Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	Elm Mount Unit
IDENTIFICATION NUMBER	AC0004
APPROVED CENTRE TYPE	Acute Adult Mental Health Care Psychiatry of Later Life Mental Health Care for people with Intellectual Disability Other
REGISTERED PROPRIETOR	HSE
REGISTERED PROPRIETOR NOMINEE	Ms Martina Queally
MOST RECENT REGISTRATION DATE	1 March 2014
NUMBER OF RESIDENTS REGISTERED FOR	39
INSPECTION TYPE	Unannounced
INSPECTION DATE	18,19 and 20 April 2016
PREVIOUS INSPECTION DATE	13, 14 August 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Dr Fionnuala O'Loughlin MCRN 008108
INSPECTION TEAM	Ms Mary Connellan
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCRN 009711

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1.0 Mental Health Commission 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, and
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 shall 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 shall 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 shall be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgment 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. 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, realistic, achievable 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 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

The approved centre was located in St Vincent's University Hospital in Dublin 4. It was opened in 2005 and replaced an earlier psychiatric unit in St Vincent's; it provided acute mental health and psychiatry of later life care to residents of the catchment area.

The approved centre was situated towards the rear of the hospital and entrance was at ground level. It was laid out over two floors and divided into three sections: Elm Mount Upper – 20 beds; Elm Mount Lower – 14 beds; and Psychiatry of Old Age Ward – 6 beds. Entrance doors to the unit were unlocked, except for the Psychiatry of Old Age Ward. Three of the beds in Elm Mount Lower were designated beds for the treatment of residents with an eating disorder; the service for eating disorders was a national facility and was not limited to the catchment area.

At the time of inspection, there were 36 residents in the approved centre, thirteen of whom were detained patients. One resident was a Ward of Court and one patient was absent without leave; one resident was on extended leave.

2.2 Conditions to Registration

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

2.3 Governance

The governance structure for the approved centre spanned two distinct services, i.e. St Vincent's University Hospital and the HSE Community Healthcare Organisation (CHO) 6. The inspection team found a lack of clarity in some aspects of governance as a result of this dual system of governance. In some instances, activities of the approved centre were governed by both services, for example, the area of risk management. In other areas they were separate; for example, in the area of staffing, where some staff were employees of St Vincent's University Hospital and some were HSE employees. There were corresponding difficulties in ascertaining some training records, as they were held separately.

The inspection team was provided with minutes of recent CHO area executive management team (EMT) meetings. The EMT group was composed of senior clinicians including the executive clinical director, the area director of nursing and heads of discipline for health and social care professionals; one member of the EMT was a service user representative. The EMT was responsible for the whole CHO 6 area and issues addressed in the meetings were not specific to Elm Mount. The implementation of a completely tobacco free campus was highlighted as an issue in the approved centre.

2.4 Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against, as applicable to this approved centre.

The inspection was undertaken onsite in the approved centre from:

18 April 2016 09:30 to 17:00
19 April 2016 09:00 to 17:00
20 April 2016 09:00 to 16:00

2.5 Non-compliant areas from 2015 inspection

The previous inspection of the approved centre on 13 and 14 August 2015 identified the following areas that were not compliant:

Regulation/Rule/Act/Code	Inspection Findings 2016
Regulation 21 Privacy	Non-compliant
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines	Compliant
Regulation 26 Staffing	Non-compliant
Regulation 30 Mental Health Tribunals	Compliant
Regulation 32 Risk Management Procedures	Non-compliant
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	Non-compliant
Code of Practice on the Use of Physical Restraint in Approved Centres	Non-compliant

2.6 Corrective and Preventative Action plan

The approved centre was required to submit details of Corrective and Preventative Actions (CAPAs) to address areas of non-compliance as a result of the inspection of 2015. In all, there were seven areas of non-compliance requiring CAPAs. The inspection team assessed the actions taken by the approved centre to implement the CAPAs submitted by the service following the 2015 report.

CAPAs in relation to Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines and Regulation 30 Mental Health Tribunals had been implemented.

The implementation of CAPAs in relation to Regulation 21 Privacy, Regulation 26 Staffing, Regulation 32 Risk Management Procedures, Code of Practice on the Use of Physical Restraint and Code of Practice on the Admission of Children had not been completed at the time of inspection, despite the service reporting that these CAPAs had been completed. The timeframe for completion had been exceeded.

2.7 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 7 Clothing	Low
Regulation 13 Searches	Low
Regulation 15 Individual Care Plan	Low
Regulation 21 Privacy	Low
Regulation 26 Staffing	Moderate
Regulation 31 Complaints Procedures	Moderate
Regulation 32 Risk Management Procedures	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	Moderate
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	High
Code of Practice on Deaths and Incident Reporting	Low
Code of Practice on Admission, Transfer and Discharge	Low

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.

2.8 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 5 Food and Nutrition
Regulation 6 Food Safety
Regulation 20 Provision of Information to Residents
Regulation 22 Premises
Regulation 24 Health and Safety
Regulation 29 Operating Policies and Procedures

2.9 Areas not applicable

The following areas were not applicable as the rule, regulation, code of practice or Part of the Mental Health Act 2001 was not relevant to this approved centre at the time of inspection.

Regulation/Rule/Act/Code
Regulation 25 Use of Closed Circuit Television
Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint
Code of Practice on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

2.10 Areas of good practice identified on this inspection

- Two wards, Elm Mount Upper and Lower, were unlocked and residents were free to come and go as they wished, depending on clinical status.
- Two full-time occupational therapists provided a programme of activities which were accessible by all residents.
- The ECT facilities were excellent and the approved centre operated as a centre for training in the area of ECT. Elm Mount, in collaboration with University College Dublin, had been instrumental in the development of a higher level course of study in UCD and facilitated the teaching principles of ECT for that course.

2.11 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.

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

There were no patients on approved leave at the time of inspection.

2.13 Resident Interviews

Residents were invited to speak with the inspection team. A poster indicating the presence of an inspection team in the approved centre and identifying a time and date for discussion was displayed in the approved centre during the inspection.

The inspection team met with four residents. Two residents were unhappy with the food provided but confirmed that a choice of food was available. One resident highlighted the lack of privacy in making a phone call and two residents referred to the change in key worker on a daily basis. Another resident reported that they found the staff to be excellent and the admission process very good.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	19	2	1	22
	Involuntary Patients	13			13
	Wards of Court	1	0		1
DAY 2	Voluntary Residents	19	2	1	22
	Involuntary Residents	13			13
	Wards of Court	1	0		1

DAY 3	Voluntary Residents	20	2	1	23
	Involuntary Patients	13			13
	Wards of Court	1	0		1

2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection and members of the senior management team were invited to attend. The meeting provided an opportunity for the inspection team to give feedback on the initial findings of the inspection and to seek clarification on some matters. Issues which were clarified included the identity of the person with overall responsibility for managing risk in the approved centre and the use of security personnel in physical restraint, including a policy on the use of security personnel within the approved centre. At the meeting, the business manager identified himself as the risk manager. In relation to a policy on the use of security personnel, the inspection team was informed that the use of security personnel was included in the policy on physical restraint, but this had not been addressed as yet.

The attendees at the feedback meeting were:

- Area director of nursing
- A consultant psychiatrist (representing the clinical director)
- Business manager (representing the registered proprietor)
- Assistant director of nursing (Elm Mount)
- CNM3 ECT department
- Nurse practice development coordinator
- Principal clinical psychologist
- Principal social worker
- CNM2 (Elm Mount)
- CNM2 liaison psychiatry
- Clinical nurse specialist (Psychotherapy)
- Occupational therapist
- CNM2 Psychiatry of Old Age

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

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

Inspection Findings

Processes: There was a policy in place on the identification of residents. The policy identified the roles and responsibilities and specified the use of two identifiers prior to administration of medication or therapeutic services. The policy did not address a procedure for identification of same or similar name residents.

Training and Education: Staff were familiar with the policy and the requirement to use two identifiers for residents.

Monitoring: The clinical nurse manager (CNM) carried out a weekly audit of the use of wristband identifiers, but no annual audit was conducted.

Evidence of Implementation: Residents wore wristbands for identification. Medication prescription booklets had resident names and dates of birth. Stickers to highlight same or similar name residents were applied to the medication booklets to alert staff to the requirement to ensure identification.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of the Judgement Support Framework.

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

3.5 Regulation 5: Food and Nutrition

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

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

Inspection Findings

Processes: There was a policy on food and nutrition which outlined the responsibilities for the management of food within the approved centre. The policy specified the assessment of dietary and nutritional status, as required.

Training and Education: Relevant staff were aware of the policy on food and nutrition and had read and understood the policy.

Monitoring: Menu plans were reviewed on a regular basis and a Nutrition Committee (joint with St Vincent's University Hospital) reviewed options on the menu cycles.

Evidence of Implementation: Menus were reviewed by the catering staff with the dietician to ensure a balanced diet was provided to residents. Food was prepared in the kitchen in the main hospital and transported to the approved centre using the 'cook-serve' process; this entailed catering staff plating up meals form a heated container. A menu was displayed at the dining room, although this was not apparent on day one and two of the inspection. A choice of meal was available, including special diets and a vegetarian option.

Water coolers were placed in each ward of the approved centre and were easily accessible by residents.

Weight charts were maintained for residents whose nutritional status indicated the requirement to maintain weight. A dietician was involved in assessing and managing the nutritional requirements of some residents and their involvement was detailed in the resident's individual care plan.

As all aspects of the Judgement Support Framework had been met, the approved centre was rated excellent on this regulation.

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

3.6 Regulation 6: Food Safety

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

Inspection Findings

Processes: There were two policies relating to food safety; one was the St Vincent's University Hospital policy and the second was the CHO 6 policy. This was because food was provided to the approved centre from the kitchens in the main hospital. The policy included procedures for preparation, storage and handling of food and its safe disposal. The policies also addressed the management of food equipment within the hospital.

Training and Education: The catering staff were aware of the contents of the policies relating to food safety. Food hygiene training was documented for catering staff and catering management had undergone Hazard Analysis and Critical Control Points (HACCP) training.

Monitoring: Food safety audits were carried out regularly. Food temperatures were checked and recorded for all cooked food. Ongoing hygiene audits were provided by an external agency.

Evidence of Implementation: Food was served from a servery in the dining rooms of the approved centre. There were appropriate hand washing facilities for catering staff within the kitchen area and staff were observed to be wearing personal protective equipment (PPE) when handling and serving food. The catering kitchen was small but very clean. There was sufficient and suitable crockery and cutlery for the number of residents.

The approved centre met all requirements of the Judgement Support Framework for this regulation.

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

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: There was a policy on the provision of clothes to residents and on the use of night clothes. The policy specified the use of night clothes, only when specified in the resident's individual care plan (ICP).

Training and Education: Staff were aware of the processes to supply residents with spare clothes and on the use of night clothes.

Monitoring: Monitoring and audits were not carried out.

Evidence of Implementation: A number of residents (six) were observed to be dressed in scrubs whilst walking around the approved centre. This clothing was unisex and did not provide warmth. When staff were asked about the use the use of this clothing, the response was that, in the case of two of these residents, their clothing was in the laundry. These residents were in the scrubs clothing on each of the three days of the inspection.

There were some spare clothes in the linen cupboard but there were no spare (new) underwear or socks. There were no pyjamas for females.

The remaining residents were dressed in day clothes with the exception of one resident who was required to remain in night clothes, as indicated in the ICP.

The approved centre was not compliant with this regulation as:

(a) residents were not provided with adequate clothing when they had an insufficient supply of their own and
(b) there was not a sufficient supply of clothing available.

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

Risk Rating			
Low	Moderate	High	Critical
X			

3.8 Regulation 8: Residents' Personal Property and Possessions

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

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

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

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

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

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

Inspection Findings

Processes: There was an up-to-date policy on residents' property and possessions. The policy identified the responsibilities to record residents' property on admission and for its safe-keeping. The policy did not identify how staff communicated to residents what may be brought into the approved centre.

Training and Education: Staff were familiar with the requirement to record a resident's property on admission and subsequently, if indicated.

Monitoring: Property lists were made in relation to residents' property but no audits had been carried out on the process.

Evidence of Implementation: Sixteen clinical files were inspected and there was a property list in each of these. These property lists were separate from the residents' ICPs.

Residents' money was kept securely in the hospital bank, where an account for each resident was set up; withdrawals were made by the resident and witnessed by a member of staff. There were some restrictions on what property a resident could keep; for example, sharp objects, cables and aerosols.

Each resident had a wardrobe and locker in which to keep their property, but these could not be locked. Additional clothes and property were stored in a locked store room.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements in policy, monitoring or evidence on implementation of the Judgement Support Framework.

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

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There was a policy on provision of recreational activities which specified the responsibility of the person in charge to provide recreation for residents. The policy provided for residents to be involved in suggestions for recreational activities and the need for a risk assessment to be carried out, where indicated.

Training and Education: Staff were familiar with the process to facilitate recreation within the approved centre.

Monitoring: A record of attendance at recreational activities was maintained in each clinical file but no analysis was carried out.

Evidence of Implementation: Residents in each of the three wards had access to TV, books, DVDS or videos and board games; there was table football in one of the wards. Residents who could leave the unit had access to the hospital coffee shop and staff facilitated one to one walks, when staff numbers permitted. An exercise bike was located in Elm Mount Upper and was freely accessible to residents. Prior to using this piece of equipment, a risk assessment was carried out. Where a resident participated in recreation, this was recorded in the clinical file.

A weekly community meeting was held at which residents could make suggestions for further activities.

Each ward had access to a garden area; garden seating was provided in two of these areas. Communal sitting rooms were comfortable and adequately sized.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of monitoring of the Judgement Support Framework.

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

3.10 Regulation 10: Religion

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 policy on religion which included processes for supporting a resident's religious practices and for identifying religious beliefs on admission.

Training and Education: Staff were aware of the policy and of the processes to facilitate a resident's practice of their religion, where practicable.

Monitoring: The policy on religion was reviewed but analysis on its implementation was not carried out.

Evidence of Implementation: A resident's religious beliefs were documented on admission and a chaplain visited the approved centre weekly. Ministers of other faiths attended as required by the residents and attendance at services was facilitated, where practicable.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of monitoring of the Judgement Support Framework.

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

3.11 Regulation 11: Visits

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy on visits which was up to date. The policy specified designated areas within the approved centre for visits and included provision for children visiting. There was a provision for persons visiting the unit to provide identification, if requested.

Training and Education: Staff were aware of the processes in relation to visits.

Monitoring: There was monitoring of a restriction of visitors but no analysis on the processes was carried out.

Evidence of Implementation: Visiting times were displayed in the unit and there was some flexibility on these times. Visiting times were from 14:00 to 16:00 and 18:00 to 20:00 daily. Whilst there was no dedicated visitors' room, residents could meet with visitors in a number of rooms, such as the 'quiet room' and the room designated for team meetings. There was no dedicated child visitors' room and no child-friendly toys/equipment for child visitors. There were comfortable chairs and coffee tables at intervals on corridors throughout the approved centre which provided comfortable spaces for visitors.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of written policy, monitoring or evidence of implementation of the Judgement Support Framework.

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

3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: There was an up-to-date policy on communication which identified the responsibilities to ensure residents could communicate freely. The policy specified the requirement to identify the communication requirements of residents at the time of admission. The policy also specified the circumstances in which mail could be examined by senior staff. It did not identify the communication methods available to residents.

Training and Education: Staff had read and were familiar with the written policy on communication.

Monitoring: Analysis of the process had not been carried out.

Evidence of Implementation: Risk assessments were carried out when a resident's access to communication was restricted; this was documented in the clinical file. Staff facilitated outgoing mail and there was access to the internet in the occupational therapy department. An interpreter service was available and this was provided regularly, particularly in respect of one resident for whom English was not the first language. Only senior staff could open a resident's mail, but staff in the unit could not identify an occasion when this had occurred.

Residents could use the phone at the nurses' station to make and receive calls, but there was no privacy for these calls. At the feedback meeting, senior staff reported that two portable phones had been purchased and were available to residents, who could then make calls in private. At the time of inspection, some staff were unaware of this arrangement and residents were observed to make calls at the nurses' station.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of written policy or monitoring of the Judgement Support Framework.

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

3.13 Regulation 13: Searches

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

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

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

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

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

(6) The registered proprietor shall ensure that there is 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: There was an up-to-date policy on searches which outlined the circumstances where a search could be carried out. The policy also specified the need to obtain a resident's consent for a search, and the procedures to be followed if consent was not provided. The policy highlighted the requirement to document the details of a search, but did not identify how the finding of illicit substances was to be handled.

Training and Education: Staff were able to articulate the processes in relation to carrying out a search.

Monitoring: There was no log maintained of searches and no analysis was completed. The service did not use a specified form when recording a search.

Evidence of Implementation: Staff reported that no searches had been carried out in the case of any current resident. However, one clinical file instructed that all possible means of self-harm were to be removed from a resident's environment and it was unclear how this could be achieved without a search being conducted. The clinical file of this resident did not record details of any search.

The approved centre was not compliant with section (10) of this regulation as it did not have written procedures in relation to searches.

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

Risk Rating			
Low	Moderate	High	Critical
X			

3.14 Regulation 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy on care of the dying. The policy identified the requirement to meet all the needs of a resident who is dying and for the involvement of family members, if requested by the resident. The policy also identified the procedure for managing a sudden death and the responsibility for notification of a death to the MHC. There was no process in place to ensure that the approved centre was notified when a resident died in another facility.

Training and Education: Staff were aware of the process and protocols for managing a resident who is dying. In practice, a resident who is dying was transferred to the general hospital.

Monitoring: No resident had required end of life care since the last inspection. A systems analysis review had been initiated in respect of one resident who had died unexpectedly.

Evidence of Implementation: No resident had required end of life care in the approved centre since the last inspection. The death of one resident had been notified to the MHC within the specified timeframe for such notifications.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of written policy and monitoring of the Judgement Support Framework.

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

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".]

Inspection Findings

Processes: There was a policy on the development of individual care plans (ICPs). The policy described the process for the development of ICPs and the involvement of the resident. The policy did not specify the inclusion of goals in the resident's ICP; the regulation requires appropriate goals for the resident to be specified.

Training and Education: Training on ICPs was conducted during the induction programme for new staff. However, no formal training on the development of ICPs was carried out.

Monitoring: Audits on ICPs were not carried out. However, senior staff reported that a review of the template used to document the ICP was in the process of being undertaken.

Evidence of Implementation: Twenty-three clinical files of a cross-section of residents were inspected and, in all cases, residents had an individual care plan. These ICPs were reviewed weekly and the attendance record at the review meetings indicated a multi-disciplinary approach to developing the care plan and incorporated a risk assessment of the resident.

Where residents attended the review meeting, this was indicated on the care plan. Prior to the review meeting, a Pre Round review was documented by a nurse in conjunction with the resident and was considered at the review meeting. Whilst each resident was assigned a key worker, this changed on a daily basis and was not consistent throughout the resident's admission.

A standardised template for recording the ICP was used for all residents. This template provided for the recording of resident needs, interventions and facilitators to carry out the intervention. The individual care plans did not identify goals for the resident, which is a requirement of the regulation.

Whilst some interventions were specific, e.g. 'meet with family', some were vague and non-specific, e.g. 'medication', 'monitor response to medication', 'psychoeducation'. The identification of persons to carry out the interventions were often unspecified, e.g. 'MDT', 'staff', 'psychiatric team'. In a few cases, this section was left blank.

The approved centre was not compliant with this regulation as:

(a) the individual care plans did not specify goals for residents and
(b) resources were not specified.

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

Risk Rating			
Low	Moderate	High	Critical
X			

3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: There was a policy on the provision of therapeutic services which included the responsibilities with regard to training. Identification of resource requirements, review of the implementation and recording residents' attendances were also specified in the policy.

Training and Education: Staff were aware of the processes relating to the provision of therapeutic services for residents.

Monitoring: Staff in the occupational therapy department monitored the range of therapeutic services available and their effectiveness.

Evidence of Implementation: Two full-time occupational therapists provided a range of therapies in the approved centre and residents were referred for individual therapeutic activities. The times and locations of therapeutic activities were displayed on a noticeboard. Where services were not available on-site, these were brought into the approved centre, e.g. attendance by the CAMHS service and an art teacher.

There were adequate facilities for therapies – two therapy rooms and an occupational therapy kitchen. A record of attendance at therapies was maintained in residents' clinical files.

Each sector team had a social worker and psychologist who provided interventions, as required.

Despite the availability of two occupational therapists in the approved centre, the attendance at activities was quite low. On the first day of inspection, three occupational therapy groups were facilitated but only three residents attended each activity. It was unclear to the inspection team why this was so.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of written policy of the Judgement Support Framework.

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

3.17 Regulation 17: Children's Education

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

Inspection Findings

Processes: There was a policy on providing education to a child resident which identified the responsibilities of staff to arrange for educational assessment of child residents and to provide appropriate educational facilities, as required. The policy identified that educational needs may be met by an external service and that a child's educational progress should be documented.

Training and Education: Relevant staff were aware of the policy regarding children's education.

Monitoring: No current or past resident since the previous inspection had required educational facilities.

Evidence of Implementation: As no current resident required educational interventions, this could not be assessed. Compliance was assessed on policy and training.

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

3.18 Regulation 18: Transfer of Residents

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

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

Inspection Findings

Processes: There was a policy on the transfer of residents which was up to date. The policy outlined the procedure for arranging a resident transfer including communication and risk assessment prior to transfer. The policy did not identify obtaining a resident's consent to the transfer, the management of medication during transfer or procedure for emergency transfers.

Training and Education: Staff were aware of the procedures in relation to the transfer of a resident. Senior staff reported that a resident's clinical file was always transferred with a resident, on transferring to the general hospital; however, this was in direct contradiction to the written policy, which stated that clinical files were not to be transferred.

Monitoring: There was no documented analysis on implementation of transfer processes.

Evidence of Implementation: The clinical file of one resident who had been transferred to a medical ward in the general hospital was inspected. The clinical file documented the need for transfer and, as the clinical file was transferred with the resident, all relevant information was transferred with them and was available to the treating team.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of written policy or monitoring of the Judgement Support Framework.

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

3.19 Regulation 19: General Health

(1) The registered proprietor shall ensure that:

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

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

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

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

Inspection Findings

Processes: There was a policy provision of general health services and a specific policy on responding to medical emergencies. The responsibility of ensuring general health care was with the multi-disciplinary team. The policy specified the need for ongoing assessment of residents' medical needs and there was a process for access to a medical practitioner. The policy also specified the procedure for referral to a specialist for medical care.

The policy on responding to medical emergencies specified staff training requirements in relation to Basic Life Support (BLS) and the management of emergency equipment.

Training and Education: Staff were aware of the process relating to the provision of general health care for residents.

Monitoring: A record of uptake of national screening processes was maintained and reviews were undertaken to ensure that a physical examination for residents in the approved centre for longer than six months was carried out. Analysis of the monitoring process was not carried out.

Evidence of Implementation: There was a resuscitation trolley and an Automatic Emergency Defibrillator (AED) in each ward. Weekly checks were maintained on this equipment. In the event of a medical emergency, the resuscitation team from the general hospital attended the approved centre. A Smoking Cessation programme had been introduced in the approved centre and residents were encouraged to participate.

Residents' general health needs were assessed on admission by the non-consultant hospital doctor (NCHD). Two residents had been in-patient for longer than six months and both had a physical examination carried out within the past six months.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of monitoring of the Judgement Support Framework.

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

3.20 Regulation 20: Provision of Information to Residents

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

Inspection Findings

Processes: There was a policy on the provision of information which included the responsibilities of staff to provide this information. The policy also identified a process to determine a resident's preferred way of receiving information and the provision of an interpreter for residents who required this service. Provision of information relating to advocacy services was included in the policy.

Training and Education: Staff were aware of the process relating to the provision of information to residents and had read and understood the policy.

Monitoring: The provision of information was monitored and audited as part of a nursing metric audit system.

Evidence of Implementation: An Information Booklet for residents and visitors had been developed by the service and included information on key working, mobile phones, personal belongings and visiting hours. It also included a schedule of meal times and provided for the inclusion and contact details of a peer advocate. It did not contain details of the complaints procedure but identified that a complaints procedure was in place and directed residents to the information leaflets on display within the approved centre.

Details of the different multi-disciplinary teams were displayed in the unit, along with the name of individuals' key workers for the day.

Diagnosis-specific leaflets were available, as were information leaflets on medications. Residents were provided with information, both verbal and written, on medication and diagnosis.

As all elements of the JSF were met, the approved centre was rated excellent in the regulation.

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

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: There was a policy on privacy which outlined the responsibilities of the person in charge and all staff. The policy highlighted the requirements for privacy in shared rooms and the provision of privacy hoods for public phones.

Training and Education: Staff were aware of the requirements of the policy on privacy.

Monitoring: There was no monitoring of the processes and no analysis of the implementation of the processes was carried out.

Evidence of Implementation: Interaction between staff and residents was observed to be courteous and respectful. Residents who were dressed in their own clothes were dressed appropriately, but those in 'scrubs' were not appropriately dressed.

All showers and bathrooms had locks for privacy and each bed in a shared room had a surround curtain. Four bedrooms in Elm Mount Lower were directly observed by occupants of some wards in the general hospital, unless they drew the window curtains; the windows did not have blinds. Two garden areas were overlooked by the general hospital and the third garden was overlooked by St Vincent's Private Hospital. Residents in the garden areas of Elm Mount Upper and Lower could be viewed by patients in the wards of the general hospital whilst residents in the garden of the psychiatry of old age garden were seen by patients in the private hospital. As a consequence, the privacy and dignity of residents using the gardens could not be assured.

The allocation of key workers for the day was displayed on a noticeboard in the wards but, as only residents' first names were used, this did not impact on privacy.

There were no public phones in the unit but residents were facilitated to make and receive calls on the phone at the nurses' station; the inspection team observed residents making such calls. There was no privacy for this. Despite the fact that the senior management team informed the inspection team that two portable phones had been procured for the unit, neither staff nor residents who spoke with the inspectors seemed to be aware of this. In their submission of a CAPA for this regulation, the service reported two portable phones had been procured.

The approved centre was not compliant with this regulation as:

(a) there was no privacy for residents using the phone at the nurses' station;
(b) all three garden areas were overlooked by other services; and
(c) four bedrooms which were overlooked did not have blinds on the windows.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	
Risk Rating				
Low	Moderate	High	Critical	
X				

3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy on maintenance of the premises which identified the responsibilities of the manager and maintenance department, including minimisation of ligature anchor points. The policy referred to legislation relating to buildings and also addressed the provision of a maintenance and cleaning programme for the approved centre.

Training and Education: Relevant staff were aware of the requirements of the processes relating to maintenance of the premises.

Monitoring: Maintenance requests were recorded in the Maintenance Log and were monitored. Hygiene audits were conducted by the company tasked with carrying out the cleaning programme and were seen by the inspection team. A ligature audit had been conducted in June 2015.

Evidence of Implementation: Accommodation was in single (10) and shared rooms; some rooms had en suite facilities. One bedroom on the lower floor was somewhat isolated and separated from the remainder of the ward by double doors.

Communal sitting and dining rooms were bright, comfortable and had adequate seating. Therapies rooms were located on the lower floor and comprised an activities room, occupational therapy kitchen and a further therapy room for facilitating relaxation. There were two ‘quiet’ rooms, one on each floor and comfortable seating situated at intervals on the corridors.

The unit was very clean and well maintained. There was a sufficient number of showers and toilets and shower fittings were anti-ligature designed. A record of maintenance issues was maintained and a cleaning schedule was in operation. As all elements of the JSF were met, the approved centre was rated excellent in the regulation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	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 detailed and comprehensive policy on ordering, prescribing, storing and administering of medicines. Roles and responsibilities were identified and legislative requirements were addressed. The policy outlined the processes for ordering, prescribing, storing and administering medicines, including the management of controlled drugs. Processes for crushing medication and for withholding and reconciling medication were also included. The process for medication management at times of admission, transfer and discharge were detailed and there was a clear process for management of medication errors.

Training and Education: Staff were aware of the processes relating to the management of medications. There was ready access to expertise in relation to medicines as the pharmacist was regularly on the unit.

Monitoring: The Medication Prescription and Administration Records (MPARs) were audited as part of nursing metrics. Pharmacy staff carried out audits on medication stock and prescription records. Incident reports were completed in respect of medication errors.

Evidence of Implementation: An MPAR was maintained for each resident which included appropriate resident identifiers and allergies. However, in one MPAR, the prescriber indicated the presence of an allergy but did not specify what the allergy was, instead referring to a previous MPAR.

The prescriber's signature and Medical Council Registration Number (MCRN) was written on each prescription and prescriptions were reviewed at least six monthly.

Medication was ordered from St Vincent's University Hospital and the order was reconciled on receipt in the approved centre. Administration records were fully documented including a resident's refusal to accept the medication. Medication storage areas were clean and were included in the cleaning schedule for the approved centre.

Medicines were stored in a drugs trolley which was kept locked or in a locked room. Controlled drugs were stored in a locked press in the clinical room. Pharmacy staff from St Vincent's University Hospital maintained a system of stock rotation and unused or out-of-date medicines were returned to the hospital pharmacy for disposal.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of evidence of implementation of the Judgement Support Framework.

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

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a written operational policy on health and safety which addressed the health and safety of residents, employees and 'other' in the approved centre. The policy specified the role and responsibilities of the registered proprietor and specified that it was in compliance with relevant legislation. The policy identified the risk management process, fire management plan and processes for infection control.

Training and Education: Staff were aware of the processes relating to health and safety.

Monitoring: The health and safety policy had been reviewed by the policy review group.

Evidence of Implementation: The implementation of the health and safety policy was governed by both the approved centre policy and those of St Vincent's University Hospital. Operational practices were in line with the policy of the approved centre.

As all elements of the JSF were met, the approved centre was rated excellent in this regulation.

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

3.25 Regulation 25: Use of Closed Circuit Television

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at anytime on request.

Inspection Findings

As CCTV was not in operation within the approved centre, this regulation was not applicable.

3.26 Regulation 26: Staffing

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

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

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

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

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

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

Inspection Findings

Processes: There was an up-to-date written policy on staffing which included responsibilities in relation to induction and training for staff. The policy addressed staff planning requirements and staff rota details and made provision for staff evaluation at the time of commencement of employment. The policy also identified the requirement for a comprehensive contract to be in place when engaging agency staff.

Training and Education: Relevant staff were aware of the policy in relation to staffing.

Monitoring: The number and skill mix of staff in the approved centre was monitored regularly. Senior staff were engaged in ongoing monitoring to improve the staffing process.

The following is a table of staff based in the approved centre on a 24-hour basis.

Ward or Unit	***Staff Grade***	***Day***	***Night***
Elm Mount Upper	CNM2	1	0
	CNM1	1	0
	RPN	4	3
	Nurses' Aid	2	0
	Occupational Therapist	2 (shared)	0
	Social Worker	Attends MDT and as required	0
	Psychologist	Attends MDT and as required	

Ward or Unit	*Staff Grade*	*Day*	*Night*
Elm Mount Lower	CNM2 CNM1 RPN Nurses' Aid Occupational Therapist Social Worker Psychologist	1 1 1 0 2 (shared) Attends MDT and as required Attends MDT and as required	0 0 2 0 0 0 0
Ward or Unit	*Staff Grade*	*Day*	*Night*
POA Ward	CNM2 RPN Nurses' Aid Occupational Therapist Social Worker Psychologist	1 2 0 2 (shared) Attends MDT and as required Attends MDT and as required	0 1 1 0 0 0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN)

Evidence of Implementation: There was an organisational chart but this covered the whole CHO 6 Area and there was no specific chart for the approved centre. Each ward in the approved centre was self-staffing and there was a published planned rota for nursing staff for day and night duty. Senior staff reported difficulties in recruiting staff and staff shortages were reported as the biggest risk factor in the organisational risk register.

The current nurse staffing levels were consistent with that submitted to the MHC at the time of registration. There was an appropriate person on duty and in charge at all times. An assistant director of nursing was based in Elm Mount and covered the three approved centres in the CHO area; at night, a CNM3 was in overall charge in Elm Mount. There was a mix of HSE and St Vincent University Hospital staff working in the unit and recruitment processes were different for these two groups. Senior staff reported that almost 98% of staff had been through the Garda vetting programme and the process was ongoing to complete documentation for vetting for all staff.

Four sector teams, a psychiatry of old age team and an eating disorder team admitted residents to the approved centre. All teams, except one sector team, were fully staffed with team members.

A staff training needs analysis had been completed and a staff training log was maintained. At the time of inspection, not all staff had up-to-date training in fire safety, BLS and Therapeutic Management of Violence and Aggression (TMVA). At least one member of staff had received training in *Children First*.

A copy of the Mental Health Act 2001 and Mental Health Commission Guidance documents were available in the approved centre.

The approved centre was not compliant with this regulation as not all staff on duty in the approved centre at the time of inspection had training in specified areas.

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

Risk Rating			
Low	Moderate	High	Critical
	X		

3.27 Regulation 27: Maintenance of Records

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

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

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

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

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

Inspection Findings

Processes: There was an up-to-date policy on the maintenance of records. The policy specified who could access confidential resident records and specified retention periods and disposal of records. The process for generating, correcting and overwriting records was specified as well as general safety issues relating to maintenance of records.

Training and Education: Staff were aware of the process involved in creating and maintaining clinical records.

Monitoring: Records were reviewed at multi-disciplinary team meetings but no formal process of audit was conducted.

Evidence of Implementation: Resident records were held securely in the nursing office. Each resident had an individual clinical record which recorded a resident's current clinical status. Stickers identified entries in the record from different disciplines and clinical files were maintained in good condition. Entries were made in black ink and signed; the time of entry was indicated by the 24-hour clock.

Documentation in respect of food safety, fire inspection and health and safety was maintained in the approved centre and was available to the inspection team.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all elements of monitoring of the Judgement Support Framework.

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

3.28 Regulation 28: Register of Residents

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

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

Inspection Findings

The register of residents contained the information specified in Schedule 1 to the Regulations.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.29 Regulation 29: Operating Policies and Procedures

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

Inspection Findings

Processes: There was a policy on the development of operational policies. The policy identified the processes in place to develop policies and the persons responsible. The policy also specified the review timeframes and the standardised format for policies.

Training and Education: The relevant staff were aware of the processes involved in developing policies for the approved centre.

Monitoring: Policies were reviewed regularly and all policies in use had been reviewed by the policy review group within the previous three months.

Evidence of Implementation: Policies had been developed for all three approved centres of the CHO 6 area and were not specific to Elm Mount. The most recent set of policies was available electronically and all were in date. The policies had been developed by a policy group which included both clinical and administrative staff. The policies followed a standardised format and identified the approver of the policies.

The approved centre was deemed excellent on quality assessment for this regulation as it met all the elements of the Judgement Support Framework.

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

3.30 Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

Inspection Findings

Processes: There was a policy which detailed the responsibilities for ensuring that the approved centre facilitated mental health tribunals. This included the provision of information to patients about the process and specified the provision of facilities in which to hold the tribunal.

Training and Education: Relevant staff were aware of the process involved in facilitating tribunals.

Monitoring: There was no analysis on the implementation of the policy.

Evidence of Implementation: The approved centre provided a suitable room in which to hold tribunals. If required by the patient, staff accompanied them to the tribunal. Patients' clinical files were provided to the legal representative prior to the tribunal.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of monitoring of the Judgement Support Framework.

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

3.31 Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was an up-to-date policy on complaints which included the process for managing complaints and the methods for making a complaint. The policy also specified the requirement to document complaints, including timelines, and communicate with the complainant during the process. The policy highlighted an appeal process should the complainant be dissatisfied with the outcome.

Training and Education: Relevant staff were trained on the complaints process and were aware of the processes involved.

Monitoring: No analysis of complaints was undertaken in the approved centre.

Evidence of Implementation: It was difficult to determine how verbal complaints were handled. Minor complaints were not documented and there was no record of complaints which were escalated to the complaints officer.

Leaflets outlining the HSE policy on handling complaints, *Your Service Your Say*, were on display in the approved centre. The nominated person to deal with complaints was not identified on these complaints notices and was not identified in the *Patient Information Booklet.* There were no contact details for the complaints officer on display within the approved centre. Where complaints were managed by the nominated person outside of the approved centre, a record was maintained and was inspected by the inspection team.

The approved centre was not compliant with this regulation as:

(a) the nominated person to deal with complaints was not identified in the approved centre;

(b) no contact details for this person were available; and
(c) there was no record of complaints escalated to the complaints officer.

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

Risk Rating			
Low	Moderate	High	Critical
	X		

3.32 Regulation 32: Risk Management Procedures

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

Inspection Findings

Processes: There was an up-to-date policy on risk management but the policy did not specify a process for identification, reporting and monitoring of risk in the approved centre. The person responsible for risk management was not identified in the policy.

Training and Education: Staff were trained in incident reporting and senior staff were trained in organisational risk management. However, this training was not documented.

Monitoring: The risk register was updated monthly. Incidents were analysed and recorded in the minutes of the risk meetings.

Evidence of Implementation: Staff were unaware of the person designated as the nominated person for managing risk within the approved centre. Because of the dual governance structure for the approved centre, it was unclear to the inspection team who had overall responsibility for risk within Elm Mount. At the feedback meeting, the business manager for the CHO area identified himself as the risk manager.

Clinical risk was assessed at the time of admission and documented in the clinical file. In addition, risk was assessed at times of transition during the admission, e.g. at transfer, prior to discharge. Individual care plans incorporated a recording of risk and this was monitored weekly by the MDT.

Incidents were recorded on a standardised form which was used throughout the approved centre. Incidents were reported through the St Vincent's University Hospital recording system for incidents and also logged onto the CHO 6 system. The system for learning from

incidents was unclear to the inspection team. A summary of incidents was forwarded to the MHC every six months.

Corporate risks were identified in the CHO Organisational Risk Register; a shortage of staff featured as the most prominent risk to the service. A ligature audit had been carried out in June 2015. The CAPA submitted by the service reported that the risk management policy had been reviewed.

The approved centre was not compliant with this regulation as:

(a) there was no comprehensive risk management policy in place.

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

Risk Rating			
Low	Moderate	High	Critical
	X		

3.33 Regulation 33: Insurance

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 was insured through the State Indemnity Scheme and a copy of the certificate in this regard was provided to the inspection team.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.34 Regulation 34: Certificate of Registration

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

Inspection Findings

The certificate of registration was displayed in a prominent place in the approved centre. It was up to date and contained the relevant information.

	Compliant	Non-Compliant
Compliance with Regulation	X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

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

Inspection Findings

Processes: There was a policy and processes in place on the operation of ECT for patients. The processes included the storage of required medicines, management of specified medical complications and obtaining consent for the procedure.

Training and Education: Staff involved in the administration of ECT were trained. There were three trained ECT nurses and training included Basic Life Support (BLS).

Monitoring: Audits of the processes for ECT were carried out annually.

Evidence of Implementation: The ECT facilities in Elm Mount were accredited by the Royal College of Psychiatrists with ECTAS (ECT Accreditation Service) approval. Elm Mount provided an ECT service for patients from the approved centre in Newcastle and the Central Mental Hospital, as required.

There was a designated ECT suite in the approved centre comprising a waiting room, treatment room and a recovery room. There were two ECT machines, both of which were serviced regularly. The protocols for dealing with medical emergencies were displayed on the noticeboard in the ECT suite and there was an adequate supply of Dantrolene in the suite. The service had developed an information booklet on ECT and a CD for patients who preferred this method of information.

There was a named consultant psychiatrist with responsibility for ECT and three trained ECT nurses. A designated consultant anaesthetist attended from the general hospital to administer anaesthesia.

No current patient was receiving ECT but, in 2015, six patients were administered ECT in Elm Mount.

	Compliant	Non-Compliant
Compliance with Rule	X	

4.2 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

As the approved centre did not have seclusion facilities, this rule was not applicable.

4.3 Section 69: The Use of Mechanical Restraint

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

As mechanical restraint was not used in the approved centre, this rule was not applicable.

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.

	Compliant	Non-Compliant
Compliance with Part 4	X	

Inspection Findings

Two patients had been administered medicine for longer than three months. In both cases, a form authorising the continued administration of this medication was completed and a copy placed in the patients' clinical files. Both were in date and included the consultant psychiatrist's assessment of capacity to consent.

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 The Use of Physical Restraint

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

Inspection Findings

Processes: There was an up-to-date policy on the use of physical restraint which specified who can carry out restraint and the training requirements for staff who carry out restraint.

Training and Education: The training records indicated that staff in the approved centre had received training in physical restraint.

Monitoring: Analysis on the processes relating to physical restraint was not carried out.

Evidence of Implementation: The physical restraint register and the clinical file of one resident who had been restrained were inspected. The duration of the episode of restraint was within the stipulated period for such restraint and was based on risk assessment of the resident's condition at the time. It was initiated by a registered nurse but one of those involved in the restraint was a member of the hospital security personnel.

There was no evidence that the resident's consultant psychiatrist had been notified of the episode and no evidence that a physical examination relating to the episode had been completed within the specified timeframe.

The episode was documented in the resident's clinical file and a clinical practice form was completed by the person initiating restraint. This form had not been signed by the consultant and a copy had not been placed in the resident's clinical file. The resident's next of kin had not been informed of the episode and the reason for this was not documented.

CAPA update provided by the approved centre indicated that CAPAs had been completed (with the exception of training which was ongoing and self-identified non-compliance of not recording NOK notification).

The approved centre was not compliant with this code of practice as:

(a) a copy of the order for restraint had not been placed in the resident's clinical file;
(b) the consultant psychiatrist was not notified of the episode of physical restraint;
(c) a physical examination of the resident had not taken place within the specified timeframe;
(d) the clinical practice form had not been signed by the consultant psychiatrist;
(e) the reason the next of kin was not informed was not documented;
(f) the resident was not informed of reasons for restraint; and
(g) security personnel involved in physical restraint were not aware of a resident's care and treatment plan.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
	X		

6.2 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.

Inspection Findings

Processes: There was a policy on the admission of children which addressed family liaison for a young person admitted and parental consent; it did not refer to confidentiality. There was a process and a specified person identified for notifying the MHC in the event of a child being admitted to the approved centre.

Training and Education: The training records indicated that 27 staff members had not received training in *Children First: National Guidance for the Protection and Welfare of Children*. The two staff nurses on duty in the ward where a young person was accommodated had not received training in *Children First*.

Monitoring: Audits on compliance with the processes relating to admission of children were not carried out.

Evidence of Implementation: When a young person was admitted, they were accommodated in a single room and were assigned a one to one special nurse who remained with the young person at all times. Provision was made to facilitate visits and prolonged stays by family members; parents were facilitated to stay overnight if they wished. Whilst in the approved centre, the young person was under the care of the adult psychiatric team but a Child and Adolescent Mental Health Services (CAMHS) psychiatrist provided advice to the team and also attended the approved centre.

Consent to admission and treatment was provided by the young person's parent; this was on an amended voluntary admission form, which was used for the admission of adults to the unit and was unsuitable. Where a young person was recently admitted, the provision of education was not a requirement at that time.

The approved centre was not compliant with this code of practice as:

(a) there were no age appropriate facilities and
(b) there was no programme of activities appropriate to age.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
		X	

6.3 Notification of Deaths and Incident Reporting

Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

Inspection Findings

Processes: The risk management policy specified the requirement for reporting a summary of incidents to the MHC, but did not identify the staff responsible for this. The policy did not identify the risk manager and did not identify the roles and responsibilities of staff in relation to reporting incidents.

Training and Education: Staff were aware of the process in reporting a death to the MHC and the processes relating to incident reporting.

Monitoring: Incidents were reviewed by both the St Vincent's University Hospital and CHO 6 groups.

Evidence of Implementation: The approved centre was not compliant with Regulation 32 Risk Management Procedures. There was an incident reporting system in place and a summary of incidents was reported to the MHC every six months.

The risk policy did not identify the risk manager. It was notable that during the course of the inspection, it was evident that senior staff were unclear who had overall responsibility for managing risk within the approved centre, as three different names were offered as the risk manager.

The approved centre was not compliant with this code of practice as:

(a) the approved centre was not compliant with Regulation 32 Risk Management Procedures;
(b) the policy did not identify the roles and responsibilities of staff in relation to reporting incidents; and
(c) the risk manager was not identified in the policy.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
X			

6.4 Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

Inspection Findings

As there were no residents in the approved centre with an intellectual disability, this code of practice was not applicable.

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

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

Inspection Findings

Processes: There was a policy and processes in place on the operation of ECT for residents. The processes included the storage of required medicines, management of specified medical complications and obtaining consent for the procedure.

Training and Education: Staff involved in the administration of ECT were trained. There were three trained ECT nurses and training included Basic Life Support (BLS).

Monitoring: Audits of the processes for ECT were carried out annually.

Evidence of Implementation: The ECT facilities in Elm Mount were accredited by the Royal College of Psychiatrists with ECTAS (ECT Accreditation Service) approval. Elm Mount provided an ECT service for residents from the approved centre in Newcastle and the Central Mental Hospital, as required.

There was a designated ECT suite in the approved centre comprising a waiting room, treatment room and a recovery room. There were two ECT machines, both of which were serviced regularly. The protocols for dealing with medical emergencies were displayed on the noticeboard in the ECT suite and there was an adequate supply of Dantrolene in the suite. The service had developed an information booklet on ECT and a CD for residents who preferred this method of information.

There was a named consultant psychiatrist with responsibility for ECT and three trained ECT nurses. A designated consultant anaesthetist attended from the general hospital to administer anaesthesia.

One resident of another approved centre was receiving ECT twice weekly in Elm Mount. The resident attended as a day patient for the administration of ECT. All documentation relating to the treatment was contained in the ECT Pack, a copy of which was retained in Elm Mount as well as a copy in the resident's clinical file. The record documented that information had been given to the resident by the consultant and an information booklet provided. Capacity to consent to the treatment was also documented; consent for each treatment was documented.

ECT was administered by a consultant psychiatrist and a cognitive assessment was recorded. There was evidence that a pre-ECT assessment had been carried out by an anaesthetist.

The ECT register contained a record of ECT treatments to date.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

6.6 Admission, Transfer and Discharge

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

Inspection Findings

Processes: There were up-to-date policies on admission, transfer and discharge.

The policy on admission included protocols for a resident's planned admission and urgent referrals. The policy specified the procedure for the admission of an involuntary patient and for residents who self-present at the approved centre.

The transfer policy included procedures for transfer of residents but did not identify procedures for emergency transfers or for transfer abroad.

The discharge policy included procedures for the discharge of an involuntary patient and specified the process for supplying medication, if indicated. The policy identified procedures for arranging follow-up and relapse prevention strategies, but did not identify procedures for addressing missed appointments. There was a separate protocol for the discharge of a homeless person.

Training and Education: Staff were aware of the processes relating to the admission, discharge and transfer of residents.

Monitoring: Nursing staff carried out nursing metrics which included monitoring of admissions and discharges.

Evidence of Implementation:

ADMISSION: The clinical file of one resident recently admitted was inspected. The decision to admit was taken by a medical practitioner. On admission, an assessment was completed which included a history, mental state and physical examinations; these assessments were recorded in the individual's clinical file. There was evidence that the admission process included a family member. A key worker was assigned to the resident but the key worker changed daily, depending on staff rotas.
The approved centre was compliant with Regulation 8 Residents' Personal Property and Possessions, Regulation 20 Provision of Information to Residents and Regulation 27 Maintenance of Records. It was not compliant with Regulation 7 Clothing, Regulation 15 Individual Care Plan or Regulation 32 Risk Management Procedures.

TRANSFER: The clinical file of one resident who had been transferred was inspected. The reason for the transfer was documented in the resident's clinical file and the decision to transfer was taken by a medical practitioner. Communication with the receiving treating team was documented in the clinical file and, as the clinical file was also transferred with the resident, all relevant information was transferred. There was no formal record of the resident's consent to the transfer and family were not involved in the transfer.

DISCHARGE: The clinical file of one resident who had recently been discharged was inspected. The decision to discharge the resident was taken by the medical practitioner and was documented in the clinical file. A discharge plan was recorded in the clinical file and included a follow-up plan and communication with the community mental health team. A

discharge meeting by the multi-disciplinary team took place and was attended by the resident. Prior to discharge, an assessment of the resident was carried out and included a mental state examination, a management plan and assessment of social needs.

The clinical file contained a copy of a discharge summary sent to the resident's GP; this included information on diagnosis, medication and follow-up arrangements.

The approved centre was compliant with Regulation 18 Transfer of Residents.

The approved centre was not compliant with this code of practice as:

(a) the approved centre was not compliant with a number of Regulations specified in the code of practice i.e. Regulation 7 Clothing and Regulation 15 Individual Care Plan;
(b) there was no record of resident's consent (or lack of) to the transfer; and
(c) there was no record of family involvement (or lack of) in the transfer.

	Compliant	Non-Compliant
Compliance with Code of Practice		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: ELM MOUNT UNIT **Date submitted:** 01/07/16

For each finding of non-compliance the registered proprietor was requested to provide 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.

1. Regulation 7: Clothing and Code of Practice: Admission, Transfer and Discharge (inspection report references 3.7 and 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. Residents were not provided with adequate clothing when they had an insufficient supply of their own	Corrective action(s): Clothing has been purchased and present on unit- various sizes male and female attire, day and night wear. **Post Holder**- ADON and CNM in Elm Mount Unit	Completed	Achievable and realistic- completed	Immediate action - completed
	Preventative action(s): Residents dealt with on an individual basis. Systems in place for replenishing supplies as required. **Post Holder**- ADON and CNM in Elm Mount Unit	Process in place to monitor and review the use of by auditing every month or more frequently as required	Achievable and realistic	Ongoing process
2. There was not a sufficient supply of clothing available	Corrective action(s):			

	Additional clothing available on unit for individual use. **Post Holder** ADON and CNM for Unit	Completed – visual evidence available	Achievable and realistic- completed	Immediate action - completed
	Preventative action(s): Resident dealt with on an individual basis. Systems in place for replenishing supplies as required **Post Holder** ADON and CNM for Unit	Process in place to monitor and review the use of by auditing every month or more frequently as required.	Achievable and realistic	Ongoing

2. Regulation 13: Searches (inspection report reference 3.13)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. The approved centre was not compliant with this section (10) of the regulation as it did not have written procedures in relation to searches.	Corrective action(s): Policy Review Group (2016) currently updating all MHC policies in line with MHC Judgement Support Framework (2016). It will address correction of this regulation. **Post – Holder** Senior Management Team- MDT members- ADON's and Policy Review Group.	Audit tools are currently being developed in consultation with the, Senior Management Team, Policy Review Group and the HSE Mental Health Division. This will enhance further compliance with the Mental Health Act 2001 (Approved Centres) Regulation (2006)	Achievable and realistic	Q 3/Q4 2016
	Preventative action(s): Policy Standardisation and practices alignment across the Approved Centre the CHO 6 as agreed by the Registered Proprietor, Senior Management	Policy Standardisation and practices alignment across the Approved Centre the CHO 6 as agreed by the, Senior Management Team in	Achievable and realistic	Q 3/Q4 2016

	Team in HSE Strategic Plan (CHO 6- 2016-2020) **Post – Holder –** Senior Management Team- MDT members- ADON's and Policy Review Group.	their Strategic Plan (CHO 6- 2016-2020)		

3. Regulation 15: Individual Care Plans and Code of Practice: Admission, Transfer and Discharge (inspection report references 3.15 and 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. The individual care plans did not specify goals for residents	Corrective action(s): Plans in place to adjust care plan template to include needs, goals interventions and outcomes **Post holders:** ADON's, CNM's and MDT members	Visual evidence of change to ICP template Policy Standardisation and practices alignment across the Approved Centre the CHO 6 as agreed by the Senior Management Team in HSE Strategic Plan (CHO 6- 2016-2020	Achievable and realistic	Policy Review Group to reformulate template Q2/Q3 2016-and ongoing as required
	Preventative action(s): Implementation of new ICP Template	Nationally Approved-Test your care Nursing Metrics system implemented in Elm mount Unit to measure care planning	Achievable and realistic	Ongoing

		auditing against National Criteria.		
2. Resources were not specified	Corrective action(s): Highlight to MDT Team persons identification of person to carry out interventions. Identification of a specific person-centred resources outlined in Individual care plans. **Post holders:** ADON's, CNM's and MDT members	Policy Standardisation and practices alignment across the Approved Centre the CHO 6 as agreed by the Senior Management Team in their Strategic Plan (CHO 6- 2016-2020)	Achievable and realistic	Policy Standardisation and practices alignment across the Approved Centre the CHO 6 as agreed by the Senior Management Team in their Strategic Plan (CHO 6- 2016-2020) Time frame 2016
	Preventative action(s): Education of MDT members of ICP in line with MHC (2012) **Post holders:** ADON's, CNM's and MDT members	MDT auditing processes to be agreed	Achievable and realistic	Work in Progress – Q3/Q4 2016

4. Regulation 21: Privacy (inspection report reference 3.21)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. There was no privacy for residents using the phone at the nurse's station	Corrective action(s): Two portable phones have been procured for unit and all MDT aware of same. Residents informed on admission that portable phones are available for use. **Post holders:** ADON's, CNM's and MDT members	Visual and verbal evidence available. Residents informed of same on admission during orientation to unit.	Completed Completed and realistic	Immediate and ongoing Immediate and ongoing
	Preventative action(s): Ensure all residents are informed on admission of the availability of mobile phones.	Visual evidence on unit of portable phones	Achievable and realistic	Immediate and ongoing

	Post holders: ADON's, CNM's and MDT members			
2. All three garden areas were overlooked by other services	Corrective action(s): Senior Management Team and Estates joint forum between SVUH and HSE to decide **Post holder** Senior Management Team in collaboration with Estates in SVUH	To be decided by Senior Management Team and Estates in SVUH	To be decided by Senior Management Team and Estates in SVUH	6-12 months
	Preventative action(s): To be decided by Senior Management Team and Estates in SVUH	To be decided by Senior Management Team and Estates in SVUH	To be decided by Senior Management Team and Estates in SVUH	6-12 months

3. Four bedrooms which were overlooked did not have blinds on the windows	Corrective action(s): Process for sourcing Privacy Glass underway with Estates dept. SVUH Interim measure All windows are dressed with curtains which can be closed to ensure additional privacy **Post holder** Senior Management Team in collaboration with Estates in SVUH	 Yes – by visible evidence in unit when completed Interim measure Completed	 Yes Yes – visibly evident	 3 months Immediate and ongoing
	Preventative action(s): As privacy glass is a permanent feature additional measures may not be necessary. **Post holder** Senior Management Team in collaboration with Estates in SVUH	Yes – visible evidence in unit when completed	Yes	3 months

5. Regulation 26: Staffing (inspection report reference 3.26)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. Not all staff on duty in the approved centre at the time of the inspection had training in specified areas	Corrective action(s): Staff training data base in place. Training needs analysis completed and schedule for training identified for 2016 **Post holders:** Registered Proprietor Senior Management Team All MDT HOD's and CNM's in units	Auditing via database statistics Central database to be compiled for all MDT members	Service will endeavour to achieve staff training numbers – however staff recruitment challenges and low number of staff on rosters hinder the process of releasing staff for training.	Ongoing and continuous
	Preventative action(s): 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 to be inputted onto central database.	Auditing via database statistics Central database to be compiled for all MDT members	Service will endeavour to achieve staff training numbers – however staff recruitment challenges and low number of staff on rosters hinder the	Ongoing and continuous

	Ensure that staff receives all required statutory and mandatory training. Ensure that training logs and records are up to date and fully reflect the competencies of staff in the service. (HSE 2016) **Post holders:** Registered Proprietor Senior Management Team All MDT HOD's and CNM's in units		process of releasing staff for training.	

6. Regulation 31: Complaints Procedures (inspection report reference 3.31)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. The nominated person to deal with complaints was not identified in the approved centre	Corrective action(s): **Complaints Policy Poster** developed and clearly displayed on notice boards in unit and CNM's offices for all residents, staff and visitors to read, see and comprehend This poster clearly outlines the name of the nominated person i.e. complaints manager Mr. Maurice Farnan- Tel. 01-2680463. Record of all complaints on unit documented and forwarded to the nominated person i.e. complaints manager – Mr. Maurice Farnan – who will maintain a record of complaints for the Approved Centre **Post Holder –** Complaints manager – Mr. Maurice Farnan, all MDT members to monitor and observe.	Observational audit to be undertaken by all MDT members and CNM of unit to monitor location of and visual evidence of complaints flyer on notice board- daily. Record of all complaints on unit documented and forwarded to the nominated person i.ie. complaints manager Mr. Maurice Farnan, who will maintain a record of complaints for Approved Centre	Achieved - completed Commenced and ongoing monitoring	Completed and ongoing process Ongoing process

	Preventative action(s): Complaints Policy Poster clearly displayed on notice boards for all residents, staff and visitors to see. This clearly outlines the name of the complaints manager for service i.e. Mr. Maurice Farnan- Tel. 01-2680463 Record of all complaints documented and forwarded to Mr. Maurice Farnan – complaints Manager Tel. 01- 2680463. He will maintain a record for the Approved Centre Copy of Your Service Your Say available and clearly displayed on unit. **Post Holders** Complaints Manager – Mr. Maurice Farnan, all MDT members and nursing staff to monitor and observe.	Ongoing observational audit to be implemented by all MDT members Mr. Maurice Farnan – Complaints Manager to monitor and maintain record for Approved Centre	Yes - completed Yes - completed Yes Yes- completed	Commenced and ongoing monitoring Commenced and ongoing monitoring Commenced and ongoing monitoring Commenced and ongoing monitoring
2. No contact details for this person were available	Corrective action(s):			

	Complaints Policy Poster- Developed and clearly displayed on notice boards in unit and CNM's offices for all residents, staff and visitors to read, see and comprehend This poster clearly outlines the name of the nominated person for the Approved Centre i.e. the complaints manager- Mr. Maurice Farnan- Tel. 01-2680463. Record maintained of all complaints by Mr. Maurice Farnan – complaints Manager – Tel. 01-2680463 **Post Holder** Complaints manager, all MDT members	Ongoing observational audit to be implemented by all MDT members Monthly ongoing audit of all complaints forwarded to complaints manager Mr. Maurice Farnan – Tel 01- 2680463	Achieved Achieved Achieved	Immediate and ongoing Immediate and ongoing Immediate and ongoing
	Preventative action(s): Complaints Policy Poster clearly displayed on notice boards for all residents, staff and visitors to see.		Achievable and realistic	Immediate and ongoing

	This poster clearly outlines the name of the complaints manager for service i.e. Mr. Maurice Farnan- Tel. 01-2680463 Nominated person available in Approved Centre to deal with all complaints is Mr. Maurice Farnan – complaints manager – Tel. 01-2680463 Record of all complaints maintained by the nominated person i.e. Mr. Maurice Farnan – complaints manager Tel. – 01-2680463 **Post Holder** Complaint's Manager, all MDT members	Ongoing observational audit to be implemented by all MDT members Documented record of all complaints maintained by complaints manager - Mr. Maurice Farnan- Tel. 01-2680463	Achievable and realistic	Immediate and ongoing Immediate and ongoing
3. There was no record of complaints escalated to the complaints officer	Corrective action(s): Nominated person i.e. complaints manager Mr. Maurice Farnan maintains a record of all complaints relating to the Approved Centre **Post Holder** Complaints Manager, all MDT members	Written evidence available	Achievable and realistic	Immediate and ongoing

	Preventative action(s): Nominated person i.e. complaints manager Mr. Maurice Farnan maintains a record of all complaints relating to the Approved Centre **Post Holder** Complaints Manager, all MDT members	Written evidence available with complaints manager – Mr. Maurice Farnan	Achievable and realistic	Immediate and ongoing

7. Regulation 32: Risk Management Procedures and Code of Practice: Notification of Deaths and Incident Reporting (inspection report references 3.32 and 6.3)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. There was no comprehensive risk management policy in place	Corrective action(s): Joint Senior Management forum between St Vincent's University Hospital and HSE in place to formulate risk management procedures. The Approved centre processes will incorporate the identification, assessment, management and ongoing review of risks on organisational and individual levels. Policy Review Group currently reviewing HSE Risk Management Policy. **Post Holder**: Registered Proprietor Senior Management Team	Processes to be agreed by Senior Management Team Processes to be agreed by Senior Management Team To be agreed	Processes to be agreed by Senior Management Team Processes to be agreed by Senior Management Team	Ongoing - 2016 Ongoing- 2016

	Preventative action(s): Joint decision to be reached by both HSE and SVUH in relation to risks management processes **Post Holder**: Registered Proprietor Senior Management Team	Processes to be agreed by Senior Management Team	Processes to be agreed by Senior Management Team	Ongoing- 2016
2. The policy did not identify the roles and responsibilities of staff in relation to reporting incidents	Corrective action(s): Policy will be reviewed by the joint HSE/ SVUH Mental health forum in relation to reporting incidents including staff responsibilities and roles. HSE – National Incident Management Systems currently being implemented in HSE facilities **Post holder** Registered Proprietor Senior Management Team	Processes to be agreed by Senior Management Team	Processes to be agreed by Senior Management Team	Ongoing- 2016
	Preventative action(s): Policy to be amended in line with agreed structures	When completed – policy will be audited in line with MHC requirements and/or		Ongoing - 2016

		changes in legislation/ practices within the Approved Centre	Processes to be agreed by Senior Management Team	
3. The risk manager was not identified in the policy	Corrective action(s): Awaiting for appointment of Risk Manager for HSE – CHO 6 Currently General Manager Mr. Maurice Farnan designated risk manager for service. Tel. 01- 2680463 **Post holder** Registered Proprietor Senior Management Team	Policy to be amended by Policy Review Group	Processes to be agreed by Senior Management Team	Q3/Q4- 2016
	Preventative action(s): Policy Review Group to amend policy to add designated name of Area Manager **Post Holder** Senior Management Team	Visual evidence when amended policy completed and implemented	Processes to be agreed by Senior Management Team	Q3/Q4 2016

8. Code of Practice: The Use of Physical Restraint (inspection report reference 6.1)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. A copy of the order for restraint had not been placed in the resident's clinical file	Corrective action(s): Remind all staff to put copy of restraint order in resident's clinical file. **Post Holder-** All MDT staff	3 monthly audit	Achievable and Realistic	Immediate and ongoing
	Preventative action(s): All MDT members to be aware of MHC requirements in relation to the use of Physical Restraint **Post Holder-** All MDT staff	3 monthly audit	Achievable and Realistic	Immediate and ongoing
2. The consultant psychiatrist was not notified of the episode of physical restraint	Corrective action(s): Remind all staff and medical personnel of need to notify	3 monthly audit	Achievable and Realistic	Immediate and ongoing

	consultant psychiatrist of episode of physical restraint. **Post Holder-** All MDT staff			
	Corrective action(s): Line managers to ensure that all staff and medical personnel comply with the need to notify consultant psychiatrist of episode of physical restraint. **Post Holder-** All MDT staff – line managers and staff on unit	3 monthly audit	Achievable and Realistic	Immediate and ongoing
3. A physical examination of the resident had not taken place within the specified timeframe	Corrective action(s): Remind all staff of need to do a physical examination of resident within the specified timeframe **Post Holders** Medical personnel and nursing staff on unit	3 monthly audit	Achievable and Realistic	Immediate and ongoing

	Preventative action(s): Line managers to ensure that all staff and medical personnel comply with the need to notify consultant psychiatrist of episode of physical restraint. **Post Holder-** All MDT staff – line managers and staff on unit		Achievable and Realistic	Immediate and on going
4. The clinical practice form had not been signed by the consultant psychiatrist	Corrective action(s):Remind all staff to ensure consultant psychiatrist signs clinical practice form **Post Holder** Consultant and all MDT staff Preventative action(s): All staff and medical personnel comply with the need to ensure that the consultant psychiatrist has signed the clinical practice form.. **Post Holder** Consultant and all MDT staff	3 monthly audit	Achievable and Realistic	Immediate and ongoing

5. The reason the next of kin was not informed was not documented	Corrective action(s):Remind all staff to ensure next of kin is informed of need for restraint **Post Holder** Nursing staff and all MDT members	3 monthly audit	Achievable and Realistic	Immediate and ongoing
	Preventative action(s): Ensure all staff are aware of the requirement to document the reason why the next of kin has not been notified if applicable. **Post Holder** Nursing staff and all MDT members			
6. The resident was not informed of reasons for restraint	Corrective action(s): Remind all staff to ensure resident is informed of reasons for restraint, which is documented **Post holder** Nursing staff and all MDT members	3 monthly audit	Achievable and Realistic	Immediate and ongoing
	Preventative action(s): Remind all staff to ensure resident is informed of reasons for restraint, which is documented **Post holder** Nursing staff and all MDT members	3 monthly audit	Achievable and Realistic	Immediate and ongoing

7. Security personnel involved in physical restraint were not aware of a resident's care and treatment plan	Corrective action(s): The person who initiates and orders the physical restraint (lead person) i.e. a registered medical practitioner, registered nurses or other members of the Multi-Disciplinary Team (MDT) will instruct all staff involved in the restraint of the residents needs as set out in their care and treatment plan. All staff involved in physical restraint should be aware of and have considered any relevant entries in the resident's care and treatment plan and any specific requirements in relation to physical restraint e.g. 'advance directives' **Role of the Lead Person** The role of this designated member of staff (lead person) is to be responsible for leading the physical restraint of the resident and for monitoring the head and airway of the resident.	3 monthly audit	Achievable and Realistic	Immediate and ongoing

	Post holder All nursing staff and MDT members			
	Preventative action(s): The person who initiates and orders the physical restraint (lead person) i.e. a registered medical practitioner, registered nurses or other members of the Multi-Disciplinary Team (MDT) will instruct all staff involved in the restraint of the residents needs as set out in their care and treatment plan. All staff involved in physical restraint should be aware of and have considered any relevant entries in the resident's care and treatment plan and any specific requirements in relation to physical restraint e.g. 'advance directives' **Post holder** All nursing staff and MDT members	3 monthly audit	Achievable and Realistic	Immediate and ongoing

9. Code of Practice: Admission of Children (inspection report reference 6.2)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. There were no age appropriate facilities	Corrective action(s): A Mental Health Forum meeting consisting of the Registered Proprietor, the Senior Management Team and a board representative from SVUH has been arranged to discuss this issue on July 8th 2016 **Post Holders** Registered Proprietor, the Senior Management Team and a board representative from SVUH	Immediate monitoring following Mental Health Forum meeting 8th July 2016 by Registered Proprietor	Registered Proprietor to instruct following Mental Health Forum – 8th July 2016	Date of Mental Health Forum Meeting – 8th July 2016
	Preventative action(s): A Mental Health Forum meeting consisting of the Registered Proprietor, the Senior Management Team and a board representative from SVUH has been arranged to discuss this issue on July 8th 2016 **Post Holder**	Immediate monitoring following Mental Health Forum meeting 8th July 2016 by Registered Proprietor	Registered Proprietor to instruct following Mental Health Forum – 8th July 2016	Following 8th July 2016

	The Registered Proprietor, Senior Management Team and a board representative from SVUH			
2. There was no programme of activities appropriate to age	Corrective action(s): Individual Care Plan to outline appropriate programme of activities. Individually assessed needs **Post holder** Nursing staff and MDT member	Monitoring of ICP by MDT members	Yes	Immediate and on going
	Preventative action(s): Individual Care Plan to outline any specific programmes/ activities appropriate to age. **Post holder** Nursing staff and MDT member	Monitoring of ICP by MDT members	Yes	Immediate and on going

10. Code of Practice: Admission, Transfer and Discharge (inspection report reference 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. The approved centre was not compliant with a number of regulations specified in the code of practice i.e. Regulation 7 Clothing and Regulation 15 Individual Care Plan	See CAPA 1 (Regulation 7: Clothing) and CAPA 15 – Individual Care Plan	As per CAPA Regulation 7 and Regulation 15	Achievable and realistic	Immediate and on going
2. There was no record of resident's consent (or lack of) to the transfer	Corrective action(s): MDT staff to record in the resident's clinical file consent to transfer **Post Holder** All MDT members ADON CNM2	3 monthly audit of all transfers within the unit	Achievable and realistic	Immediate and on going
	Preventative action(s): Monitoring of ICP			

3. There was no record of family involvement (or lack of)	Corrective action(s): MDT staff are aware of and comply with the requirement to inform next of kin of reason for transfer and document same **Post Holder** All MDT members ADON CNM2 of unit	3 monthly audit of all transfers within the unit	Achievable and realistic	Immediate and on going
	Preventative action(s): MDT staff are aware of and comply with the requirement to inform next of kin of reason for transfer and document same **Post Holder** All MDT members ADON CNM2 of unit	3 monthly audit of all transfers within the unit	Achievable and realistic	Immediate and on going