the consultant psychiatrist responsible for the care and treatment of the patient. One seclusion order had not been signed by the consultant psychiatrist responsible until seven days later. One initial seclusion order had not been placed in the resident's clinical file. Three clinical forms and documentation showed no evidence of notification of next of kin.

The approved centre was deemed to still be in breach of the requirements of the Rules on the Use of Seclusion because:

(a) three residents had prolonged seclusion beyond what was strictly necessary (section 1.3);
(b) the extension and ending of seclusion was based on ethically unsound principles by requiring "remorse" as a prerequisite for ending seclusion (1.4);
(c) there continued to be deficits with required document recording (sections 6.2, 9.3 3.7);
(d) not all staff involved in seclusion were up to date with mandatory training (section 11); and
(e) two names of patients who were secluded were noted to have not been included with the summary information requested by the MHC (10.4).

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
			X

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

5.1 Part 4: Consent to Treatment

56.- *In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –*

(a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

(b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. - *(1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.*

(2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – *Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-*

(a) the patient gives his or her consent in writing to the continued administration of that medicine, or

(b) where the patient is unable to give such consent –

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

61. – *Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –*

(a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

(b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

Inspection Findings

Four patients were in the approved centre for longer than three months and receiving medication. Those clinical files were reviewed by the inspection team. Four patients did not consent to treatment and an assessment of capacity had been completed and documented for each patient. *Form 17 Administration of Medication for More Than 3 Months Involuntary*

Patient (Adult) - Unable to Consent had been completed within the timeframe and a copy of these were in each respective clinical file. All had documented consideration of capacity by both the responsible consultant psychiatrist and the second opinion consultant psychiatrist. There was a written record of the specific medications prescribed and a written record of the information provided to each patient. For two patients this was explained orally as deemed appropriate for those patients. There was a written record detailing that treatment was in the respective patient's best interest.

The associated Corrective and Preventative Actions from the 2015 inspection had been completed by the approved centre.

The approved centre was deemed compliant for Part 4 Consent to Treatment.

	Compliant	Non-Compliant
Compliance with Part 4	**X**	

6.0 Inspection Findings and Required Actions – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)
Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services".

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

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

6.1 Admission of Children

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

Processes: The approved centre had a policy and procedures in place relating to the assessment and admission of a child '(16-18 years)'. This had been developed and approved in July 2013 and was due for revision in July 2016. The policy outlined the decision to admit a child to the approved centre was to be made by a consultant psychiatrist following a full assessment, including assessment of risk by the non-consultant doctor on duty. There were procedures in place with regard to family liaison, parental consent and confidentiality. There were procedures in place to identify the person responsible for notifying the Mental Health Commission (MHC) of all children admitted to the approved centre within 72 hours of admission.

Training and Education: There was an identified child and adolescent consultant psychiatrist for the approved centre. Records made available to the inspectors showed one social worker had attended Children First training in 2015. Twelve of 39 nursing staff had completed Children First training on dates prior to the last inspection. Training in Children First Policy had been an identified Corrective and Preventative Action (CAPA) relating to this Code of Practice from the 2015 inspection. There was no evidence that this had commenced at the time of the focused inspection.

Monitoring: There had been eight child admissions to the approved centre since the last inspection. Each of these had been notified to the MHC, both on admission to and on discharge from the approved centre. There was no evidence of audit or analysis relating to

the admission of children to the approved centre. There was no annual report on the admission of children to the approved centre.

Evidence of Implementation: There had been eight child admissions to the approved centre that were representative of seven individuals since the last inspection in December 2015. This was comparable to the number of children in 2015 where there had been 16 child admissions to the approved centre. The average length of stay was 3.8 days; ranging from 1 day to 13 days. Two individuals were from outside the catchment area, the remaining from the Laois/Offaly area. Four of the eight admissions were transferred to a child and adolescent unit when a bed became available. This included one of the individuals who was from outside the catchment area. The remainder were discharged.

The inspection team reviewed all the clinical files for the children that had been admitted to the approved centre since December 2015. All had been admitted under exceptional circumstances or emergency basis and appropriate facilities were sought as soon as possible. This had been an identified CAPA following the inspection in December 2015.

All the children were under the care of a child and adolescent psychiatrist while in the approved centre. Two children had been referred to the approved centre for admission by other child and adolescent psychiatrists from their respective community teams.

One child was nursed, as per the approved centre's policy, in a single room. A 1:1 nursing special was provided for the care of this individual. The remaining children were nursed in the high observation bed area with other adult residents. The inspectors had been informed by clinical nurse managers in both the male and female wards that the practice was to care for children in single rooms, if at all possible, as outlined in the above mentioned policy. This had not happened for seven of the eight admissions reviewed.

Under 2.5 of the code of practice the following findings were made:

(a) The approved centre had polices and protocols in place relating to the admission of a child. This included the provision of a single room which had not been adhered to for seven admissions.

(b)There were no age appropriate facilities or programmes of activities appropriate to age and ability provided.

(c) Provisions were not in place to ensure the safety of the child and to respond to the child's special needs in an adult setting. Children were cared for in a high observation dormitory with adult residents. There was a nurse present in the high observation area at all times but this nurse was also caring for all the other residents in high observation at the time. Should there be an emergency with other residents, the child would be unobserved. There was no 1:1 nursing of children in the high observation area.

(d) Accommodation was designated by gender. Staff did acknowledge gender sensitivity and there was consideration in this regard in the delivery of care.

(e) Not all staff had received training relating to the care of children.

(f) There was no reference in the clinical files to arrangements for the continuation of the child's education.
However, all the children that had been admitted since the 2015 inspection had been transferred to another age-appropriate facility if not discharged after one night.

(g) The advocacy network did attend the approved centre. There was no provision for age appropriate advocacy services.

(h) Children had their rights explained to them and information about the ward and facilities was provided.

(i) There was evidence from the clinical files that all the children had had a risk assessment as was the policy in the approved centre.

(j) There was a child and adolescent psychiatrist based in the Young Adult Mental Health Service (YAMHs), St Fintan's Hospital, Portlaoise, who had admitting privileges for the approved centre, and who managed the care and treatment of all children who were admitted.

(k) Visiting times were publicly displayed and a review of the clinical files indicated flexibility with the parents of children in the approved centre.

(l) There was a policy and procedures in place with regard to family liaison, parental consent and confidentiality.

(m) The MHC had been notified of all child admissions and discharges within 72 hours.

Under 3.2 of the code of practice the following findings were made:

All the children who had been admitted since the previous inspection were voluntary and, where applicable, parental consent was sought and documented. The clinical file of a child who had been admitted previous to the last inspection under the Mental Health Act 2001, Section 25 (10) was reviewed. All legal requirements had been fulfilled.

The approved centre was deemed to still be in breach of the requirements of this Code of Practice because it was non-compliant with section 2.5 as listed above, specifically:

(a) provisions were not in place to ensure the safety of the child and to respond to the child's special needs in an adult setting as there was no 1:1 nursing and the child was in a dormitory with other adult residents;
(b) there were no age appropriate facilities or programmes of activities appropriate to age and ability provided; and
(c) there was no provision for age appropriate advocacy services.

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
			X

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016

Completed by approved centre: Department of Psychiatry, Midland Regional Hospital **Date submitted:** 4 November 2016

For each finding of non-compliance the registered proprietor provided a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.

Regulation 15: Individual Care Plan

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

Date received	*4th November 2016*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1.Corrective Action:- In response to the Focused Inspection, the old individual care plan was amended/modified to reflect the comments and feedback from the MHC. The new ICP was introduced through an ICP replacement programme for all residents in the Department of Psychiatry over the weekend 27th – 28th August 2016. Further modifications were implemented in Version 5 of the ICP dated 12th October 2016.These modifications included the insertions of sections to capture the resource requirements and patient goals.	1. No MDT input into the development of 19 ICP's. 2. Not all patients were involved in their ICP 3. 28 ICP's did not specify resources 4. Resident goals had not been specified in 13 ICP's	Weekly / Monthly Audits. External support provided to review documentation, provide advice and training for staff and audit compliance with the regulation.	In place	Weekly/Monthly

Post-Holder(s): ECD/Heads of Service / MDT		The Executive Clinical Director (ECD) has met with each Consultant led team to ensure a consistent approach across all sectors.		
2. Corrective Action:- ICP policy reviewed on 24th & 25th September 2016 to reflect the changes in the ICP documentation. Post-Holder(s): Heads of Service / CNMIII & CNMII	1. Timeframes for assessment, planning, implementation & evaluation of the ICP were not included in the policy. 2. The process for resident's access to their ICP was not described in the policy. 3. The resident to have access to the identity of their healthcare worker 4. A written record indicating that all staff involved in the ICP had read and understood the Policy.	ICP policy was reviewed and signed off for implementation by the Senior Management Team on the 28th September 2016. This policy is now live and actively in use by all staff.	Completed 28th September 2016	Completed

3. Corrective Action: Training in relation to ICP development and documentation has been delivered to members of the MDT Post-Holder(s):Heads of Service/ CNMIII/ CNMII/ Practice Development Co-Ordinator/ External Provider	1. No MDT input into the development of 19 ICP's. 2. Not all patients were involved in their ICP 3. 28 ICP's did not specify resources 4. Resident goals had not been specified in 13 ICP's 5. No evidence of on-going ICP training as suggested in the CAPA from 2015	ICP Training delivered by internal & external providers to all grades of staff including; Consultants, NCHDs, MDT members and nursing grades. The training was provided on the following dates: 18/08/2016 (38 Staff) 30/09/2016 (35 staff) 3/10/2016 (26 staff) 4/10/2016 (18 staff) 6/10/2016 (8staff) 7/10/2016 (32 staff) 11/10/2016 (17 staff) 12/10/2016 (14 staff) 13/10/2016 (7 staff) To provide assurance of the carryover of the change in practice in the creation and implementation of ICPs, the external support has provided 1:1 mentoring	Training sessions as outlined in previous column have been Completed. Further ICP training scheduled to provide ongoing access to education and awareness of the ICP process.	Training scheduled up to 31st December 2016.

		sessions with 3 Consultants and their MDT members upon their request. There is also informal ongoing consultations with all staff on the wards. In addition, training was provided by Clinical Risk Advisors from the States Claims Agency on "Documentation and Recording in Clinical Practice, Implications for Quality & Patient Safety. (111 staff attended this training.) Training records available		
4. Corrective Measure: All residents cases are reviewed on a weekly basis by the Consultants and team co-ordinator with the key-worker and available MDT members. As of the week of 19th September 2016, all members of the MDT have been instructed of the requirements to document all care/interventions in the ICP document by the Heads of Service. DON & Consultants to process map an MDT meeting	1. No MDT input into the development of 19 ICP's. 2. Not all patients were involved in their ICP 3. 28 ICP's did not specify resources	Weekly / monthly audits are being carried out on the ICP documents and the most recent audits by the external assistance have shown the Resident & MDT involvement in the ICP and significant improvement in all	Weekly / Monthly audits	Weekly / Monthly audits until end of December 2016. Frequency to be reviewed end of December 2016.

Post-Holder(s): Heads of Service/ ADON/ Redeployed Senior Nurse for Quality & Improvement Project.	4. Resident goals had not been specified in 13 ICP's	aspects of the audit process. A single audit tool for use in CHO 8 has been agreed and introduced. This will provide consistency and reliability in measurements.		To be completed in November 2016
5 Corrective Measure: Where a client need is identified for any input of MDT who are not available to attend the MDT meeting, a referral form is completed and the identified need is prioritised with the resident being reviewed in the approved centre Post-Holder(s):Head of Mental Health Service CHO 8 A resource section has been added to the current ICP form since 28th August 2016. All staff have been briefed about the requirement to complete this section of the ICP	1. No MDT input into the development of 19 ICP's 2. 28 ICP's did not specify resources	MDT resources put in place includes OT Maternity leave cover from 26/09/2016, and the utilisation of existing Psychology & Social work resources to provide inputs to ICP. All of the above is reflected in regular audits and any incidence of unmet MDT need is documented in the ICP.	Weekly / Monthly audits	Weekly / Monthly audits until end of December 2016. Frequency to be reviewed end of December 2016.

Post-Holder(s): CNMIII / Practice Development Co-Ordinator / External provider				
6 Corrective Action: Each resident is provided with an admission pack on admission which comprises of their ICP, a Patient Expectation sheet (reviewed weekly), Patient information leaflet for ICP, a welcome pack, Mission Statement for Department of Psychiatry, Philosophy of care, Key information sheet, Recovery programme timetable,, Quality of care Questionnaire, a copy of the Mental Health Act 2001. Post-Holder(s): Key worker, MDT	1. Not all patients were involved in their ICP	Residents can acknowledge their involvement in their ICP through written or verbal interaction and they will be given the opportunity to sign their ICP. This opportunity is regularly reviewed and continuous efforts are made by staff to engage the resident in their ICP. A resident's refusal to sign the ICP is documented. The Patient Expectation Sheet is reviewed weekly to encourage the resident to set personal goals. . A poster has been placed in a prominent position on both the male and female	Weekly / Monthly audits	Weekly / Monthly audits until end of December 2016. Frequency to be reviewed end of December 2016.

		wards which explains the ICP process and encourages residents to participate and become informed.		
Regulation 23: Ordering, Prescribing, Storing and Administration of Medications				
The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation: ***(Note to Approved Centre: Please submit CAPAs by completing the table below)***				
	(Please record date received – to be completed by Mental Health Commission)			

CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1.Corrective Measure:- The word "unwilling" has been replaced by "unable" in the Medication Management Policy A new medication Management Policy has been approved by the Drugs & Therapeutics Committee Post-Holder(s):Chief Pharmacist / MDT/ ADON	The word "unwilling" to give consent to be removed from the policy document as per amendment to the Mental Health Act	New Medication Management Policy implemented in practice. Signature sheet in place to acknowledge that the MDT have read and understood the policy	Completed	Completed
2.Corrective Measure:- Pharmacy staff have completed a number of audits of medication management incorporating the key performance indicators from the Judgement Support Framework document Post-Holder(s): Senior Pharmacist/ ECD/ DON	14 of the MPAR's did not contain the required MCRN of the prescribing doctor.	A Pharmacist has been made available to the DOP 3 days per week. This will increase to a full time post on the 1st December 2016 Regular live auditing has been commenced by the pharmacist on a weekly basis and is circulated to inform MDT meetings.	Full time Pharmacist in place by the 1st December 2016	Ongoing weekly audits

			Weekly audits commenced 13th September 2016	
3 Corrective Measure: Training in medication management has been provided for nursing and medical staff. Post-Holder(s): Consultants/ DON/ Senior Pharmacist Weekly assessment of medication kardex's by senior clinicians' at the ward rounds Post-Holder(s):Consultants A Drugs & Therapeutics Committee has been established. Terms of Reference have been developed and approved. The D&T committee will report on a monthly basis to the Q&S Committee. Post-Holder(s): MDT Incident reports completed on any identified medication errors Post-Holder(s): MDT	14 of the MPAR's did not contain the required MCRN of the prescribing doctor.	Training: 30/09/2016 (41 staff) 11/10/2016 (7 staff) 13/10/2016 17/10/2016 Weekly audits Minutes of meetings held on 27/09/2016 11/10/2016 25/10/2016 Training provided for staff on Incident reporting	Training attendance records available Training sessions as outlined in previous column have been Completed. Weekly audits commenced 13th September 2016 Monthly analysis of incident reports provided to Q&S meeting and D&T committee	Training scheduled up to 31st December 2016. Ongoing weekly audits Monthly analysis of medication incidents.

Section 69: The Use of Seclusion				

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation: ***(Note to Approved Centre: Please submit CAPAs by completing the table below)***				
Date received	*(Please record date received – to be completed by Mental Health Commission)*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1. Corrective Action:- A Policy on the Use of Seclusion has been updated to include provision for the frequency of training and identifies appropriately qualified persons to deliver that training. The policy will include a section on the seclusion of a child. Post-Holder(s):ADON / MDT	Three residents had prolonged seclusion beyond what was strictly necessary (Section 1.3) The extension and ending of seclusion was based on ethically unsound principles by requiring “remorse” as a prerequisite for ending seclusion (1.4) There continued to be deficits with required document recording (Sections 6.2, 9.3 &	New use of seclusion policy developed. Signature sheet in place to acknowledge that the MDT have read and understood the policy	In place	Complete

	3.7) Two names of patients who were secluded were noted to have not been included with the summary information requested by the MHC			
2.Corrective Action:- Daily review of seclusion orders by second Consultant Psychiatrist. All terminology and decision making is in line with best practice. Training was provided by Clinical Risk Advisors from the States Claims Agency on "Documentation and Recording in Clinical Practice, Implications for Quality & Patient Safety. (111 staff attended this training.) Training records available Post-Holder(s):Consultants / Use of Seclusion Audit group	As above	A Use of Seclusion audit on a monthly basis to include each episode of seclusion. A Use of Seclusion checklist has been developed in line with the Rules of the Use of Seclusion and implemented. Oversight is provided by a second Consultant Psychiatrist and an Assistant Director of Nursing.	Monthly seclusion audit	Monthly audit

		Training records are available		
3 Corrective Action: Seclusion training provided for all staff Post-Holder(s):Consultants/DON/ADON	Not all staff involved in seclusion were up to date with mandatory training (Section 11)	Training provided on: 25/07/2016 (12 staff) 09/08/2016 (12 staff) 07/10/2016 (24 staff)	Training attendance records available Training sessions as outlined in previous column have been Completed	Further dates planned up to end of December 2016 14/15/16th Nov 2016 12/13/14th Dec 2016.
4 Corrective Action: Management of the Use of Seclusion is a standing item on the agenda for all meetings in the Department. Post-Holder(s):Chairperson of meetings An incident report is completed for every episode of seclusion. Post-Holder(s):CNMIII/ ADON/ Risk & Patient Safety Advisor A seclusion Project group has been formed and tasked with developing an audit tool, examining the use of seclusion on an on-going basis to ensure compliance		Minutes of meetings Monthly analysis of incident forms provided at Q&S Committee Audit of Seclusion episodes done from 1st Jan – 30th Sept 2016.	In place In place	Complete Incident analysis provided on a monthly basis Monthly audit of seclusion

and developing the processes required to submit an annual report on seclusion to the MHC Post-Holder(s): Seclusion audit group		A significant reduction in the use of seclusion is evidenced since the 22nd September 2016 by the fact that there has only been 2 episodes of seclusion of half an hour and three and half hours duration respectively. Both of these episodes displayed 100% compliance with the Rules Governing the Use of Seclusion.	Results of Audit provided to the Senior Management Team and discussed at section meetings	

Admission of Children

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

(Note to Approved Centre: Please submit CAPAs by completing the table below)

Date received	*(Please record date received – to be completed by Mental Health Commission)*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1. Corrective Action:- All children admitted to a single room with 1:1 nursing care	Provisions were not in place to ensure the safety of the child and to respond to the child's special	Audit of Child admissions since June 2016 shows all admissions were	In place	Complete

Post-Holder(s):ADON	needs in an adult setting as there was no 1:1 nursing and the child was in a dormitory with other adult residents.	placed in a single room with 1:1 nursing supports in place. Children are not routinely admitted to the DOP Portlaoise. All appropriate options available to the child are exhausted in the first instance this includes: 1) consultation with a community CAMHS Consultant and the ECD to assure that all out patient solutions have been exhausted; 2) immediately seeking a bed in a specialist child facility		
2. Corrective Action Childrens First training provided for the MDT Post-Holder(s): YAHMS/CAHMS Consultants/ Social Worker/ Nursing Administration	No evidence of training commenced	Training provided on: 12/09/2016 27/09/2016 3/10/2016 13/10/2016. Attendance records available. Current	Training attendance records available Training sessions as outlined in previous column have been Completed	Further dates planned up to end of December 2016

		status is 50% attendance rate. 100% compliance by February 2016.		
3. Corrective Action:- A list of the activities/facilities available in the Department of Psychiatry which are child appropriate have been collated by CAHMS/YAHMS Social worker. Post-Holder(s): Social Worker/CNMIII	There was no age appropriate facilities or programmes of activities appropriate to age and ability provided.	Copy of the list of activities/facilities available in DOP which are child appropriate are available in the Department	In Place	Complete
4. Preventative: Service contacted Bernardos / Citizens Information Service & Irish Advocacy Network re provision of age appropriate advocacy service	There was no provision for age appropriate advocacy services	There does not appear to be any age appropriate advocacy services available in Ireland at this time. As an interim solution appropriate access to CAMHS Social Work service is available.		