Elm Mount Unit, St Vincent's University Hospital

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coimisiún meabhair - shláinte
mental health commission

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ELM MOUNT UNIT, ST VINCENT'S UNIVERSITY HOSPITAL

Elm Park, Dublin 4

Date of Publication: 11th March 2023

ID Number: AC0149

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life
Other: Eating disorder care

Conditions Attached:
None

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

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

Inspection Team:
Marianne Griffiths, Lead Inspector
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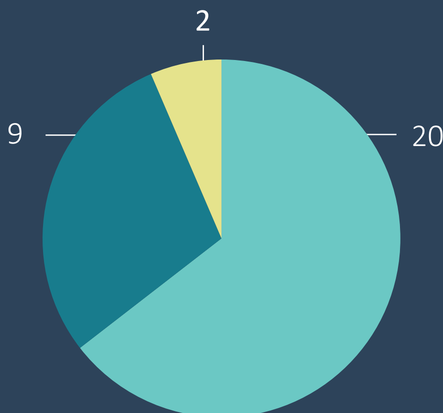
Dr Susan Finnerty MCRN009711

Inspection Date:
18 – 21 July 2023

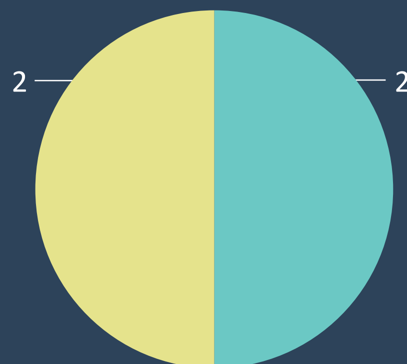
Previous Inspection date:
16 – 19 August 2022

Inspection Type:
Announced Annual Inspection

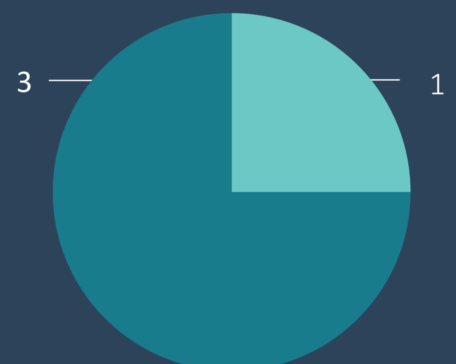
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



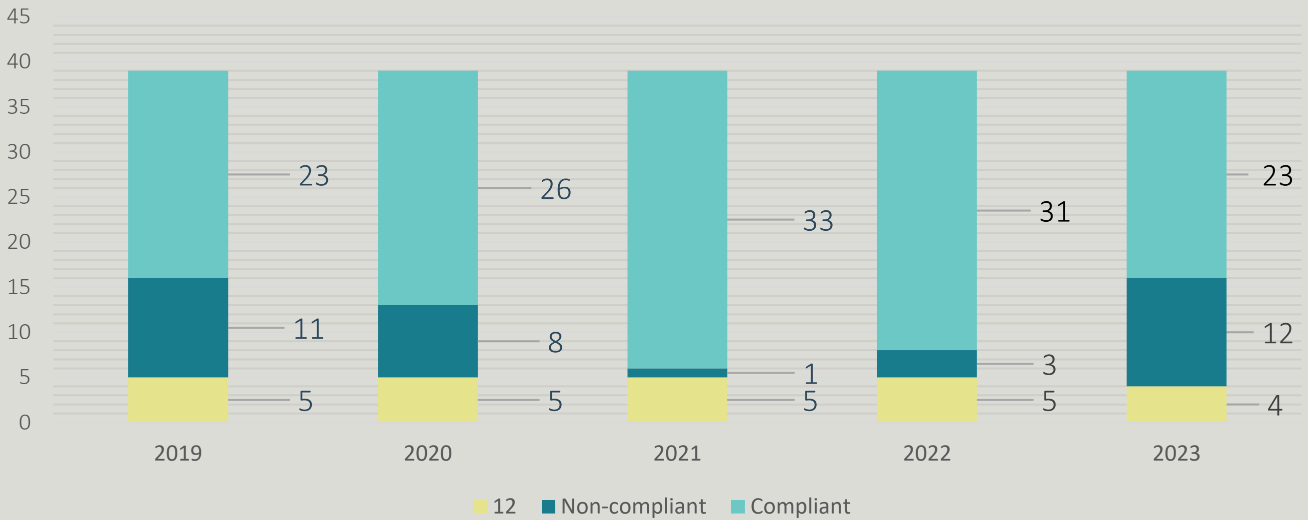
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2019 – 2023

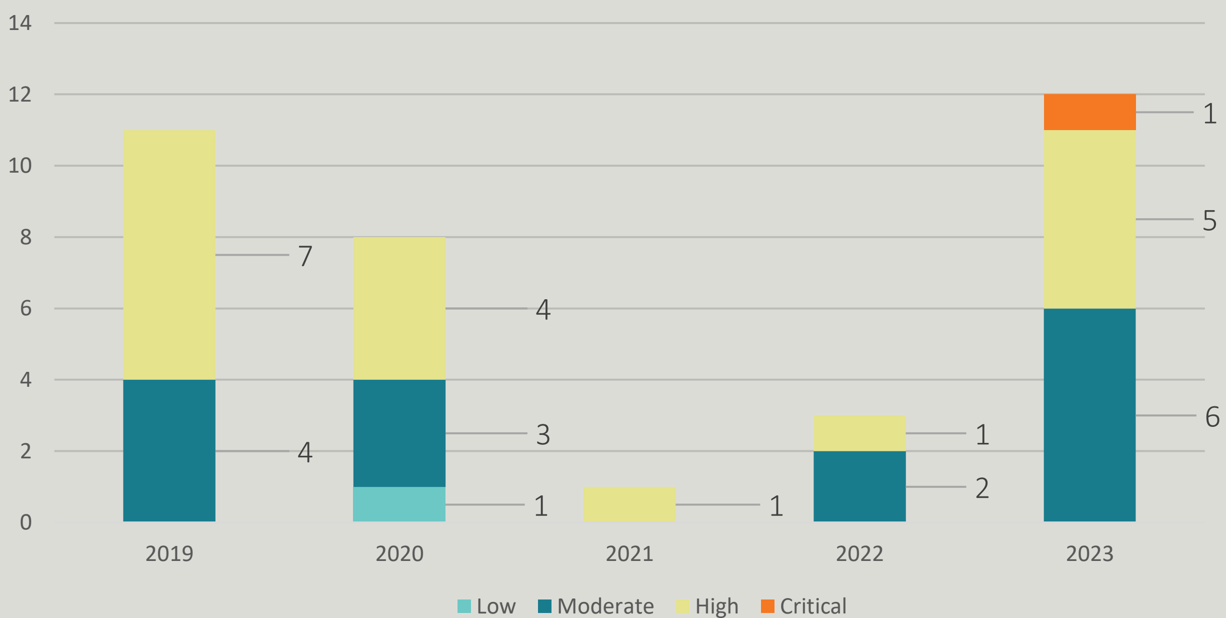
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

Elm Mount Unit was located on the grounds of St Vincent's University Hospital (SVUH) Elm Park, Dublin. It provided acute admission, psychiatry of later life, and eating disorder services for admissions by five sector teams located within a defined catchment area. An in-reach model of care was in place. Elm Mount Unit had an operational bed capacity of thirty six and at the time of the inspection accommodated 28 residents.

The approved centre was split into three units: Elm Mount Upper, Elm Mount Lower and a Psychiatry of Old Age Unit. Although registered for thirty-nine beds, the approved centre was operating with an operational capacity of thirty-six beds. Three of the beds in Elm Mount Lower were for the care and treatment of residents with an eating disorder who were from the Community Healthcare East catchment area.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	68%	76%	97%	91%	66%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate action notice	*21/7/2023*	*Regulation 32: Risk Management found non-compliant with risk rating of critical on inspection.*	*The approved centre provided initial assurances.*

Regulatory compliance meeting	*15/8/2023*	*Following initial correspondence, the MHC deemed it necessary to meet with the service.*	*Verbal assurances were provided at the regulatory compliance meeting. A SMART action plan followed which the MHC continue to monitor.*

Safety of people in the approved centre

The approved centre demonstrated that they provided safe care in the following areas:

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre***: There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Assessment and management of individual risk***: All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Access to essential information***: The approved centre clinical files were in order and it was easy to find essential information about each resident. The approved centre Health and Safety Statement was available to staff.
- ***Maintenance:*** There was a maintenance programme.
- ***Infection control***: The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Mandatory training:*** Not all staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Hazards:*** Were not entirely minimised: linen trolleys and mobility equipment were stored on a corridor and in resident bathrooms.
- ***Ligature anchor points:*** Were not minimised to the lowest level, based on individual risk assessment.
- ***Safety: Visiting arrangements:*** Due to the fact that there was no dedicated visiting spaces in the approved centre, and visits took place in communal spaces and shared bedrooms, appropriate steps were not taken to ensure the safety of residents and visitors during visits.
- ***Medication:*** While the ordering and storing of medications were carried out in a safe manner, the administration and prescribing of medication was not consistently carried out in a safe manner. Three Medication Prescription Administration Records (MPARs) did not include all administration records or code to indicate if medication was given or omitted. Two MPARs did not record stop dates for medications that were discontinued. In one MPAR the minimal dose interval for a PRN ('take as required') medication was illegible. In one MPAR, the allergy section, which records allergies or sensitivities to any medications, was not adequately completed.

Appropriate care and treatment of residents

The approved centre demonstrated that they provided appropriate care and treatment in the following areas:

- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination as part of a six-monthly general health assessment and were monitored in accordance with clinical guidelines.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs, goals that had been decided with the resident's input, and appropriate interventions to address those goals. There was an identified staff member allocated within the ICP document to deliver interventions.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT).
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan.
- ***Access to other medical services:*** Specialist therapeutic interventions, were accessible to residents when required.

However:

- ***Individual Care Plans: multi-disciplinary team working:*** Four individual care plans (ICPs) were not reviewed by all of the relevant members of the residents' multi-disciplinary team. Their ICP was conducted by medical and nursing staff only.
- ***Transfers:*** The approved centre did not comply with Regulation 18: Transfer of Residents. A clinical file of a resident transferred to another healthcare facility in an emergency situation, was found to show that no referral letter or resident transfer form was sent from the approved centre to the receiving facility when the resident was transferred there.
- ***Environment: Space:*** Communal space within the approved centre was inadequate. The sitting rooms and garden area in Elm Mount Upper did not provide enough space for residents to move around. The sitting room in the psychiatry of old age unit was also cramped.
- ***Environment: Furnishings:*** The garden furniture in the psychiatry of old age unit was unsuitable: the seats were very low in height, and were wide and shallow which posed difficulties for elderly residents with limited mobility. Furnishings in the Elm Mount Upper sitting rooms were limited.
- ***Admission of Children:*** A clinical file of a young person who had been admitted to the approved centre showed that while provisions were in place to ensure the safety of the young person, respond to their special needs as young people in an adult setting, and ensure the right of the young person to have their views heard, age appropriate facilities were not provided as the approved centre was an adult mental health facility.
- ***Discharges:*** While the discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan, the approved centre's discharge process had deficits as follows:

  The clinical file of a resident who was discharged showed that a resident's discharge plan did not include documented communication with the relevant mental health staff, and it did not include a reference to early warning signs of relapse and risks. The clinical file did not include a preliminary

discharge summary being sent to the relevant health care professional within three days nor did it contain a comprehensive discharge summary issued within 14 days.

Respect for residents' privacy, dignity and autonomy

The approved centre demonstrated that they respected people's privacy, dignity and autonomy in the following areas:

- ***Sleeping accommodation:*** Residents slept in a mixture of dormitory style accommodation with a number of single occupancy rooms.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Mechanical restraint was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained by mechanical means, including information on attempts to reduce or eliminate the use of restraint for that person. The approved centre was non-compliant with the Code of Practice on Physical Restraint. Seclusion was not used in the approved centre.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Rights-based care: Visits/Relationships: Privacy:*** Visiting areas were not suitable for child visitors. Visits happened in communal areas and bedroom areas, some of which were shared bedrooms.
- ***Use of restrictive practices: Rights-based Care: Physical Restraint:*** There were a significant number of deficits in the physical restraint process in the sample (3) of physical restraint episodes inspected:
    - a) One clinical practice form was not signed by the consultant psychiatrist or the duty consultant psychiatrist within 24 hours.
    - b) Where it was the resident's wish that their representative was not to be informed of the restraint, no such communication should occur outside the course of necessary legal or professional requirement; however, documentation indicated contradictory information: that the representative had been contacted, whereas the resident had requested for their representative not to be contacted.
    - c) An in-person debrief did not occur for two physical restraints episodes.

d) In the case of the debrief that took place there was no discussion of alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. Similarly, there was no documentation indicating whether or not the resident wished to participate or if they did not wish to participate in the debrief contained within the clinical file, no discussion regarding the resident's preferences in the event of a restrictive intervention being needed in the future, and no documentation as to if the resident was given the option of having their representative or their nominated support person to attend the debrief with them, and, if the resident's representative or nominated support person did not attend the debrief, a record of the reasons why this did not occur was not present.
e) There was no clinical record in the three episodes reviewed that the resident was provided appropriate emotional support following the physical restraint.
f) Two episodes of physical restraint were not reviewed by members of the multi-disciplinary team within five working days from the date of the restraint.
g) In one clinical file, while it was reviewed by the multi-disciplinary team following the episode of physical restraint within five working days, the review itself was not completed to include all aspects required by the code of practice.
h) The oversight committee was attended by nursing staff only and was not multi-disciplinary as required.

Responsiveness to residents' needs

The approved centre demonstrated that they were responsive to people's needs in the following areas:

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated. The Elm Mount Lower facility had a large outdoor space, which is well-maintained and accessible to residents. This area offers a conducive environment for various outdoor activities, contributing significantly to the overall well-being and comfort of the residents. There were outdoor spaces off the POA ward. That space, though smaller in comparison, are equally vital in providing diverse outdoor experiences for the residents housed in these parts of the facility. The outdoor area off Elm Mount Upper did not provide adequate outdoor space to the residents of the ward.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Residents' feedback:*** All feedback was complimentary toward the staff. A number of residents expressed dissatisfaction with the lack of recreational space, and residents indicated that they would like to have access to more activities at the weekend. Residents felt it was difficult to accommodate their visitors on the unit due to the lack of space. When asked to rate the service out of 10 with 1

being poor and 10 being excellent, the average score emerged as 7.3 out of 10. Please refer to section 5.1. of this report for more information.

However:

- ***Recreational Activities:*** Residents had a lack of recreational activities, especially at weekends. Spaces for recreational activities were limited also. Materials for recreational activities were sparse and included only games, jigsaws and two televisions.
- ***Visits: Private areas and areas for socialisation:*** There was no dedicated private spaces for visits to take place between residents and their visitors.

Governance, Leadership and Accountability

The approved centre had the following governance structures and processes in place:

- ***Structure in place:*** Elm Mount Unit approved centre was under the governance of Community Healthcare East (CHE) Mental Health Service. The mental health services were responsible for the governance of Elm Mount unit and the senior management met quarterly with representatives of St. Vincent's University Hospital Elm Park (SVUH) in order to facilitate collaborative working.
- ***Leadership:*** The Executive Management Team meetings took place on a monthly basis and included each of the clinical Heads of Discipline and senior administration. The Quality and Patient Safety committee met monthly and its membership also included the Heads of Discipline. There were well established processes for staff management including both formal and informal performance appraisal and supervision.
- ***Restrictive practices reduction:*** The service had developed and implemented a policy on the reduction of restrictive practice. The approved centre was compliant with the Rule Governing Mechanical Restraint and it was not compliant with the Code Of Practice on Physical Restraint. Seclusion was not used in the approved centre.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. There was a plan in place for the reconfiguration of the approved centre in order to address some of the risks identified with the current environment. The Elm Mount Reconfiguration and Expansion Plan (2022-2026) gave a detailed plan for how this could be achieved.
- ***Quality improvement:*** Regular audits had been completed by the approved centre. Staff training and development had expanded to include Sensory Modulation Training. There had been a recent focus upon quality of one to one interventions delivered by healthcare staff.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. There were several processes in place for resident and carer engagement with the approved centre. Resident representatives were included in the design of programmes, interventions and services. Resident evaluations were carried out regularly. Feedback was provided via the HSE *Your Service Your Say* complaints process.

- ***Advocacy services:*** Residents in the approved centre had access to an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 83% over the last four years. The compliance rate decreased since 2022 when it had a 91% compliance rate, to this year 2023 when it had a 66% compliance rate. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Regulatory compliance and engagement:*** The approved centre was non-compliant with 12 areas of the inspection and Regulation 32: Risk Management received a critical risk rating.
- ***Risk:*** The approved centre had significant deficits in their risk management processes. These were as follows:
  a) Not all clinical risks were identified, assessed, treated or monitored on the unit as precautions were not consistently in place to control for the risk of assault.
  b) Precautions were not put in place to control for all structural and health and safety risks. Three risks were identified regarding the Elm Mount Upper premises: the layout of the dormitories contained 'blind spots' in terms of observation; a narrow corridor and a lack of space for residents to move about.
  c) Arrangements for the protection of vulnerable adults were not consistently in place within the approved centre.
  d) The approved centre did not maintain a record of all incidents and did not notify the Mental Health Commission of incidents occurring in the approved centre.
  e) Hazards and ligature anchor points were not minimised.
- ***Policies:*** Ten of the approved centre's written operational policies and procedures had not been reviewed within the required three-year timeframe.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The acquisition of indoor and outdoor furniture for resident comfort, with new garden furniture installed in Elm Mount Upper, Lower, and POA garden areas.
2. Recent completion of new flooring in the Elm Mount Lower Unit.
3. The establishment of a Restrictive Practices oversight committee.
4. There had been a recent focus upon quality of 1:1 interventions delivered by healthcare staff. This included the procurement of educational resources focused upon well-being and mental health promotion. These resources drew upon evidence based guidance and included the use of Wellness Recovery Action Plan (WRAP) tools.
5. Staff training and development had expanded to include Sensory Modulation Training. Funding had been made available for a Postgraduate Diploma in Professional Practice and a Post Graduate Diploma in Professional Management of Complex Behaviour in Clinical Practice.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Elm Mount Unit was located within the campus of St Vincent's University Hospital (SVUH) Elm Park, Dublin. It provided an acute admission service for five sector teams located within a defined catchment area. These included two sector teams for Churchtown, two for Milltown and one known as Vergemount that covered parts of the inner city. The service was sectorised with catchment areas based on electoral divisions. General adult residents from the sector teams remained under their team's care where an in-reach model of care applied. Psychiatry Old Age (POA) teams within these areas also admitted residents to the approved centre. The POA Multi-Disciplinary Team was responsible for the treatment and care for all inpatient in the Elm Mount POA unit.

Although registered for thirty-nine beds, the approved centre had an operational capacity of thirty-six beds at the time of the inspection. The approved centre was sub dived into three areas. Each of the three areas had its own dining room, clinical room and sitting room. Elm Mount Upper had eighteen beds, mainly located within dormitory style accommodation with a number of single occupancy rooms. There was an external garden that residents could readily access. It contained shrubbery and plants and was well maintained. The garden was small in space and frequently used for smoking. The residents in Elm Mount Upper had access to a refurbished sensory room which was used under nursing supervision. There a second sitting room located within Elm Mount Upper. Both sitting rooms were modest in size and were plain and clinical in terms of decoration.

Elm Mount Lower was located on the basement floor and had twelve operational beds, mainly dormitory style with some single room accommodation available. Three of the beds in Elm Mount Lower were for the care and treatment of residents with an eating disorder who were from the Community Healthcare East catchment area. Insofar as was possible, residents were designated their own room in Elm Mount Lower; either in a single room or as the sole occupant of a dormitory. A specialist team provided the care and treatment of residents with an eating disorder. The access corridor to Elm Mount Lower contained external clinics which included space for the delivery of health and social care services to out-patients.

Elm Mount unit contained a six bedded POA unit, with two single and two double bedrooms. This was located adjacent to Elm Mount Upper. The POA had access to a garden from a communal sitting area. This garden contained furniture that was unsuitable for the needs of the residents. POA residents were sometimes cared for in Elm Mount Lower or Upper due to full capacity of the POA ward.

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

Resident Profile	
Number of registered beds	***39***
Total number of residents	**28**
Number of detained patients	6
Number of wards of court	0

Number of children	0
Number of residents in the approved centre for more than 6 months	2
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Elm Mount Unit approved centre was under the governance of Community Healthcare East (CHE) Mental Health Service. The wider service was made up of East Wicklow and Dublin Southeast. The mental health services were responsible for the governance of Elm Mount unit and the senior management met quarterly with representatives of St. Vincent's University Hospital Elm Park (SVUH) in order to facilitate collaborative working. An accommodation committee had been set up by the management of Elm Mount to identify specific issues pertaining to the premises escalated to the SVUH management. This included regular discussions about the plans by SVUH to start building works at the back of Elm Mount approved centre in the coming months.

The approved centre was represented at a number of multi-disciplinary management meetings which contributed to its governance. The Executive Management Team meetings took place on a monthly basis and included each of the clinical Heads of Discipline and senior administration. Minutes of these meetings included updates for each of the disciplines regarding their ongoing work in CHE MHS as well as the ongoing challenges presented in terms of staff recruitment. Issues pertaining to safeguarding and assisted decision making each featured as part of the discussions held at these meetings as did the implementation of the Mental Health Commission Quality Framework. At the time of the inspection, many of the approved centre policies had recently expired and were awaiting a three yearly review required under Regulation 29, Operating Policies and Procedures.

The Quality and Patient Safety committee met monthly and its membership also included the Heads of Discipline. Items discussed pertaining to Elm Mount unit included; health and safety inspection visits, planned staff training and Corrective and Preventative Actions emerging from the 2022 Mental Health Commission report. Ongoing ICP training sessions for staff and a presentation of communications sent from external agencies pertaining to Patient Safety and to Open Disclosure were documented within these minutes. Discussion about the overall risk management reporting process for CHE MHS also took place at these meetings. Risks identified within the approved centre included not having a dedicated psychology service for in-patient Adult Mental Health Services as well as staff recruitment. Despite the development of a robust incident reporting and management system some structural risks associated with the Elm Mount Unit environment remained unmitigated at the time of the inspection. The clinical risks associated with the behaviour of a particular resident were not identified, assessed, treated, reported or monitored. Not all incidents were recorded and escalated appropriately.

Elm Mount Unit Local Operational Management meetings occurred monthly . The minutes of these meetings illustrated a focus upon improvements to the physical structure of the Elm Mount building such as new flooring and the procurement of anti-ligature furniture. Attendees discussed the challenges presented within the approved centre in providing a safe service at these meetings in order to identify and minimise risks. The

Local Compliance Committee for the approved centre met every two months and addressed issues pertaining to regulatory compliance such as: the updated therapeutic programme, the application for funding for the provision of a recreational activities programme, the maintenance work's schedule and a review of the local risk register. The Approved Centre a Quarterly Meeting and Walkaround, focusing on Regulation 22 (Premises) and Regulation 32 (Risk Management, particularly regarding ligature risks). This group, comprising Nurse Management, staff from the Approved Centre, HSE Estates, SVUH Maintenance, the HSE Fire Officer (on request), QPS Advisor, Senior Operations Manager, Business Analyst, and the Registered Proprietor Nominee, played a vital role in monitoring the progress of minor capital projects. These projects included decorative and anti-ligature works, ensuring schedules were adhered to, addressing any arising issues, and identifying opportunities for improvement. Additionally, this group was instrumental in deciding on plans for annual minor capital and one-off capital investments, underlining their crucial role in upholding high standards of safety and quality in the facility's environment.

The Restrictive Practice Reduction Committee had recently been formed and had met once since its establishment. This meeting was attended by nursing representatives, however the makeup of this committee was to be multi-disciplinary going forward. This committee aimed to continue to foster a culture of positive behaviour support and least restrictive practices within Elm Mount.

There were well established processes for staff management including both formal and informal performance appraisal and supervision. Staff training was a challenge for the nursing and medical departments. The approved centre had trained six trainers in the area of Management of Violence and Aggression. At the time of the inspection [July] the medical team had recently gone through a period of change whereby new Non Consultant Hospital Doctors had commenced within the CHE MHS within the previous weeks. This had presented challenges for the completion of mandatory training for medical staff. Nursing vacancies were identified within the approved centre. Three occupational therapists and one occupational therapy assistant had commenced working in Elm Mount. Social Work and Psychology staff attended the approved centre on an in-reach basis; relevant social work and psychology staff from the community teams attended Elm Mount unit ICP meetings and completed one to one therapeutic work with residents from their respective teams.

There was a proposal in place for the reconfiguration of the approved centre in order to address some of the risks identified with the current environment. The Elm Mount Reconfiguration and Expansion Plan (2022-2026) gave a detailed plan for how this could be achieved. Potential benefits of the project included the development of a larger, brighter space which would reduce the risk of injury and overcrowding and consequently improve patient safety. At the time of the annual inspection this plan remained in its early stages and funding for it had not been confirmed at the time of the inspection. Each department had operational goals that aligned with the strategic plan.

There were several processes in place for resident and carer engagement with the approved centre. Resident representatives were included in the design of programmes, interventions and services. Resident evaluations were carried out regularly. Feedback was provided via the HSE *Your Service Your Say* complaints process.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2019 and 2023 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 9: Recreational Activities	✗	Moderate	✓		✓		✓		✗	Moderate
Regulation 11: Visits	✓		✓		✓		✓		✗	High
Regulation 15: Individual Care Plan	✗	High	✗	Moderate	✓		✓		✗	Moderate
Regulation 18: Transfer of Residents	✓		✓		✓		✓		✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storage and Administration Medicines	✗	High	✗	Low	✓		✓		✗	High
Regulation 26: Staffing	✗	High	✓		✓		✗	Moderate	✗	High
Regulation 29: Policies and Procedures	✓		✓		✓		✓		✗	Moderate
Regulation 32: Risk Management	✗	High	✓		✓		✓		✗	Critical
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	High	✓		✓		✓		✗	High
Code of Practice Admission of Children		N/A		N/A		N/A		N/A	✗	Moderate
Code of Practice on Admission, Transfer and Discharge	✓		✗	Moderate	✓		✓		✗	Moderate

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.

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engage with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- The Peer Advocacy in Mental Health representative was contacted to obtain residents' feedback about the approved centre.

With the residents' permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

Three residents spoke with the inspection team. Each of the three residents indicated that they would like to have access to more activities at the weekends. All three residents spoke in complimentary terms about the approachability and kindness of the staff. One resident reported that they did not feel safe in the approved centre and that there was an atmosphere of tension present at times. Residents also indicated that the lack of space on the unit meant that it was difficult to accommodate visitors to the unit. They expressed dissatisfaction with the lack of access to recreational space on the ward. One resident spoke about their ICP in positive terms indicating that the care and treatment process was collaborative. Two of the residents indicated that the food choices were predictable and would have preferred a more varied menu.

Six residents completed the Mental Health Commission questionnaire. Five of the six respondents indicated that they felt they had space for privacy. Five of the respondents stated that they were 'always' able to give feedback to staff or make complaints when they are not satisfied with any part of their stay in the approved centre. Three residents indicated that they were 'always' involved in goal setting for their individual care plan with two 'sometimes' involved and one respondent choosing not to be involved themselves. All respondents knew their allocated key worker. When asked to rate the service out of 10 with 1 being poor and 10 being excellent, the average score emerged as 7.3 out of 10.

5.2 Advocacy

Residents in the approved centre had access to an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative. This report stated that residents were complimentary

of the quality service they received from the nursing staff who were described as ‘kind’ and ‘supportive’ despite being very busy. Residents were also pleased with the access provided to the OT activities programme. Some challenges reported by residents to the advocate included; inadequate orientation to the approved centre on admission, stresses associated with sharing rooms with other residents particularly those who were very unwell and dissatisfaction with the food which was described as ‘bland.’

6.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Executive Clinical Director
- Clinical Director
- Head of Service
- Registered Proprietor Nominee
- Director of Nursing
- Assistant Director Of Nursing
- Psychologist
- Quality and Compliance Lead
- Occupational Therapy Manager in Charge
- Principal Social Worker
- Two Clinical Nurse Manager 3s
- Three Clinical Nurse Manager 2s

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs.

Resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(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

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. A source of safe, fresh drinking water was available at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Nursing staff used the MUST Nutritional Assessment Tool and referrals were made to the dietitian and speech and language therapist (accessed through the main hospital), where necessary.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(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

The approved centre provided suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

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

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours, unless by choice or specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

(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

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed on the 9th of July 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP or in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

The approved centre did not provide access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents provided feedback that indicated a lack of available activities or recreational groups in the approved centre, particularly at the weekends. Available recreational materials were limited to a cupboard containing games, jigsaws and two televisions. Opportunities for the engagement in outdoor recreational activities were limited for residents of Elm Mount Upper. Residents in the POA and Elm Mount Lower wards could access outdoor areas for recreation. The approved centre did not contain a gym area.

The approved centre was non-compliant with this regulation because the approved centre did not provide access for residents to appropriate recreational activities insofar as was practicable, 9.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents’ rights to practice religion were facilitated within the main hospital insofar as practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

NON-COMPLIANT

Risk Rating HIGH

(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

The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed on the 9th of July 2023.

Visiting times were appropriate and reasonable. Appropriate arrangements were not made for residents and visitors. The approved centre did not provide a separate visitors' room or visiting area where residents could meet visitors in private, having due regard to the wellbeing, safety and health of residents and visitors. There was no separate visitors' room on the upper level; a quiet room was sometimes used, but this was a communal area for residents. There was no identified visiting space on the lower floor or in the psychiatry of old age (POA) unit. Some visits were conducted in shared bedrooms.

Due to the fact that there was no dedicated visiting spaces in the approved centre, and visits took place in communal spaces and shared bedrooms, appropriate steps were not taken to ensure the safety of residents and visitors during visits. The visiting areas were not suitable for child visitors.

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

a) **The registered proprietor did not take all reasonable steps to ensure that appropriate arrangements were made for residents and visitors due to the fact that there was no dedicated space for visits, 11 (1).**

b) **The registered proprietor did not take all reasonable steps to ensure the safety of residents and visitors. Visits were conducted in communal areas and bedroom areas, some of which were shared bedrooms, 11 (3).**

c) **The registered proprietor did not ensure that appropriate arrangements and facilities were in place for children visiting a resident, 11 (5).**

Regulation 12: Communication

COMPLIANT

(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

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed on the 9th of July 2020.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents had access to Wi-Fi, and could use their mobile phones unless otherwise risk-assessed. Cordless phones were available on each unit, as were electronic tablets, for use by the residents.

It was the approved centre's policy that the clinical director (or senior staff member designated by the clinical director) only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others. There were no restrictions on communication for any resident at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

(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

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed on the 9th of July 2020, and included all requirements related to:

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record was available for each of the searches examined; these records included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed on the 9th of July 2020.

As no resident had passed away in the approved centre since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating **MODERATE**

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

Each resident had an Individual Care Plan (ICP). Ten ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

All ICPs reviewed identified appropriate goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. Six of the ten ICPs appropriate reviewed by the MDT in consultation with the resident. In the case of four ten ICPs inspected, the weekly review was conducted by medical and nursing staff only; no health or social care professionals were in attendance at the review meetings as required.

The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was non-compliant with this regulation because four individual care plans (ICPs) were not reviewed by the multi-disciplinary team. Their ICP review was conducted by medical and nursing staff only, 15.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

(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

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs).

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Functional assessments and assessments of needs were carried out with residents. There were therapeutic programmes timetable on notice boards in all units. These included sensory modulation, emotional regulation, social integration, cookery, baking, and gardening provided in group and individual settings. Staff also provided one to one interventions to residents including support with activities of daily living, social engagement and budgeting. An OT also facilitated a fitness group.

The occupational therapy team was located within the approved centre with psychology and social work staff providing and in-reach service. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

NON-COMPLIANT

Risk Rating **MODERATE**

(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

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed on 9th of July 2020. The clinical file of one resident who had been transferred from the approved centre was inspected. It was an emergency transfer. Clinical notes indicated that communication had taken place between the approved centre and the receiving facility; however, neither a referral letter nor transfer form from the approved centre was had been sent to the receiving facility.

The resident's clinical file was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included the resident's medication prescription and administration record (MPAR), which recorded a list of current mediations.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all relevant information about the resident was provided to the receiving facility, as no referral letter or resident transfer form was sent from the approved centre to the receiving facility as part of the transfer process, 18 (1).

Regulation 19: General Health

COMPLIANT

(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

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed on the 9th of July 2020. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The clinical files of two residents who had been in the approved centre for over six months were examined on inspection. The six-monthly health assessments documented, where applicable, a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, and body mass-index, weight, and waist circumference. For residents on anti-psychotic medication, there was an annual assessment of their electrocardiogram (ECG) heart function.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

(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

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed on the 9th of July 2020.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs.

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. Where residents shared a room, bed screening was provided to ensure their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(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

Residents in Elm Mount Upper did not have sufficient access to appropriate personal space. Appropriately sized communal rooms were not consistently provided. Residents in Elm Mount Upper had access to a very small garden area that was used for smoking. There were two sitting rooms that were small in size and sparsely furnished. Residents in Elm Mount Upper had access to a quiet room. The psychiatry of later life (POA) unit sitting room contained insufficient space for adequate comfort . The POA garden space was suitable for six residents. Residents on Elm Mount Lower had access to sufficient personal space. Bedroom spaces on all wards were of an adequate size.

Not all hazards were minimised in the approved centre: storage space for equipment was very limited; linen skips were stored in the Elm Mount Lower corridor, and hoists and trolleys were stored in one of the resident's bathrooms, both of which were potential trip hazards. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

There was suitable and sufficient heating in day areas and bedrooms. Rooms were ventilated. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs. The approved centre did not have suitable furnishings for the mix of residents, as the garden furniture in the POA was unsuitable, as the seats were very low in height, were wide and shallow which posed difficulties for elderly residents with limited mobility. Furnishings in the Elm Mount Upper sitting rooms were also limited.

The approved centre was kept in a good state of repair externally and internally. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs, and furnished to support resident independence and comfort.

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

a) **The approved centre did not have suitable furnishings, as the garden furniture in the POA was unsuitable for elderly residents with limited mobility. The furnishings in the sitting rooms in Elm Mount Upper were not sufficient so as to provide a comfortable environment, 22 (2).**
b) **The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs of the residents and patients and their safety and well-being, as ligature anchor points throughout the approved centre were not minimised to the lowest practicable level, 22 (3).**
c) **Not all hazards were minimised within the approved centre, as linen trolleys and mobility equipment were stored on a corridor and in the resident bathrooms, 22 (3).**
d) **The residents did not have access to adequate communal space within the approved centre, as the sitting rooms and garden area in Elm Mount Upper did not provide adequate space for residents to move around. The sitting room in the POA unit was also cramped, 22 (3).**

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

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed on the 9th of July 2020, and included the following requirements:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing resident medication.
- The process for administration of resident medication, including routes of medication.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All MPARs contained a record of the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident. Three MPARs examined did not include all administration records or code to indicate if mediation was given or omitted. Two MPARs did not record stop dates for medications that were discontinued. In one MPAR, the minimal dose interval for a PRN ('take as required') medication was illegible. In one MPAR, the allergy section, which should record allergies or sensitivities to any medications, was not adequately completed.

Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified, and Scheduled 2 and 3 controlled drugs were secured separately from other medications to ensure further security.

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

a) **Three MPARS did not include all administration records or code to indicate if mediation was given or omitted, 23 (1).**

b) Two MPARS did not record stop dates for medications that were discontinued, 23 (1).

c) In one MPAR the minimal dose interval for a PRN (‘take as required’) medication was illegible, 23 (1).

d) The allergy section of one MPAR was not adequately completed, 23 (1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed on the 9th of July 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed on the 9th of July 2020, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. Not all healthcare staff had received mandatory training in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001. The following table contains a breakdown of the numbers and percentages of staff trained in each of the mandatory areas.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (47)	35	74%	39	83%	37	79%	47	100%
Medical (36)	28	78%	22	61%	22	61%	36	100%

Occupational Therapist (4)	4	100%	4	100%	3	75%	4	100%
Social Worker (10)	8	80%	9	90%	9	90%	10	100%
Psychologist (12)	7	58%	12	100%	7	58%	10	83%

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

a) **The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all healthcare staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26 (4).**
b) **At the time of the inspection, not all healthcare staff had completed Mental Health Act training. Therefore, the registered proprietor did not ensure that all staff members were made aware of the provisions of the Act and all the regulations and rules made thereunder, commensurate with their role, 26 (5).**

Regulation 27: Maintenance of Records

COMPLIANT

(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

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in November 2019, and included the following:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence with no loose pages.

Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorized access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

NON-COMPLIANT

Risk Rating MODERATE

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

The following policies were out of date and had not been reviewed within the required three-year timeframe, having due regard to any recommendations made by the Inspector or the Commission:

- Regulation 8 Residents' Personal Property and Possessions
- Regulation 12 Communication
- Regulation 13 Searches
- Regulation 14 Care of the Dying
- Regulation 19 Responding to Medical Emergencies
- Regulation 23 The Ordering, Prescribing, Storing and Administration of Medication
- Regulation 24 Health and Safety
- Regulation 26 Staffing
- Regulation 27 Maintenance of Records
- Regulation 32 Risk Management Procedures.

The approved centre was non-compliant with this regulation because not all of the approved centre's written operational policies and procedures had been reviewed within the required three-year timeframe, 29.

Regulation 30: Mental Health Tribunals

COMPLIANT

(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

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary. The approved centre provided laptops and iPads to access the Mental Health Tribunals remotely.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(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

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in April 2021, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

The registered proprietor ensured that the quality of service, care, and treatment was not adversely affected by reason of the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating **CRITICAL**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed on the 9th of July 2020, and included the following:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Not all clinical risks in terms of assaultive behaviour were identified, assessed, treated, reported and monitored. As a result they were not documented as required. Although structural and health and safety risks had been identified and assessed by the approved centre, they had not been consistently treated and precautions had not been put in place to reduce their impact upon staff and residents. Three major structural risks were identified on Elm Mount Upper:

- The layout of the dormitories contained 'blind spots' in terms of observation.

- The cramped and narrow design of the corridor at the entrance to Elm Mount Upper containing the ECT suite.
- The lack of space for residents to move around on Elm Mount Upper.

Ligature points were effectively mitigated. Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre, and documented in the risk register as appropriate.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during physical restraint, mechanical restraint, specialised treatments (ECT), resident transfer, and resident discharge. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults were not appropriate or implemented as required, as arrangements for the protection of vulnerable adults were not consistently in place within the approved centre.

Incidents were recorded and risk-rated in a standardised format. Not all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting: incidents which had occurred but not been reported were evident. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre had not provided a six-monthly summary report of all incidents to the Mental Health Commission for the period from July to December of 2022 as required. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

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

a) **Not all clinical risks were identified, assessed, treated or monitored on the unit as precautions were not consistently in place to control for the risk of assault, 32 (2)(c)(iii).**
b) **Precautions were not put in place to control for all structural and health and safety risks. Three risks were identified regarding the Elm Mount Upper premises: the layout of the dormitories contained 'blind spots' in terms of observation; a narrow corridor and a lack of space for residents to move about, 32 (2)(b).**
c) **Arrangements for the protection of vulnerable adults were not consistently in place within the approved centre, 32 (2)(f).**
d) **The registered proprietor did not ensure that the approved centre maintained a record of all incidents and did not notify the Mental Health Commission of incidents occurring in the approved centre, 32 (3).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

There was an up-to-date certificate of registration displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

Evidence of Implementation: One episode of mechanical restraint was reviewed on inspection. Mechanical restraint was only used where there was an enduring risk of harm to the patient or others, and addressed an identified clinical need. It was used only when other less restrictive alternatives were unsuitable. Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf.

The clinical file contained a contemporaneous record that specified that there was an enduring risk of harm to the self or others, and that restrictive alternatives were implemented without success prior to the prescription of mechanical restrain. The documentation also recorded the type of mechanical restraint, the situation in which mechanical restraint was being applied, the duration of the restraint, the duration of the mechanical restraint order, and the required review date.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 Consent to Treatment

COMPLIANT

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

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

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

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

INSPECTION FINDINGS

The clinical file of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined.

In respect both patients, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment and that the patient was unable to consent.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for both patients. These forms documented the following:

- The names of the medications prescribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.

- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.
- Any views expressed by the patient in relation to their consent to medication.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was reviewed in February 2023. It addressed the following:

- The provision of information to the resident which should include information about the resident's rights presented in accessible language and format.
- Information regarding who can initiate and who may carry out physical restraint.
- Information regarding the safety, safeguarding and risk managements that should be followed during an any episode of physical restraint.

Policies and procedures regarding staff training included the following:

- Who will receive training based on the identified needs of residents who are restrained and staff.
- The identification of appropriately qualified person(s) to give the training.
- The mandatory nature of training for those involved in physical restraint.
- The areas to be addressed withing the training programme.

The approved centre had a written policy on the reduction of physical restraint. The policy addressed the following:

- How the approved centre aims to reduce, or where possible eliminate, the use of physical restraint.
- The role of leadership and the use of data to inform practice, specific reduction tools in use, and the use of post incident reviews to inform practice.
- How the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. All staff who participate, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures.

Monitoring: The approved centre had not established a multi-disciplinary review and oversight committee, to meet quarterly and analyse every episode of physical restraint. At the time of inspection, the oversight committee was attended by nursing staff only.

Evidence of Implementation: Three episodes of physical restraint, were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there

were no other less restrictive methods available to manage the person's presentation. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical files. A physical examination of the resident had been completed no later than two hours after the start of each episode of restraint.

The orders for physical restraint did not exceed a duration of ten minutes. In one of the three episodes, the physical restraint was extended by a renewal order for a period which did not exceed ten minutes, with the continuous period of restraint not exceeding 30 minutes. The relevant section of the clinical practice forms (CPFs) had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode. In two of the episodes, it was signed by the consultant psychiatrist (CP) within 24 hours. However, in one episode, the CPF was not signed by the CP within 24 hours as required.

In all cases, the resident was informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical file as soon as was practicable. Where it was the resident's wish in accordance with their individual care plan (ICP) that their representative was not to be informed of the episode of restraint, no such communication took place. However, in two of the episodes, the clinical files recorded contradictory information, indicating both that the resident had requested for the representative not to be informed, and that the representative had been informed.

The Mental Health Commission was notified of the start time and date, and the end time and date, of each episode of physical restraint within three days of each episode. Staff involved in the episodes of physical restraint had taken into account any relevant entries in the person's ICP pertaining to the person's specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training.

The resident was continuously assessed throughout the uses of restraint to insure their safety. The physical restraint in each instance was ended by the person who had led it. The time, date, and reason for ending the physical restraint was recorded in the clinical file.

In one of the episodes of physical restraint, the resident was given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process within two working days. However, for the other two episodes, no in-person debrief took place. In respect of the debrief which took place:

- The decision of the resident regarding their wish to participate (or not participate) in the debrief was not recorded.
- The debrief did not include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future.
- The debrief did not include a discussion regarding the resident's preferences in the event of a restrictive intervention being needed in the future.
- The debrief did not document if the resident was given the option of having their representative or their nominated support person to attend the debrief with them, and, if the person's

representative or nominated support person did not attend the debrief, a record of the reasons why this did not occur.

Following the debrief, the resident's individual care plan (ICP) was not updated to updated to reflect the outcomes of the debrief; in particular, the person's preferences in relation to restrictive interventions going forward was not recorded. There was no clinical record in the three episodes reviewed that the resident was provided appropriate emotional support following the episode.

Recording of the Use of Physical Restraint: The episodes of restraint were recorded in the clinical file. The episodes of restraint were clearly recorded in the clinical practice form as required. There was a copy of the clinical practice form in the clinical file and it was available to the Mental Health Commission on request.

Clinical Governance: Two episodes of physical restraint were not reviewed by members of the multi-disciplinary team within five working days from the date of the restraint. In the case of the episode, which was reviewed, the review did not include the following:

- The identification of the trigger events which contributed to the restraint episode.
- A review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support.
- The identification of alternative de-escalation strategies to be used in future.
- The duration of the restraint episode and whether this was for the shortest possible duration.
- An assessment of the factors in the physical environment that may have contributed to the use of restraint.

The multi-disciplinary team did not record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the resident.

There was a named senior manager responsible for the approved centre's reduction of physical restraint.

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

a) **The oversight committee was attended by nursing staff only and was not multi-disciplinary as required, 7.8.**
b) **One clinical practice form was not signed by the consultant psychiatrist or the duty consultant psychiatrist within 24 hours, 3.7(c).**
c) **Where it was the resident's wish that their representative was not to be informed of the restraint, no such communication should occur outside the course of necessary legal or professional requirement; however, documentation indicated contradictory information: that the representative had been contacted, whereas the resident had requested for their representative not to be contacted, 3.9(b).**

d) An in-person debrief did not occur for two physical restraints episodes, 5.3.

e) In the case of the debrief that took place there was no discussion of alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future, 5.3 (iv). Similarly, there was no documentation indicating whether or not the resident wished to participate or if they did not wish to participate in the debrief contained within the clinical file, 3.5(iii), no discussion regarding the resident's preferences in the event of a restrictive intervention being needed in the future, 5.3(v), and no documentation as to if the resident was given the option of having their representative or their nominated support person to attend the debrief with them and, if the resident's representative or nominated support person did not attend the debrief, a record of the reasons why this did not occur, 5.3(vi).

f) Following an in-person debrief, one resident's individual care plan was not updated to reflect the outcomes of the debrief and in particular, the resident's preferences in relation to restrictive interventions going forward, 5.5.

g) There was no clinical record in the three episodes reviewed that the resident was provided appropriate emotional support following the physical restraint, 5.7.

h) Two episodes of physical restraint were not reviewed by members of the multi-disciplinary team within five working days from the date of the restraint, 7.3.

i) One clinical file was reviewed by the multi-disciplinary team following an episode of physical restraint within five working days, but did not include all aspects required under 7.3.

j) The multi-disciplinary team did not record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the resident for one episode of physical restraint, 7.4.

Admission of Children

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in June 2023. It addressed the following:

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

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: The clinical file of a young person who had been admitted to the approved centre was examined on inspection. Age appropriate facilities were not provided as the approved centre was not a dedicated Child and Adolescent facility. Provisions were in place to ensure the safety of the young person, respond to their special needs as young people in an adult setting, and ensure the right of the young person to have their views heard.

Staff having contact with the young person had undergone Garda vetting, and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Staff observation acknowledged gender sensitivity, and appropriate accommodation was designated, including age- and gender-segregated sleeping and bathroom areas. Observation arrangements, including assignment of designated staff members, was provided as considered clinically appropriate

The young person had their rights explained and information about the ward and facilities were provided in a form and language they could understand. Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre. Appropriate visiting arrangements for the young person's family were available, including children. The Mental Health Commission was notified of the admission within 72 hours using the associated notification form. Consent for treatment was obtained from one or both parents of the young person.

The approved centre was non-compliant with this code of practice because age appropriate facilities were not provided as a young person was admitted to an adult mental health facility, 2.5 (b).

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was reviewed annually and was last reviewed in January 2023. It contained protocols that were developed in line with best international practice, including

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary patient who had received ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed able to consent to receiving ECT. Capacity to consent ensured that the patient could understand the nature of ECT (including risks, benefits, and alternatives), understand why ECT was proposed and the broad consequences of not receiving ECT, and make a free choice to receive or refuse ECT. Consent was obtained in writing for each ECT treatment session, including anaesthesia. All consent was obtained by the consultant psychiatrist, or registered medical practitioner (RMP) under supervision of the clinical psychiatrist, prior to each ECT treatment session and recorded in the clinical file.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that

proved ineffective before prescribing ECT, the discussion with the patient and next of kin, and a current mental state examination. Cognitive assessments were completed and recorded before and after each ECT session. The process was in line with best international practice by the consultant psychiatrists.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre-ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post-ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT were recorded.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in May 2021, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in July 2020, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2021, included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, risk assessment, and all other relevant information. A key worker system was in place, full physical examination carried out, and a family member or carer was involved in the admission process with the resident's consent.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge and a follow up plan. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate. The discharge plan did not record

documented communication with the relevant general practitioner or primary care team or community mental health staff, or include a reference to early warning signs of relapse and other risks.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; and a comprehensive risk assessment and risk management plan. The discharge was coordinated by the key worker. The clinical file did not evidence that the preliminary discharge summary was sent to the relevant general practitioner or primary care team or community mental health staff within three days, or that a comprehensive discharge summary was issued within 14 day.

Family members, carers or advocates were involved in the discharge process, where appropriate.

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

a) A resident's discharge plan did not include documented communication with the relevant general practitioner or primary care team or community mental health staff, 34.2.
b) A resident's discharge plan did not include a reference to early warning signs of relapse and risks, 34.2.
c) The approved centre did not comply with Regulation 18: Transfer of Residents.
d) The clinical file did not evidence a preliminary discharge summary being sent to the relevant general practitioner or primary care team or community mental health staff within three days, 38.3.
e) The clinical file did not evidence a comprehensive discharge summary issued within 14 days, 38.3 (b).

Appendix 1: Corrective and Preventative Action Plan

Regulation 09: Recreational Activities					
Reason ID : 10004441		**The approved centre did not provide access for residents to appropriate recreational activities insofar as was practicable, 9.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Conducted an immediate assessment to identify the barriers to providing appropriate recreational activities. These issues involved staffing, resources, or scheduling. Allocated necessary resources to ensure a range of recreational activities can be offered, including purchasing equipment or materials needed for activities. Organize training sessions for staff on the importance of recreational activities in the residents' well-being	Participation Rates: Review Recreation activity log book. Resident Surveys Staff Feedback Audit and Review	Achieved	31/08/2023	All Nursing and HCA staff Accounts Department

	and how to effectively organize and facilitate such activities. Development of a Recreational Activity Schedule: Developed a new, inclusive schedule of recreational activities that takes into account the interests, abilities, and needs of all residents. Ensure this schedule is flexible and adaptable.				
Preventative Action	Policy Review and Update: Reviewed and updated policies related to recreational activities to ensure they support the provision of a wide range of activities that are accessible to all residents. Regular Feedback Loops: Established regular feedback mechanisms with residents and staff	Policy on Regulation 9 Recreational Activities. Staff meeting minutes Staff training log register Audit report	Achieved	31/08/2023	CNMs Accounts Dept

	to assess the effectiveness of recreational activities and identify areas for improvement. Continuous Staff Education: Implement ongoing education and training for staff on developing and facilitating recreational activities, emphasizing inclusivity and adaptability. Monitoring and Reporting System: Develop and implement a monitoring system to track the availability, accessibility, and participation in recreational activities. This system should include regular reporting to management.				

Regulation 11: Visits

Reason ID : 10004442		The registered proprietor did not take all reasonable steps to ensure that appropriate arrangements were made for residents and visitors due to the fact that there was no dedicated space for visits, 11 (1). The registered proprietor did not take all reasonable steps to ensure the safety of residents and visitors. Visits were conducted in communal areas and bedroom areas, some of which were shared bedrooms, 11 (3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Space surveyed in each ward by nursing team to identify appropriate visiting area. Risk Assessment completed to evaluate the selected space's suitability. New weighted furniture ordered and delivered to furnish same. Visiting Protocol developed.	Space identified in each ward Risk Assessment Visiting Protocol	Achieved in Elm Mount Upper Dec 2023. Ongoing process in POA and EML, rooms are identified and coordination of reconfiguring happening presently.	31/12/2023	CNM2
Preventative Action	Designated space for visiting assigned to each ward.	Space identified in each ward Risk Assessment Visiting Protocol	Achievable	31/12/2023	CNM2
Reason ID : 10004443		The registered proprietor did not ensure that appropriate arrangements and facilities were in place for children visiting a resident, 11(5).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Risk Assessment conducted to evaluate the selected space's	Risk Assessment Visiting Protocol	Achieved	31/12/2023	CNM2

	suitability Visiting Protocol developed Child friendly resources such as colouring pencils, paper available to occupy children when visiting.				
Preventative Action	Designated child friendly space allocated in each ward.	Risk Assessment Visiting Protocol	Achievable	31/12/2023	CNM2

Regulation 15: Individual Care Plan

Reason ID : 10004471		Four individual care plans were not reviewed by the multi-disciplinary team. Their ICP review was conducted by medical and nursing staff only, 15.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	1. Immediate Review: • Conduct an immediate review of the four ICPs by a fully constituted multi-disciplinary team. • Document the outcomes of the review and any changes made to the care plans as a result. 2. Training and Awareness: • Arranged a training session for all staff involved in developing and reviewing ICPs, emphasising the importance of multi-disciplinary team involvement. • Developed and distributed a quick-reference guide detailing the process for ICP reviews, including the roles	Audit Results ; Staff Feedback; Patient Outcomes	Achieved - if member of MDT cant attend due to leave etc, same documented	30/09/2023	MDT

	and responsibilities of each discipline.				
Preventative Action	ICP compliance "pointers" devised by CNM3 and sent to all HODs to discuss with each of their disciplines Regular education - weekly doctor and nursing meeting; Policy Reviewed and Updated; Regular Audits; Establish a feedback mechanism for staff to report obstacles in implementing multi-disciplinary reviews, ensuring continuous improvement.	Monthly Audit - results and recommendations presented to compliance committee and QPS committee Shared also with the wider MDT	Achieved	30/09/2023	MDT CNM3

Regulation 18: Transfer of Residents

Reason ID : 10004459		The registered proprietor did not ensure that all relevant information about the resident was provided to the receiving facility, as no referral letter or resident transfer form was sent from the approved centre to the receiving facility as part of the transfer process, 18 (1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Education completed with medical and nursing team by CNM3 regarding comprehensive transfer documentation, namely evidencing a referral letter and resident transfer form was sent to the receiving facility.	Quarterly Audit, overseen by CNM3 Results and recommendations shared with wider team, compliance committee and QPS forum.	Achievable	31/08/2023	NURSING and Medical Staff CNM3 ADON Clinical Director
Preventative Action	Regular Education regarding Regulation 18 provided by CNM3 to nursing and medical staff Laminated sign put in each ward nursing office signposting reminders regarding documentation requirements with the transfer regulation.	Quarterly Audit overseen by CNM3 Results and recommendations shared with wider team, compliance committee and QPS forum.	Achievable	31/08/2023	Nursing and Medical Staff CNM3 ADON Clinical Director

Regulation 22: Premises

Reason ID : 10004445		The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs of the residents and patients and their safety and well-being, as ligatures throughout the approved centre were not minimised to the lowest practicable level, 22(3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Works schedule in place to address minimising ligatures throughout the approved centre. All wardrobes in each ward are now anti ligature. All lights are now energy saving anti ligature design, overseen by SVUH Estates. 7 bathrooms are in the process of being fitted with all anti lig features. Anti lig windows are forecast to be fitted early 2024.	Compliance Committee Review Quarterly Walkaround	In Progress	30/04/2024	Approved Centre MDT CNMs of each ward HSE Estates SVUH Estates Registered Proprietor Nominee Clinical Director Adon CNM3 PIC Accounts Dept
Preventative Action	To continue to plan and facilitate the schedule of anti lig works. Liaise on a quarterly basis with post holders. Annual audit to commence this month	Ligature Audit Quarterly Walkaround	Achievable	30/04/2024	Approved Centre MDT CNMs of each ward HSE Estates SVUH Estates Registered Proprietor Nominee Clinical Director Adon CNM3 PIC Accounts Dept

Reason ID : 10004446		Not all hazards were minimised within the approved centre, as linen trolleys and mobility equipment were stored on a corridor and in the resident bathrooms, 22 (3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Appropriate storage identified in each ward to store mobility equipment. Laminated label attached to laundry trolley to return same to storage area when not in use.	"Safety pause" initiated and utilised during shift to address any health and safety hazards. Quarterly Audit	Achieved	31/07/2023	CNM1/2/3 HCA Staff
Preventative Action	Education given to staff regarding the hazards re health and safety on the ward. Hseland Managing Health and Safety in the Healthcare Setting completed by nursing managers. Health & Safety folder devised by CNM3 for each ward.	Quarterly Audit Excel Database of staff hseland training	Achieved	31/07/2023	CNM3

Reason ID : 10004447		The residents did not have access to adequate communal space within the approved centre, as the sitting rooms and garden area in Elm Mount Upper did not provide adequate space for residents to move around. The sitting room in the POA unit was also cramped, 22 (3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A schedule of accommodation was developed between the Approved Centre	Feasibility Study	Achievable	30/09/2024	MDT MH Executive Management Team SVUH Estates HSE Estates

	and HSE Estates in 2023, as planned. HSE Estates will appoint a Design Team in Q1 2024 to review the Schedule of Accommodation and carry out a feasibility study. It is envisaged that the feasibility study will be complete by end of Q3 2024. This will inform the future design of the Approved Centre and the associated capital submission.				
Preventative Action	Engagement is currently underway between the Approved Centre, SVUH and HSE Estates in respect of the reconfiguration of external garden space to provide greater opportunity to all residents to access appropriate communal external space, as part of the development of the SVUH energy centre	Feasibility Study	Achievable	30/09/2024	MDT MH Executive Management Team SVUH and HSE Estates HSE Estates

	works. There is a meeting with SVUH on 2nd Feb, at which we will receive clarity on the works schedule.				
Reason ID : 10004448		**The approved centre did not have suitable furnishings, as the garden furniture in the POA was unsuitable for elderly residents with limited mobility. The furnishings in the sitting rooms in Elm Mount Upper were not sufficient so as to provide a comfortable environment, 22 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Garden furniture removed from POA courtyard and allocated to Elm Mount Lower Garden to more suitable clientelle. Appropriate Picnic bench, table and garden chair ordered to replace same. Appropriate weighted soft furniture ordered to provide comfortable environment in sitting rooms	Risk assessment Liaison between nursing management, accounts and furniture companies Completed Delivery of furniture	Achieved	04/12/2023	CNM2/3 Accounts Dept Registered Proprietor Nominee
Preventative Action	Robust weighted furniture obtained to ensure quality, comfort and durability. Regular liaison with accounts/general	Ongoing Risk Assessment	Achieved	04/12/2023	ADON, CNM 2/3; Registered Proprietor Nominee, Accounts

	manager to avail of funding if necessary to maintain furniture				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10004464		**Three MPARS did not include all administration records or code to indicate if mediation was given or omitted, 23 (1). Two MPARS did not record stop dates for medications that were discontinued, 23 (1). The allergy section of one MPAR was not adequately completed, 23 (1). In one MPAR the minimal dose interval for a PRN ('take as required') medication was illegible, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Education session completed with nursing and medical team re above areas of non compliance. Medication Management and Prescribing with Compliance (HSELAND) completed by nursing and medical staff.	Daily tracker implemented on each ward to ensure all administration signatures or codes were recorded. Weekly Audits in each ward overseen by CNM3 Findings and recommendations were discussed weekly at Consultant, NCHD and Nursing Meeting. Recommendations presented at local compliance and local QPS meetings monthly.	Achieved	30/09/2023	CNM3 Nursing and Medical Staff
Preventative Action	Nursing staff completed weekly medication audits for 3 months post inspection.	Findings of weekly audits were discussed weekly at Consultant, NCHD and Nursing	Achieved	30/09/2023	Nursing and Medical Staff

	Education re compliance given by CNM3 to nursing and medical staff at induction. Small checklist attached to each kardex re recording compliance.	Meeting. Recommendations were presented at local compliance and local QPS meetings monthly.			

Regulation 26: Staffing					
Reason ID : 10004468		**The registered proprietor did not ensure that all staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all healthcare staff were trained in Fire Safety, Basic Life Support, and Management of Violence and Aggression, 26(4). At the time of the inspection, not all healthcare staff had completed Mental Health Act training. Therefore, the registered proprietor did not ensure that all staff members were made aware of the provisions of the Act and all the regulations and rules made thereunder, commensurate with their role, 26 (5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Audit conducted to identify mandatory training uptake	Excel shared database measuring the percentage of uptake in training Monthly reports to compliance committee regarding statistics which is then discussed at monthly QPS meeting. Quarterly reports to CHE EMT detailing training statistics, completion rates, and any impediments to achieving full compliance.	Achievable	31/12/2023	Each HOD Training Compliance Committee Local Compliance Committee
Preventative Action	Training needs analysis conducted Schedule of mandatory training given bi annually.	Traffic Light System in place to alert when a staff member' training status is nearing expiry. This is	Achievable	31/12/2023	CNM3 PMCB Training Team BLS Training Team Fire Training Team All HODs

		monitored by all HODs with oversight by Training Compliance Committee			

Regulation 29: Operating Policies and Procedures					
Reason ID : 10004458		**Not all of the approved centre's written operational policies and procedures had been reviewed within the required three-year timeframe, 29.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is an MDT Policy group in place for the Approved Centres of the CHO where all policies are to be reviewed in a timely manner and in line with best practice	Tracker with timelines being utilised by Chair of MDT Policy Group to guide process Ratification of policies by Quality and Safety Executive Committee (QSEC) monthly	Achievable	31/07/2023	Chair of Policy Group ADON
Preventative Action	There is an MDT Policy group in place for the Approved Centre's of the CHO where all policies are to be reviewed in a timely manner and in line with best practice	Ratification of Policies monthly by QSEC	Achievable	31/07/2023	Chair of MDT Policy Group ADON

Regulation 32: Risk Management Procedures					
Reason ID : 10004460		**Not all clinical risks were identified, assessed, treated or monitored on the unit as precautions were not consistently in place to control for the risk of assault, 32 (2) (c)(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All residents risk assessments were updated by staff and were reviewed at their relevant MDT meeting. If any risk of assault was identified, control measures were put in place to mitigate the risk. Incidents are reviewed weekly by the MDT and QPS advisor and risk assessments are updated accordingly.	The inputting of NIRF forms is up to date following our inspection in July. Quarterly reports are presented by the QPS advisor at the monthly Local QPS meeting	Achievable	30/09/2023	MDT QPS Advisor ADON CNM3 Clinical Director
Preventative Action	The approved centre has a non regulatory policy in place for the risk of assault. A risk assessment for violence and aggression in place for each ward in the unit. On admission individual risk factors are identified and assessed, including general	The inputting of NIRF forms is up to date following our inspection in July. Quarterly reports are presented by the QPS advisor at the monthly Local QPS meeting	Achievable	30/09/2023	QPS Advisor MDT ADON CNM3 CLINICAL DIRECTOR

	health risks, risk of absconsion, risk of aggression etc This risk assessment informs the ICP for every resident. Staff trained and updated re individual risk assessments. Staff trained in PMCB. Reviewed weekly at MDT and updated post any incident. MDT approach to clinical risk. Onsite training re incident recording and categorisation being provided by QPS Advisor.				
Reason ID : 10004461		**Precautions were not put in place to control for all structural and health and safety risks. Three risks were identified regarding the Elm Mount Upper premises: the layout of the dormitories contained 'blind spots' in terms of observation; a narrow corridor and a lack of space for residents to move about, 32 (2)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A Local MDT working group established to review the structural and health and safety risks associated with the dorms, corridors and communal space. Capital approval and	Feasibility study	Achievable	30/09/2024	MDT MH Executive Management Team SVUH ESTATES HSE ESTATES

	funding granted to undertake feasibility study to inform future design of the approved centre and associated submission.				
Preventative Action	The recommendations of the Local MDT group includeS recommendations for interim management plans to address the risks and recommendations for consideration in the future design of the Approved Centre, which will commence following completion of the feasibility study which is due to be completed by Q3 2024	Feasibility Study	Achievable	30/09/2023	MDT EXecutive Management Team SVUH/HSE Estates
Reason ID : 10004462		**Arrangements for the protection of vulnerable adults were not consistently in place within the approved centre, 32 (2)(f).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Mental Health Safeguarding Lead (Senior Social Worker) provides	There is an orientation program for new staff and ongoing training and	Achievable	30/09/2023	Safeguarding Lead MDT Clinical Director ADON/CNM3 CNM's of each ward

	guidance and support to all Mental Health staff in responding to Adult Safeguarding concerns, including the use of the Preliminary Screening Form and the formulation of an Initial Safeguarding Plan, in conjunction with the resident. Arrangements for the protection of vulnerable adults was supported through the recently appointed PQSW (5th Sep), assigned to the Safeguarding Lead. A training schedule is in place for Adult Safeguarding along with this dedicated support on site in respect of the Sexual Safety Policy.	refresher courses for all team members. Regular audits are conducted to ensure policy adherence and immediate action is taken if gaps are identified.			
Preventative Action	Local Sexual Safety Policy in place since September 2023 Regular and open	Signature Log regarding understanding of policy Safeguarding	Achievable	30/09/2023	Safeguarding Lead MDT Clinical Director ADON/CNM3 CNM's of each ward

	communication with Safeguarding Lead Monthly safeguarding MDT meetings regarding vulnerable adults who are presently resident in the approved centre	Training Meeting Minutes/Care Plan			
Reason ID : 10004463		**The registered proprietor did not ensure that the approved centre maintained a record of all incidents and did not notify the Mental Health Commission of incidents occurring in the approved centre, 32 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	We have critically reviewed our internal and external notification processes to expedite the reporting of incidents. Internally, staff are trained on immediate actions and reporting lines. Externally, we have established rapid communication channels with relevant authorities, including but not limited to the Gardaí and MHC, to ensure timely and accurate information sharing.	Quarterly Reports re Incidents presented at local QPS which is then shared with relevant staff	Achieved	31/07/2023	Executive Management Team ADON; CNM3 ; QPS Advisor

	Sexual Safety Policy ratified to address reporting issues regarding sexual safety incidents and the categorisation of same.				
Preventative Action	Quality and Safety Advisor attends the approved centre to oversee our incident reporting weekly. Provides immediate and inhouse training regarding noitification and incident process	NIMS reporting system Quarterly reports presented by QPS advisor at local QPS for discussion and analysis. Reports re Q4 2023 will be presented in Feb 2024.	Achieved	31/07/2023	QPS Advisor CNM3; ADON; CNM2

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10004472		The oversight committee was attended by nursing staff only and was not multi-disciplinary as required, 7.8. Two episodes of physical restraint were not reviewed by members of the multi-disciplinary team within five working days from the date of the restraint, 7.3. The multi-disciplinary team did not record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the resident for one episode of physical restraint, 7.4.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The oversight committee sought other disciplines to perform as an MDT oversight committee. OT and SW representation allocated and in operation since August 2023. Documentation education regarding 5 day post restraint MDT review given by chair of Oversight Committee. Documentation aids in the form of checklists and stickers created to signpost 2 day MDT Debrief and 5 DAY MDT Review. Missed opportunities, Alternative de escalation strategies	Quarterly Audits completed re Physical Restraint. Results and recommendations shared with the wider team. Shared at monthly local compliance committee and presented to the QPS meeting by CNM3. Oversight committee also oversees every physical restraint, documents any non compliance and shares learning with staff.	Achieved	31/10/2023	Medical and Nursing Staff

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
	documented on documentation sticker.				
Preventative Action	CNM3 advised both disciplines to complete HSELAND E learning - Changes to the Rules to the COP. COP Physical Restraint 2023 accessible for all staff to read on share drive. Documentation checklists and stickers developed for 2 day MDT Debrief and 5 day MDT review post physical restraint.	Quarterly Audits. Restrictive Practice and Oversight Monitoring form for each physical restraint.	Achieved	31/10/2023	Medical and Nursing staff Oversight Committee overseen by Compliance Committee
Reason ID : 10004473		**One clinical practice form was not signed by the consultant psychiatrist or the duty consultant psychiatrist within 24 hours, 3.7(c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A notification monitoring system is now in place to ensure the Consultant has signed the notification within 24-hour deadline.	Quarterly Audit Restrictive Practice and Oversight Monitoring form for each physical restraint	Achieved	31/07/2023	CNM2 Consultant/Duty Consultant
Preventative Action	Notification process initiated to improve the compliance of	Quarterly Audit Restrictive Practice and Oversight	Achieved	31/07/2023	CNM2 Consultant/Duty Consultant

	the 24 hour timeframe. Specific Tray now in EMU to store forms to reduce misplacement. Sign on tray for Consultant to sign within 24 hours. Flow Chart devised for notification process and displayed in office.	Monitoring form for each physical restraint			
Reason ID : 10004474		**Where it was the resident's wish that their representative was not to be informed of the restraint, no such communication should occur outside the course of necessary legal or professional requirement; however, documentation indicated contradictory information: that the representative had been contacted, whereas the resident had requested for their representative not to be contacted, 3.9(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Alignment of documentation emphasized with staff. The outcome of consent obtained/ not obtained to inform NOK/representative re physical restraint should be the same on the clinical practice form and contemporaneous notes.	Quarterly Audit re Physical Restraint Restrictive Practice and Oversight Monitoring form for each physical restraint	Achieved	31/10/2023	Nursing Staff

Preventative Action	Documentation folder created for each ward in the approved centre by member of the Oversight Committee	Quarterly Audits Restrictive Practice and Oversight Monitoring form for each physical restraint	Achieved	31/10/2023	Nursing Management Audit Team Oversight Committee
Reason ID : 10004475		**An in-person debrief did not occur for two physical restraints episodes, 5.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Documentation checklists were developed by the Oversight Committee and disseminated to the wider team. Stickers were ordered for 2 DAY MDT Debrief and 5 DAY MDT Review to ensure they both occur post physical restraint.	Quarterly Audit Restrictive Practice and Oversight Monitoring form for each physical restraint	Achieved	31/10/2023	Oversight Committee MDT Audit Team
Preventative Action	Aligned and standardised documentation in place. Reference folder made by a member of the oversight committee to guide all parts of documentation process re physical restraint	Quarterly audit Restrictive Practice and Oversight Monitoring form for each physical restraint	Achieved	31/10/2023	Oversight Committee MDT Audit Team
Reason ID : 10004476		**In the case of the debrief that took place there was no discussion of alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future, 5.3 (iv).**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
		Similarly, there was no documentation indicating whether or not the resident wished to participate or if they did not wish to participate in the debrief contained within the clinical file, 3.5(iii), no discussion regarding the resident's preferences in the event of a restrictive intervention being needed in the future, 5.3(v) and no documentation as to if the resident was given the option of having their representative or their nominated support person to attend the debrief with them, and, if the resident's representative or nominated support person did not attend the debrief, a record of the reasons why this did not occur, 5.3(vi).			
Corrective Action	Documentation aids in the form of checklist sticker created to signpost 2 day MDT Debrief. Picture of the sticker will be submitted as a supporting document to display all aspects of documentation above.	Quarterly Audit Restrictive Practice & Oversight Monitoring Form	Achieved	31/10/2023	Oversight Committee
Preventative Action	HSELAND E learning - Changes to the Code of Practice Physical Restraint to enhance learning re same. Standardised documentation process in place	Quarterly Audits Restrictive Practive and Oversight Monitoring Form	Achieved	31/10/2023	Oversight Committee Nursing and Medical staff
Reason ID : 10004477		Following an in-person debrief, one resident's individual care plan was not updated to reflect the outcomes of the debrief and in particular, the resident's preferences in relation to restrictive interventions going forward, 5.5.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Education regarding the updating of care	Quarterly audit Restrictive Practice	Achieved	31/10/2023	MDT

	plan following an in person debrief given to the MDT. Checklist sticker created to signpost staff to update ICP with outcomes of the debrief.	and Oversight Monitoring Form			
Preventative Action	Checklist sticker in place making it a standardised process of documentation. Enusre stickers are kept in stock, stock check done weekly regarding stationery, office supplies	Quarterly Audit Restrictive Practice and Oversight Monitoring Form	Achieved	31/10/2023	MDT
Reason ID : 10004478		**There was no clinical record in the three episodes reviewed that the resident was provided appropriate emotional support following the physical restraint, 5.7.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Education given to the MDT regarding the need for documentation regarding emotional support following physical restraint. Checklist sticker created, including emotional support to be documented in notes.	Quarterly Audit on the COP : Physical Restraint Restrictive Practice and Oversight Monitoring Form	Achieved	31/10/2023	MDT
Preventative Action	Folder created by member of Oversight	Quarterly Audit	Achieved	31/10/2023	MDT

	Committee to guide staff in every step of documentation. Checklist sticker to signpost all aspects of care required post physical restraint.				
Reason ID : 10004480		**One clinical file was reviewed by the multi-disciplinary team following an episode of physical restraint within five working days, but did not include all aspects required under 7.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Checklist sticker and documentation checklist created to include all aspects required under 7.3	Quarterly Audit Restrictive and Oversight Monitoring Form	Achieved	31/10/2023	Oversight Committee MDT
Preventative Action	Documentation folder guiding all aspects of documentation created by member of the Oversight Committee to guide staff in ensuring all areas in section 7.3 of the code are adhered to. One in each ward of the unit.	Quarterly Audit Restrictive Practice and Oversight Monitoring Form	Achieved	31/10/2023	Oversight Committee MDT

COP Relating to Admission of Children under the Mental Health Act 2001					
Reason ID : 10004440		Age appropriate facilities were not provided as the young person was admitted to an adult mental health facility, 2.5 (b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The service has a systematic approach in place to avoid child admissions to an adult unit. The admission of a child or adolescent to an adult psychiatric unit using the Mental Health Act is always a last resort option.	If there is no available alternative and the decision has been arrived at with due consideration of the risks to the child of not admitting him or her and potential adverse effects of such an admission, this admission will be for the shortest period, the young person will be transferred to an age appropriate facility as soon as is practicable.	Achievable - barriers however can be having no available beds in CAMHS to provide the age appropriate care at the time of an unavoidable admission	31/07/2023	Admitting Clinicians, Head of Service, Executive Clinical Director, Clinical Director, Area Director of Nursing Clinical Director in CAMHS. All work together to find the more appropriate setting for the child on the same or next day (if admission to an adult mental health facility is unavoidable)
Preventative Action	The preventative action includes the consistent approach of the admitting clinicians to adhere to the regulation. The team must escalate through the appropriate channels, exhaust all options, both public	Annual audit conducted by Auditing Team If there is no available alternative and the decision has been arrived at with due consideration of the risks to the child of not admitting him or her and potential	Achievable - barriers however can be having no available beds in CAMHS to provide the age appropriate care at the time of an unavoidable admission	31/07/2023	Admitting Clinicians, Head of Service, Executive Clinical Director, Clinical Director, Area Director of Nursing Clinical Director in CAMHS. All work together to find the more appropriate setting for the child on the same or next day (if admission to an adult mental health facility is unavoidable)

	and private, prior to admission. If admission is unavoidable, the transfer of the child must occur at the earliest possible opportunity the next day.	adverse effects of such an admission, this admission will be for the shortest period, the young person will be transferred to an age appropriate facility as soon as is practicable.			

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10004435		A resident's discharge plan did not include documented communication with the relevant general practitioner or primary care team or community mental health staff, 34.2. A resident's discharge plan did not include a reference to early warning signs of relapse and risks, 34.2.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Regular Code of Practice education sessions with medical and nursing staff regarding comprehensive discharge and early warning sign documentation ongoing.	Quarterly audit completed during the year. Results and recommendations shared with the wider team. Presented at the Local Compliance Committee and further discussed at Local QPS	Achievable	31/07/2023	Nursing and Medical Staff CNM3 ADON Clinical Director
Preventative Action	Code of Practice Signs developed by CNM3 to assist with documentation, displayed on "compliance board" in nursing office. 1:1 filing cabinet with educative resources designed to assist Nurses/Doctors in addressing early warning signs with their caseload of residents during their discharge planning.	Quarterly audit completed during the year. Results and recommendations shared with the wider team. Presented at the Local Compliance Committee and further discussed at Local QPS	Achievable	31/07/2023	CNM3 ADON CLINICAL DIRECTOR

Reason ID : 10004437		The approved centre did not comply with Regulation 18: Transfer of Residents.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Education completed with medical and nursing team by CNM3 regarding comprehensive transfer documentation, namely evidencing a referral letter and resident transfer form sent to the receiving facility in the residents file.	Quarterly Audit overseen by CNM3 Results and recommendations shared with the wider team, reported to Local Compliance Committee and presented at monthly local QPS forum.	Achievable	31/08/2023	Nursing and Medical Staff CNM3 ADON Clinical Director
Preventative Action	Laminated sign put in all ward offices signposting essential documentation during the transfer of a resident. Code of Practice Admission Transfer and Discharges available to all staff for reference.	Quarterly Audit overseen by CNM3 Results and recommendations shared with the wider team, reported to Local Compliance Committee and presented at monthly local QPS forum.	Achievable	31/08/2023	CNM3 ADON Clinical Director
Reason ID : 10004438		**The clinical file did not evidence a preliminary discharge summary being sent to the relevant general practitioner or primary care team or community mental health staff within three days, 38.3. The clinical file did not evidence a comprehensive discharge summary issued within 14 days, 38.3 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Education given by CNM3 to medical	Quarterly Audit overseen by CNM3	Achievable	31/08/2023	CNM3 Medical Staff Clinical Director

	staff regarding the timely documentation requirements under the COP. Education piece is also part of Induction process for all new incoming medical staff.	Results and recommendations shared with the wider MDT. Reported to Local compliance and QPS committee also.			
Preventative Action	Support sought from administrative staff to aid timely discharge documentation. Tracker devised by admin to monitor discharged residents files to help alert medical staff regarding preliminary discharge summaries being sent to the GP/CMHT/Primary Care Team within 3 days and also a comprehensive discharge summary being sent within 14 days.	Quarterly Audit overseen by CNM3 Results and recommendations shared with the wider MDT. Reported to Local compliance and QPS committee also.	Achievable	31/08/2023	Admin staff, nurse support worker, CNM3, Adon , Clinical Director

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

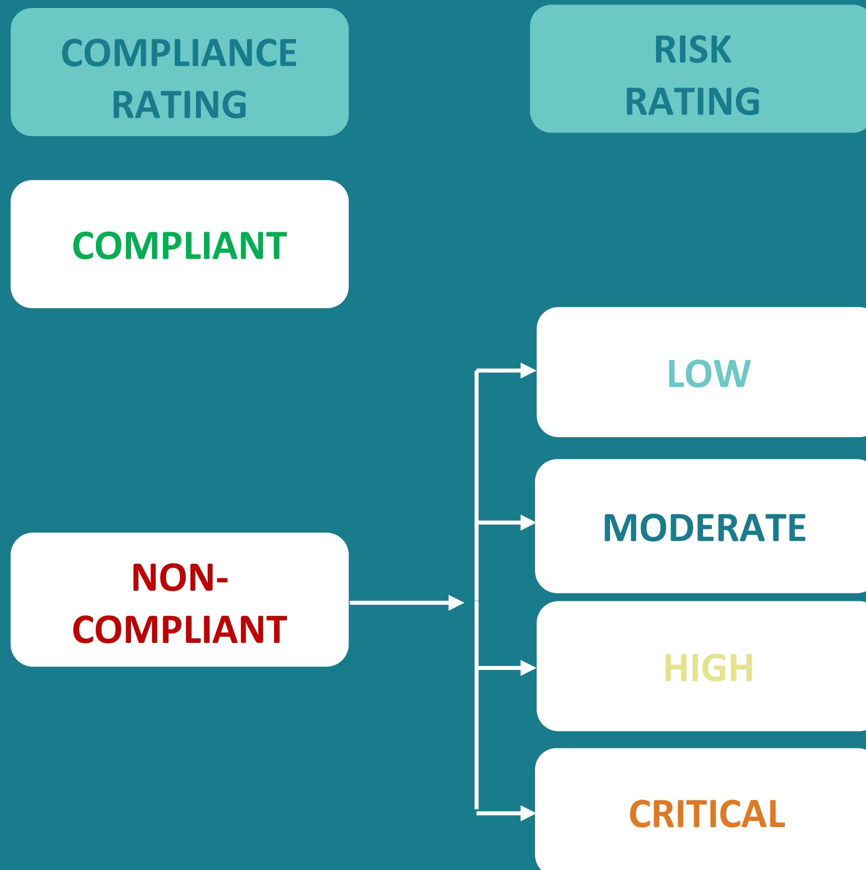
Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.