Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	St Edmundsbury Hospital
IDENTIFICATION NUMBER	AC0057
APPROVED CENTRE TYPE	General Adult
REGISTERED PROPRIETOR	Mr Paul Gilligan
REGISTERED PROPRIETOR NOMINEE	Not applicable
MOST RECENT REGISTRATION DATE	25 May 2016
NUMBER OF RESIDENTS REGISTERED FOR	52
INSPECTION TYPE	Unannounced
INSPECTION DATE	24, 25, 26 August 2016
PREVIOUS INSPECTION DATE	5, 6, 7 October 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Dr Enda Dooley MCN 004155
INSPECTION TEAM	Ms Orla O'Neill
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCN 009711

Contents

1.0 Mental Health Commission Inspection Process

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

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

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

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

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

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

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART).

The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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

2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

St. Edmundsbury Hospital was located in the Lucan area of west Dublin and was situated in extensive open grounds with wooded parkland adjacent to the hospital. The hospital accommodation consisted of a converted 19th century dwelling house which is utilised for dining, social, and therapeutic purposes and an attached modern block which contained accommodation for the residents. Accommodation was almost exclusively in single en suite rooms with a small number of twin rooms. The reception and admission area of the hospital had recently been renovated to provide a more welcoming experience for new residents.

St. Edmundsbury Hospital (SEH) provided treatment for voluntary residents only. Therapeutic services and programmes were provided either on-site or in St. Patrick's University Hospital (SPUH). The approved centre provided transport between St. Edmundsbury and St. Patrick's Hospitals to enable residents to attend therapeutic and recreational programmes in both locations.

2.2 Conditions to Registration

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

2.3 Governance

St. Edmundsbury Hospital was part of St Patricks Mental Health Services and came under the overall management of a Board of Governors established by charter. The direct operation of the hospital came within the competence of a Senior Management Team. A detailed clinical and corporate governance structure was in place. Minutes of all governance committee meetings were provided to the inspectors. These indicated that a variety of governance issues were considered on a regular basis and that consideration of issues relating to St. Edmundsbury was integral to the governance structure.

2.4 Inspection scope

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

The inspection was undertaken onsite in the approved centre from:

Wednesday 24 August 2016 -09.30 to 17.15.
Thursday 25 August 2016 -08.45 to 17.30.
Friday 26 August 2016 -08.30 to 16.00.

2.5 Non-compliant areas from 2015 inspection

The previous inspection of the approved centre on 5,6,7 October 2015 indicated compliance with all relevant Regulations, Rules and Codes of Practice.

2.6 Corrective and Preventative Action plan

No Corrective and Preventative Actions were required following the previous inspection.

2.7 Non-compliant areas on this inspection

The approved centre was compliant with all relevant Regulation, Rules, and Codes of Practice. It was not necessary for the centre to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance.

2.8 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 4 Identification of Residents
Regulation 5 Food and Nutrition
Regulation 6 Food Safety
Regulation 7 Clothing
Regulation 8 Residents' Personal Property and Possessions
Regulation 10 Religion
Regulation 11 Visits
Regulation 12 Communication
Regulation 14 Care of the Dying
Regulation 15 Individual Care Plans
Regulation 16 Therapeutic Services and Programmes
Regulation 18 Transfer of Residents
Regulation 19 General Health
Regulation 20 Provision of Information to Residents
Regulation 21 Privacy
Regulation 22 Premises
Regulation 23 Ordering, Storage, Prescribing, and Administration of Medicines
Regulation 24 Health and Safety
Regulation 26 Staffing
Regulation 27 Maintenance of Records
Regulation 29 Operating Policies and Procedures
Regulation 31 Complaints Procedure
Regulation 32 Risk Management Procedures

2.9 Areas not applicable

The following areas were not applicable as the rule, regulation, code of practice or Part 4 of the Mental Health Act 2001 was not relevant to this approved centre at the time of inspection.

Regulation/Rule/Act/Code
Regulation 17 Children's Education
Regulation 25 Use of Closed Circuit Television (CCTV)
Regulation 30 Mental Health Tribunals
Rules Governing the Use of Electro-Convulsive Therapy (ECT)
Rules Governing the Use of Seclusion
Rules Governing the Use of Mechanical Means of Bodily Restraint
Part 4 of the Mental Health Act – Consent to Treatment
Code of Practice relating to the Admission of Children under Mental Health Act 2001
Code of Practice – Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

2.10 Areas of good practice identified on this inspection

- The reception and admission area of the approved centre have been renovated to provide a more welcoming environment.
- Service user privacy has been augmented through the provision of salto locks on all bedroom doors with cards provided to residents.
- The dining rooms facility was in the final stages of remodelling and renovation to increase the size of the facility and ensure the highest standards of food provision.
- The approved centre had developed a Relaxation through Activity group to provide residents with an alternative means of promoting relaxation.

2.11 Reporting on the National Clinical Guidelines

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

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

The approved centre did not admit patients on an involuntary basis and, therefore; this section did not apply.

2.13 Resident Interviews

Residents were invited to speak with the inspection team. During the course of this inspection the inspection team met with a number of residents on an informal basis. In addition three residents requested to meet with the inspectors. Their comments regarding the facility and their interaction with staff were positive. One resident recommended the provision of outdoor facilities for children who might be visiting.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	41	0	0	41
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 2	Voluntary Residents	41	0	0	41
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 3	Voluntary Residents	43	0	0	43
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0

2.15 Feedback Meeting

At the conclusion of the inspection a feedback meeting was held. This was attended by the Inspection Team and the following service representatives

- Registered Proprietor
- Clinical Director
- Director of Nursing (SPUH)
- Director of Nursing (SEH)
- Director of Psychology
- Director of Services
- Occupational Therapy Manager
- Head of Social Work
- Consultant Psychiatrist (Deputy Clinical Director)
- Programme Manager (Clinical Governance)
- Nurse Practice Development Coordinator
- Clinical Nurse Manager 2

The inspection team outlined the changes which had occurred in the Judgement Support Framework (JSF) assessment structure based, in significant part on feedback from services. The inspectors outlined initial tentative findings of this inspection and accepted clarifications from the service. The inspectors were informed that, among other proposed improvements, it was hoped to provide suitable outdoor spaces to facilitate family visits and visits by children, particularly during the summer period.

3.0 Inspection Findings and Required Actions - Regulations

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

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

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

Inspection Findings

Processes: The approved centre had a written policy on the identification of residents. This policy was in date and was approved. The policy outlined processes for ensuring the accurate identification of residents and also outlined staff responsibilities for managing the process. The procedure for ensuring the confidentiality and data protection of resident identification data was outlined in the policy. The policy outlined procedure for documentation of at least two resident identifiers. Processes were in place to ensure clear differentiation of residents with same or similar names.

Training and Education: Staff had signed the policy to confirm that they had read and understood it. Staff interviewed were able to articulate the processes involved.

Monitoring: An annual audit had been undertaken of identification processes and the findings had been reviewed and analysed to identify opportunities in the processes.

Evidence of Implementation: All clinical files inspected contained at least two, person specific, identifiers. The identifiers were appropriate to the communication abilities of the residents. Identifiers, including photographic identification, were used when administering medication or other therapeutic services. Clinical files of residents with similar names were differentiated by use of a specific warning sticker.

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

3.5 Regulation 5: Food and Nutrition

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

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

Inspection Findings

Processes: The approved centre had a written policy in place concerning the provision of food and nutrition to residents. This policy was in date and had been approved. The policy outlined the roles and responsibilities of staff in the provision of food, including special or therapeutic diets. The policy outlined processes for assessing the dietary and nutritional needs of residents and for monitoring food and water intake when required.

Training and Education: Staff had read the policy and had signed this to confirm that they were aware and understood it. Relevant staff who were interviewed, in particular the catering manager, were able to articulate the processes for providing food and nutrition, including specialised diets.

Monitoring: The catering manager and food company nutritionist had reviewed all menus and devised a three week menu cycle to ensure choice and best practice nutritional status. This review had been analysed to identify opportunities for improvement in the process and these had been implemented.

Evidence of Implementation: The approved centre menus had been overseen and approved by a nutritionist to ensure that they were adequate for resident needs. Residents were provided with a varied and wholesome diet which was attractively presented. Hot and cold drinks were provided to residents on a regular basis and residents had ready access to a supply of drinking water.

A choice of hot meals was provided on a daily basis. The approved centre had access to the services of a dietician where required. Where appropriate, weight charts and intake and output charts were maintained on residents but this was not deemed necessary in the case of any current resident. Lectures on nutritional issues were incorporated in the resident education programme.

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

3.6 Regulation 6: Food Safety

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

Inspection Findings

Processes: The approved centre had policies in place relating to food safety issues which were drafted by the private food company contracted to provide meals (Aramark) and separately by the approved centre. These policies were in date and were approved. The contracted food company provided evidence of ISO quality compliance to the approved centre. The policies outlined processes for complying with relevant food safety legislation requirements, for the storage, preparation, handling, and distribution of foodstuffs, and for the management of catering and food safety equipment.

Training and Education: Relevant catering staff had signed the relevant policies to confirm that they had read and understood them. Catering staff were able to articulate the processes involved in ensuring food safety within the approved centre. Records were available indicating that all staff had up to date training in Hazards Analysis and Critical Control Points (HACCP).

Monitoring: Aramark completed a number of food safety audits which were documented. Food temperatures were recorded in line with safety recommendations and a log was maintained. Analysis of audit findings was undertaken to identify opportunity for improvement in the food safety processes.

Evidence of Implementation: Appropriate hand washing facilities were available to catering staff and appropriate Personal Protective Equipment (PPE) was utilised by staff. There was adequate catering equipment and suitable facilities for the refrigeration, storage, preparation, cooking and serving of food were provided. Appropriate cleaning practices were in place and regular hygiene audits were undertaken. Food preparation was undertaken in line with HACCP audits. Residents had access to adequate supplies of cutlery and crockery**.**

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

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: The approved centre had a written policy relating to access to, and provision of, suitable clothing. The policy was in date and had been approved. The policy outlined roles and responsibilities of staff in relation to the provision of clothing. Procedures for documenting the wearing of night clothing by day, should this arise, were outlined in the policy.

Training and Education: Staff had signed the policy to indicate that they had read and understood it. Staff interviewed were able to articulate the processes for ensuring that residents had access to suitable clothing.

Monitoring: The approved centre monitored the availability of emergency clothing should this be required and a process for documenting the provision and use of emergency clothing was in place.

Evidence of Implementation: Residents were supported in keeping and wearing their personal clothing. Residents were observed to be dressed in appropriate personal day clothing and all residents had adequate storage space within their bedrooms for their personal effects. Arrangements were in place to facilitate the laundering of personal clothing outside the approved centre should this be required. No current resident required the provision of emergency clothing but this could be provided should the need arise.

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

3.8 Regulation 8: Residents' Personal Property and Possessions

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a written policy regarding the management of residents' personal possessions and monies. The policy was in date and had been approved. It outlined the role and responsibility of staff in documenting and safeguarding the property of residents. The policy outlined information processes for both residents and their families. Processes for documenting and securing residents' property was outlined in the policy as was the procedure for providing residents with control of their own property and monies.

Training and Education: Staff had signed the policy indicating that they had read and understood it. Staff interviewed were able to articulate the procedures involved in securing and safeguarding resident property.

Monitoring: Personal property logs were maintained and monitored. A recent audit of processes was documented and this was being utilised to develop improvements in the processes.

Evidence of Implementation: All residents had personal safes within their wardrobes and were responsible for their personal possessions and monies. Secure facilities were available within the approved centre for the security of valuables. There was no effective limitation on the personal possessions or valuables brought in by a resident. A property checklist was maintained and was signed by the resident and staff. Residents were encouraged and facilitated in maintaining control over their own property and possessions.

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

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: The approved centre had a written policy concerning recreational activities which was implemented during the course of this inspection (REC0001 – 25/08/2016). This was in addition to a separate policy (TP0001) concerning the operation of the Twilight Programme. The policies outlined the role and responsibilities of staff in the facilitation and operation of recreational activities. The policies outlined a process for determining resident needs and preferences in relation to recreational activity.

The policies did not outline a process to risk assess residents in relation to participation. The policy outlined a procedure for communicating the availability of activities. Facilities available for activities were outlined in the policies.

Training and Education: Relevant staff had signed the policies indicating that they had read and understood them. Staff interviewed were able to articulate the processes involved in facilitating resident participation in activities, particularly in the Twilight Programme.

Monitoring: The approved centre maintained a record of the occurrence of planned recreational activities and a record of resident participation. An audit of processes and procedures had been undertaken and analysed to identify opportunity for improvement.

Evidence of Implementation: Residents had access to a variety of recreational activities within and external to the approved centre which were appropriate to their needs. The Twilight Programme provided activities in the evening and at weekends. Information regarding available activities was provided in verbal and written format.

The development of activities involved residents. If required a risk assessment in relation to participation could be undertaken but this was rarely indicated. Activities were adequately resourced and residents were free to partake or abstain depending on personal preference. Adequate communal spaces were available and both indoor and outdoor recreation was available.

The approved centre was compliant with this regulation. Not all aspects of the JSF criteria under the Processes pillar were implemented and the quality assessment was satisfactory.

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

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: The approved centre had a written policy concerning the facilitation of religious practice. This policy was in date and was approved. There was a separate policy regarding criteria for the employment of chaplains. The policy outlined roles and responsibilities in relation to identifying residents' religious preferences at the time of admission. It also outlined processes for the facilitation of practice and for respecting individual religious beliefs in the course of daily activities.

Training and Education: Staff had read the policy and those interviewed were able to articulate process within the approved centre for facilitating religious observance and participation or otherwise.

Monitoring: An audit had been undertaken on the implementation of the policy and this was documented.

Evidence of Implementation: In so far as practicable residents were facilitated in religious practice. A multidenominational oratory was available within the approved centre and regular Roman Catholic services were held. Residents had access to multi-faith chaplains and where practicable and subject to MDT review residents were facilitated to attend external religious services. Care and services provided were respectful of personal religious beliefs and residents were free to partake or abstain from religious practice as they saw fit.

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

3.11 Regulation 11: Visits

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a written policy concerning visiting arrangements. This policy was in date and had been approved. The policy outlined the roles and responsibilities of staff in facilitating visits and also outlined processes for restricting visits, whether at the request of a resident or clinically indicated. The provision of suitable locations was outlined as were procedures for facilitating and overseeing visits by children.

Training and Education: Staff had signed the policy indicating that they had read and understood it. Staff interviewed were able to articulate the process involved in facilitating visits.

Monitoring: An audit of visiting signage processes had been undertaken and analysed to assess whether changes in processes were required.

Evidence of Implementation: Visiting times were publicly displayed throughout the approved centre and were also available in the Information Booklet. Visiting times were appropriate. No current resident had any restriction in visitors applied. Suitable visiting areas were available throughout the approved centre. Any children visiting were required to be accompanied at all times by an adult. Suitable facilities were available for children visiting.

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

3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: The approved centre had a number of written policies concerning various aspects of communication by residents and these were in date and approved. The policies outlined the role and responsibility of staff in facilitating resident communication. The policy outlined processes for facilitating communication by a variety of means.

Processes were outlined for the assessment of resident communication skills and any impediments to this. The policy outlined procedures required where examination of resident communications by staff was considered necessary, including risk assessment. Access to an interpreter, should this be required, was outlined in the policy.

Training and Education: Staff had signed the policy and were able to articulate their role in the procedures involved.

Monitoring: Resident communication processes had been audited in 2015 and analysis of the findings was being utilised to bring about improvement in communication facilities.

Evidence of Implementation: Individual risk assessments were undertaken where any consideration was given to monitoring communication by staff. This was not indicated for any current resident. Residents had access to a variety of means of communication – post, phone, email and internet.

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

3.13 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a written policy on the implementation of searches and a separate policy on processes involved when illegal drugs or alcohol were detected. Both policies were in date and were approved. The policy outlined procedures for the management and applications of searches involving residents, including consent processes. Roles and responsibilities of staff in relation to the implementation of personal searches were outlined.

The requirement for individual risk assessment in relation to the implementation of personal searches was documented. Processes for communicating the policy and for informing any resident affected of what is happening and why were outlined. Procedures for safeguarding the privacy and dignity of any resident affected were outlined as was the requirement to ensure comprehensive documentation of the procedure.

Training and Education: Staff had signed the policy to indicate that they had read and understood it. Staff interviewed were able to articulate the processes involved in undertaking and documenting a search.

Monitoring: Due to the rarity of searches a search log was not maintained but each documented Search Record was reviewed to ensure that the requirements had been observed. While it was documented that an audit of processes had been undertaken there had been no documented analysis completed to identify opportunities for improvement in the processes.

Evidence of Implementation: Any searches undertaken were based on an individual risk assessment. Resident consent was sought for all searches and the provision or refusal of consent was documented. A procedure was in place to inform a resident of the reason for a search being undertaken. A minimum of two nurses were involved in any search and due consideration was given to resident privacy and dignity in any search undertaken. A written record of every search undertaken was maintained both on a Search Record and in the individual clinical file. This included the identification of the staff undertaking the search.

The approved centre was compliant with this regulation. Not all aspects of the JSF criteria under the Monitoring pillar were implemented and the quality assessment was satisfactory.

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

3.14 Regulation 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a number of written policies dealing with the care of the dying and sudden death. The policies addressed the roles and responsibilities of staff in relation to the care of the dying resident and the provision of support to families. Processes in relation to do not attempt resuscitation (DNAR) orders were addressed in the policy. Advance directive were addressed in a separate policy.

Processes for the maintenance of dignity and for communication with families were outlined. Supports available to staff following a death were outlined in a separate policy. Procedures for managing sudden death were outlined, including the required notifications processes. Processes for notification to the approved centre of the death of residents occurring elsewhere were outlined.

Training and Education: Staff had signed the policy to confirm that they had read and understood it. Staff interviewed were able to articulate the processes involved in dealing with a resident who might be dying or where unexpected death occurred.

Monitoring: No resident had died since the last inspection and, therefore; this pillar was not applicable.

Evidence of Implementation: No resident had died since the last inspection and, therefore; this pillar was not applicable.

Compliance rating was based on the Processes and Training and Education pillars.

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

3.15 Regulation 15: Individual Care Plan

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

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

Inspection Findings

Processes: The approved centre had a written policy concerning the operation of the ICP process. The policy outlined roles and responsibilities of staff in the process. It also outlined procedure for the initial development of the plan and the required components. Time frames for development were outlined. The involvement of the resident and access by the resident to their Care Plan were also addressed in the policy.

Training and Education: Staff had signed the policy to indicate that they had read and understood it. Staff interviewed were able to articulate the requirements of the policy in terms of developing and reviewing the plan. A new ICP booklet had been recently introduced and all clinical staff had received training in the procedure.

Monitoring: An active audit process was on-going and the findings were analysed to identify opportunities for improvement in the processes.

Evidence of Implementation: Each resident was assessed on admission and an initial care plan drafted. Within seven days a definitive individual care plan was devised by the MDT with resident involvement. The care plan was based on comprehensive assessment. Residents and, where appropriate and with consent, their families were involved in the ICP process. Care plans reviewed identified appropriate goals, actions, resources and review processes.

Plans identified a named keyworker and also outlined, where appropriate, a risk management plan. The care plan was reviewed and updated by the MDT, in consultation with the resident, on a weekly basis. Residents had access to their individual care plans. The care plan in its new format constituted a composite set of documents within the clinical file but separate to the progress notes.

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

3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: The approved centre had a number of written policies regarding the provision of therapeutic services. These were in date and approved. These policies outlined the role and responsibilities of staff in the provision of service to residents. The policies outlined processes for the provision of therapeutic services, including by external providers, associated resource issues, together with the documentation and evaluation of the processes. Processes for assessing suitability and the availability of suitable facilities were addressed.

Training and Education: Staff had signed the various policies to confirm that they had read and understood them. Staff interviewed were able to articulate the processes involved in the provision of therapeutic services and their role in these.

Monitoring: On-going audits of all programmes were documented and a review process was in place at management level. Analysis of audit findings was utilised to improve the processes associated with the various therapeutic programmes.

Evidence of Implementation: The range of programmes available in the approved centre was appropriate to the assessed needs of the resident population as outlined in ICPs. Programmes were evidence based. A list of therapeutic programmes available within the approved centre was available in various areas of the approved centre. Programmes available included Mindfulness, Relaxation, Stress Management, Psychology Skills, and Psychotherapy. Where a resident required a service which was not available arrangement were put in place to provide this from an external provider. Adequate therapeutic resources were in place and a number of dedicated therapy rooms were available within the approved centre. Records of resident participation in programmes were kept in the individual clinical file and within resident ICP's.

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

3.17 Regulation 17: Children's Education

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

Inspection Findings

Children were not admitted to St. Edmundsbury and, therefore; this regulation was not applicable.

3.18 Regulation 18: Transfer of Residents

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

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

Inspection Findings

Processes: The approved centre had a written policy concerning the transfer of residents which was in date and was approved. Roles and responsibilities of staff in relation to implementing transfer processes, including continuity of care and safety processes, were outlined in an appendix to the policy. The policy outlined criteria for transfer and decision making in relation to initiating a transfer procedure.

Communication requirements and documentation procedures with any receiving centre were outlined. The policy outlined consent procedures in the transfer process. A separate policy outlined processes to be followed in the case of emergency transfer.

Training and Education: Staff had read the policy and had signed to confirm this. Staff interviewed were able to outline the procedures involved in effecting a transfer.

Monitoring: An audit of transfer processes had been undertaken and associated analysis had identified opportunities for improvement in the process. These included the initiation of a transfer log which had recently been introduced.

Evidence of Implementation: The clinical file of a resident who had recently been transferred to an external hospital for assessment (though in effect discharged with a view to re-admission following investigation) indicated that communication with the receiving facility documenting reasons for transfer, pre-transfer assessment, resident's consent were completed. Copies of documentation forwarded were retained.

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

3.19 Regulation 19: General Health

(1) The registered proprietor shall ensure that:

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

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

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

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

Inspection Findings

Processes: The approved centre had a number of written policies addressing the provision of general health care to residents. These were all in date and were approved. The policy on emergency medical response outlined the roles and responsibilities of staff in the process, the management and documentation requirements, together with the training requirements for all staff involved.

Processes for the provision of routine general health care were outlined in policy. These included the roles and responsibilities of staff, provision for access to a registered medical practitioner and procedures for on-going medical care. Referral and documentation procedures were outlined as were the procedure for accessing recommended national screening programmes.

Training and Education: Staff had signed the relevant policies to confirm that they had read and understood them. Staff interviewed were able to outline the processes involved in providing general health care and in responding to emergencies.

Monitoring: A number of audits on various aspects of general medical screening and assessment had been undertaken. These had been analysed to identify opportunities for improvement in the processes.

Evidence of Implementation: The approved centre had access to an emergency trolley which was checked at weekly intervals. No recent emergency responses were documented. A full general health assessment was undertaken as part of the admission process. Residents received general medical inputs in line with their ICP. Admission were short term and no resident had been in the approved centre over six months. Opportunities were provided to residents to pursue healthy lifestyle choices through the provision of exercise facilities and healthy diet choices. All medical interventions were documented. While residents had access to national screening programmes this was not a priority due to the limited length of stay.

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

3.20 Regulation 20: Provision of Information to Residents

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

Inspection Findings

Processes: The approved centre had a series of written policies regarding the provision of information to residents. All were in date and approved. The policies outlined the roles and responsibilities of staff in the process. They also outlined processes for verifying the communication needs of residents, including interpretation services when required. Procedures for the provision of information to relatives and processes for facilitating advocacy support were outlined.

Training and Education: Staff had signed the policy to confirm that they had read and understood it. Staff interviewed were able to outline the processes for ensuring that residents had access to information based on the policy requirements.

Monitoring: The provision and suitability of information was monitored on an on-going basis by the Clinical Governance Committee. In addition, audit of information provision processes had been undertaken and analysed to identify opportunity for improvement in the processes.

Evidence of Implementation: All residents in the approved centre were given a copy of a detailed Information Booklet which outlined a variety of housekeeping arrangements. Details of the Multi-Disciplinary Team (MDT) composition were available on large notices placed in public areas of the approved centre. Written and electronic information on diagnosis and treatment issues, including medication effects, was readily available to all residents.

In addition residents had ready access to the pharmacist who attended MDT meetings and was available to discuss and provide information on medication effects. Information provided was evidence based and was approved by the clinical governance committee. Information provided on health and safety issues was in readily understandable format. Residents had access to information relating to advocacy and also relating to relevant voluntary agencies involved with the approved centre.

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

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: The approved centre had a suite of written policies dealing with protection of privacy and dignity. These outlined the roles and responsibilities in relation to the safe guarding of privacy. Procedures to address any failure in the part of staff to protect resident privacy were outlined in the relevant policy. The approved centre had a service user and family charter which outlined resident rights in this respect

Training and Education: Staff had signed the policy to indicate that they had read and understood the policies. Staff who were interviewed were able to articulate the procedure for safeguarding resident privacy and their role in supporting these.

Monitoring: An audit of privacy facilities within the approved centre had been undertaken and analysis of findings had indicated that no further action was required at present.

Evidence of Implementation: Residents were observed to be addressed in a respectful manner by staff. Staff were appropriately dressed and identified. No inappropriate comments were made and staff only discussed residents' condition on an appropriately private basis. Residents were appropriately dressed and the majority of residents had single rooms. In all cases staff were observed to knock before entering a resident's private room. Residents all had keys to secure their rooms and all toilet and bathroom facilities were lockable. Where residents were sharing bedroom accommodation adequate provisions were in place to safeguard personal privacy and dignity. Rooms were not overlooked by public areas and appropriate screening was in place where required. No personal information was detailed on public notice boards.

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

3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had multiple written policies concerning various aspects of the maintenance of the premises. The policies outlined the roles and responsibilities in relation to the safety and maintenance of the premises and cross-referenced relevant legislative provisions.

Training and Education: Staff had signed the policies relevant to their particular area of work to confirm that they had read and understood these. Staff were able to articulate the requirements of the policy in relation to their area of responsibility.

Monitoring: Audits had been undertaken in relation to various aspects of premises maintenance including a hygiene and infection audit and a ligature audit. Findings were analysed to provide opportunity for improvement in the processes.

Evidence of Implementation: Residents had access to adequate personal and communal space with the approved centre. The approved centre accommodation was furnished and equipped to ensure adequate comfort and privacy for residents. Rooms and communal spaces were adequately ventilated and well lit. Appropriate signage was in place to facilitate resident orientation and safety.

Residents had access to extensive garden and outdoor areas. The physical environment of the approved centre encouraged and facilitated meaningful activities. Residents had key control to their own doors. As part of the maintenance process steps were taken to minimise hazards and risks within the approved centre. The approved centre had a scheduled

programme of maintenance, cleaning, and renovation. It was maintained clean and free of odours. Any faults or problems identified were reported to the Services department and rectified.

Adequate toilet and bathroom facilities were available to residents, including assisted facilities should these be required. Lifts were available within the approved centre. Dedicated therapy rooms were available. Suitable furnishings to support resident independence and comfort were provided. Remote areas of the approved centre were monitored and back-up power was available on site. Arising from a ligature audit it was planned to refurbish resident bathrooms on a phased basis.

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

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

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

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

Inspection Findings

Processes: The approved centre had a number of written policies which addressed processes involved in various aspects of medication management. The policies outlined the roles and responsibilities of clinical staff in the context of legislative and professional guidance. Processes for ordering, storing, prescribing, and administering medications (including controlled medications) were outlined. Processes applied in situations where medication was withheld or refused were documented. Separate polices addressed issues relating to medication reconciliation and the management of errors or adverse events.

Training and Education: Staff had signed that they had read and understood the relevant policies. Staff interviewed were able to articulate the process involved in the control and management of medication. Staff had access to written and electronic information on medication issues. Staff were aware of the importance of reporting adverse events and of the procedures for doing so.

Monitoring: A number of audits were undertaken in relation to various aspects of the medication management process. These audits were analysed and the results utilised to improve the processes where indicated. A standard form was utilised for the reporting of any adverse events.

Evidence of Implementation: All medication prescription and administration records (MPARs) were reviewed. Appropriate resident identifiers were utilised in the medication administration process. Any allergies or sensitivities were documented. All prescription and administration records were consistent with policies requirements and the prescriber signature and Medical Council Registration Number (MCRN) was documented in all cases. Prescriptions were reviewed weekly and any change or amendment was fully re-written. Medications were administered by a nurse with the exception of controlled drugs which involved two qualified nurses. Medication stocks were verified on a weekly basis and regular reconciliation and removal of unutilised medication was undertaken by the pharmacist. Appropriate locked facilities were available for the storage of medications. The fridge used for medication storage was not used for other items and had a temperature log maintained and documented.

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

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: The approved centre had a series of policies covering various aspects of the health and safety process. It was specified that these applied to residents, staff, and visitors. All policies were in date and were approved by management. Roles and responsibilities were allocated. Health and Safety representatives, Health and Safety Manager and Fire Officers were all identified in the policies.

The approved centre had a Safety Statement which outlined the risk management process and fire management plan. The policies outlined processes involved in infection control, first aid response and falls prevention. Staff training requirements in relation to health and safety were outlined in the policies as were the monitoring and continuous improvement processes required.

Training and Education: Staff had signed the policy to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to health and safety and their role in observing these.

Monitoring: The Health and Safety policy was monitored in accordance with Regulation 29: Operational Policies and Procedures. A number of audits of various processes relating to health and safety had been undertaken, analysed and utilised to identify improvements in the processes associated with health and safety.

Evidence of Implementation: The written policies and procedures accurately reflected the operational practices in the approved centre.

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

3.25 Regulation 25: Use of Closed Circuit Television

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

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

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

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

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

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

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

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

Inspection Findings

Closed Circuit Television (CCTV) was not used within the approved centre to monitor or observe residents and, therefore; this regulation was not applicable.

3.26 Regulation 26: Staffing

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a range of policies (approximately seventy in all) dealing with the recruitment, selection, vetting, and training of staff. These policies were in date and were approved by management. The policies outlined the roles and responsibilities of staff in relation to the recruitment and training of staff. The organisational structure of the approved centre was outlined in both policy documents and in the Safety Statement. Relevant policies outlined process for staff planning in the particular area.

Details of staff rosters for the approved centre were provided to the inspectors together with the processes for communicating these to staff. Processes for the induction and orientation of new staff were outlined in policy. Relevant polices outlined processes for specifying and ensuring that on-going staff training requirements were met, including the required qualification of training personnel. Procedures for the use of agency staff were outlined in policy as were procedures for staff evaluation.

Training and Education: Staff had signed that they had read and understood the policies that were relevant to their discipline and work area. Relevant management staff were able to articulate the processes involved relating to staff recruitment and training.

Monitoring: An on-going process of review of the implementation and effectiveness of staff training processes was undertaken by senior management and was documented. This included the number and skill mix of staff within the approved centre. A constant process of analysis was undertaken to identify and implement improvements in staff training processes.

Evidence of Implementation: An organisational chart identifying the management structure and lines of responsibility within the approved centre was available to the inspectors. The inspectors were provided with a copy of the staff roster for the approved centre which was consistent with the staffing levels provided at time of registration. Staffing levels and skill mix were sufficient to meet resident needs. Staff were recruited, selected, and vetted in accordance with the approved centre's policies. An appropriately qualified member of staff

was in charge at all times. The approved centre had a written staffing plan which took into account factors specific to the approved centre. Where agency staff were utilised they were subject to the same recruitment and vetting processes regular staff.

Annual training plans were maintained and documented for all staff. All staff had undergone induction and orientation training. All healthcare staff were trained in fire safety, basic life support, management of actual or potential aggression (MAPA), child protection and the Mental Health Act. Training was documented and was up to date for all staff. Staff had undertaken a variety of training programmes which were documented and were relevant to the assessed needs of the resident population. Training logs were maintained for all staff. Staff were provided with training opportunities and a record of all in-services training was maintained by the approved centre.

The Mental Health Act 2001 together with association Regulations, Rules, and codes were available to all staff.

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

Ward or Unit	***Staff Grade***	***Day***	***Night***
St.Edmundsbury Hospital	Director of Nursing	1	-
	CNM2	1	-
	RPN	5	3
	HCA	-	-
	Occupational Therapist	1.5	-
	Social Worker	1.3	-
	Psychologist	2.4	-
	Family Therapist	1.4	-
	CB therapist	2.0	

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

Cognitive Behavioural (CB)

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

3.27 Regulation 27: Maintenance of Records

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a number of policies dealing with various aspects of the creation, access to, retention, and destruction of records. These polices were all in-date and were approved. These policies outlined the roles and responsibilities of staff in the process of document management. The processes required in record generation and content required were outlined. Processes to ensure privacy and confidentiality of records were outlined as were procedures for providing resident access to records. Relevant policies outlined retention and destruction processes. Security processes in relation to the storage of and access to personal records were outlined.

The most recent report in relation to food safety, health and safety and fire safety were retained in the approved centre and were available to the inspectors.

Training and Education: Staff had signed the relevant policies to indicate that they had read and understood them. Staff interviewed were able to articulate the requirements of the policies and their role in implementing these. All clinical staff had received training in record keeping as part of the induction training process.

Monitoring: The approved centre had undertaken a series of audits on various aspects of document management process. These had been analysed to provide opportunities for improvement in the management processes.

Evidence of Implementation: All clinical records were up-to-date, in good order, and were stored securely. All records were stored together. Each resident in the approved centre had an individual record. Individual records reflected the current status of the resident. All records contained individual identifiers unique to the particular resident. Records were accessible to authorised staff only.

Resident access to their records was in accordance with the Data Protection Acts. Entries were only made by authorised staff and data was observed to be recorded and documented in line with policy requirements.

Records within the approved centre were securely stored. Reports on food safety, health and safety, and fire safety were retained within the approved centre. Records were retained and destroyed in accordance with the policy of the approved centre.

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

3.28 Regulation 28: Register of Residents

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

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

Inspection Findings

Processes: The approved centre had a written policy concerning the roles and responsibilities involved in accurately maintaining an up to date register of residents. This policy was in date and had been improved.

Evidence of Implementation: The approved centre had a documented register of residents which was provided to the inspectors. The register contained the information required under Schedule 1 to the Regulation. The register was up to date and specified the resident status.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.29 Regulation 29: Operating Policies and Procedures

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

Inspection Findings

Processes: The approved centre had a written policy concerning the development and maintenance of policies. This policy document was in date and had been approved. The policy outlined roles and responsibilities of various staff and groups, both clinical and management, within the approved centre for the development and approval of operating policies. Procedures for disseminating policies and for reviewing and updating them on a timely basis were outlined. The policies outlined processes to ensure that a standardised policy layout was used by the approved centre.

Training and Education: Staff had signed the policy to indicate that they had read and understood it. Relevant staff were able to articulate the processes involved and their role in these.

Monitoring: An audit had been undertaken of the processes involved and analysis of these was utilised to review and identify opportunities for improvement in the procedures.

Evidence of Implementation: Operational policies were developed with input from clinical and management staff and incorporated input from service user representatives with the hospital. Policies took account of legislative requirements. Policies were communicated to staff and the relevance of any particular policy was identified on the title page. Obsolete policies were removed from common circulation.

All policies required under these regulations were reviewed within three years. Polices had a standardised format which was consistent. Service polices made specific reference to the approved centre when required.

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

3.30 Regulation 30: Mental Health Tribunals

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

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

Inspection Findings

The approved centre did not admit patients on an involuntary basis and, consequently, this regulation was not applicable.

3.31 Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a written policy on complaints which was in date and was approved. The policy outlined roles and responsibilities of staff in relation to managing the complaints process and included the identification of a nominated complaints officer to oversee the process. The process for documenting, investigating, and responding to complaints, including timeframes involved was specified.

The policy also outlined procedure for communicating the policy and procedure to residents or others. The procedure for making complaints was outlined. The policy outlined processes required to communicate the outcome of any complaints and included escalation and appeals procedures.

Training and Education: Management staff within the approved centre were able to outline the complaints management processes. Staff had signed that they had read and understood the policy. Staff interviewed were able to articulate the process for managing complaints within the approved centre.

Monitoring: An audit had been undertaken of complaints processes and this was documented. Analysis had been undertaken and reviewed by senior management with a view to identifying opportunities for improvement in the processes.

Evidence of Implementation: A designated person (Programme Manager for Clinical Governance) was identified as responsible for dealing with all complaints. Complaints were dealt with in a standardised manner. Residents were informed of the methods of complaint in the information booklet and on public notices within the approved centre. Access to the assistance of an advocate was available if required.

Any complaints were addressed rapidly and this was documented clearly. A procedure was in place to address minor complaints locally. Complaints were recorded in a complaints log. Timeframes were adhered to and there was evidence of formal response to complainants. The complainant's satisfaction with the matter was documented in the complaints log. Documentation of complaints was kept separate from the clinical file and there was no evidence that any resident was negatively affected as a result of making a complaint.

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

3.32 Regulation 32: Risk Management Procedures

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

Inspection Findings

Processes: The approved centre had an over-riding risk management policy which was supported by multiple policies dealing with various aspects of the procedure. The policy outlined roles and responsibilities of staff from the registered proprietor down in the process, and identified the person with overall responsibility for risk management. Responsibility for the compilation of six-monthly summary incident reports was outlined. The procedures for the management of clinical, operational, and structural risks were outlined. The processes for managing specific risks as required were documented. The procedure for review of the risk register was documented.

The procedure for risk reporting and rating was outlined. A procedure was in place for management oversight of complaints and a process was in place to systematically document incidents and to compile and submit summary reports to the (Mental Health Commission (MHC) as required. Procedures for responding to emergencies and for the protection of children and vulnerable adults were documented.

Training and Education: Staff were trained in risk management processes and reporting as part of the induction training procedure. Staff had signed the policy to indicate that they had read and understood it. Staff interviewed were able to articulate the processes involved.

Monitoring: The risk register was monitored on a regular basis as part of the overall governance process. Regular audits were documented and analysed to identify opportunities for improvement in the processes. All incidents were documented and risk rated.

Evidence of Implementation: Responsibilities were allocated at management level in relation to risk management processes. The designated risk manager was readily identified to all staff. Governance and risk management processes were in place aimed at reducing identified risks to the lowest level possible. Clinical, organisational, and structural risks were incorporated in the risk register. Appropriate steps had been taken within the approved centre to minimise risks to residents during the course of remedial works.

Individual risk assessments were undertaken on admission and prior to specialised treatments such as ECT (Electro-Convulsive Therapy). The MDT was involved in the assessment and management of risk and this was documented in the clinical file and ICP. Corporate risks were identified in the risk register. Processes were in place to minimise risk to children vulnerable adults. Incident reports were documented in a standardised form. Six-monthly summary reports were forwarded to the MHC. An emergency plan which incorporated evacuation procedures was in place.

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

3.33 Regulation 33: Insurance

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

Inspection Findings

Documentary evidence of insurance cover for the approved centre was provided to the inspectors. Insurance cover was in place in relation to property, public liability, employer's liability and clinical issues.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.34 Regulation 34: Certificate of Registration

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

Inspection Findings

There was an up-to-date certificate of registration displayed in a public area directly inside the main door of the approved centre.

	Compliant	Non-Compliant
Compliance with Regulation	X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

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

Inspection Findings

Processes: The approved centre only admitted voluntary patients and, therefore; this rule was not applicable.

4.2 Section 69: The Use of Seclusion

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

Inspection Findings

Seclusion was not used in the approved centre and, therefore; this rule was not applicable.

4.3 Section 69: The Use of Mechanical Restraint

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

Inspection Findings

The approved centre did not use mechanical restraint and, therefore; this rule was not applicable.

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

5.1 Part 4: Consent to Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

The approved centre did not admit patients on an involuntary basis and, therefore; Part 4 of the Act in relation to Consent to Treatment was not applicable.

6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: The approved centre had a written policy on physical restraint which was a common policy utilised by St. Patrick's Mental Health Services. The policy was in date and was approved. It addressed processes for the utilisation of physical restraint, including staff responsibility for initiating, overseeing, and documenting any episode of restraint which might occur. The policy met all the requirements of the Code of Practice.

Training and Education: Staff had signed the policy to indicate that they had read and understood it. Staff who were interviewed were able to outline the procedures involved in any episode of physical restraint. Review of training logs indicated that all staff of the approved centre had up to date training in the management of actual or potential aggression (MAPA).

As the approved centre did not utilise physical restraint and no episodes of restraint had been undertaken since last inspection the monitoring and implementation pillars were not applicable. This Code has been rated on the basis of the processes and Training pillars.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

6.2 Admission of Children

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

Inspection Findings

The approved centre did not admit children and, therefore; this code of practice was not applicable.

6.3 Notification of Deaths and Incident Reporting

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

Inspection Findings

Processes: The approved centre had a risk management policy which outlined processes required for the notification of deaths and incidents to the MHC. The policy identified a risk manager and specified responsibility for reporting deaths and incidents. The policy outlined the procedure for clarifying responsibility for the compilation and submission of six-monthly incident summary reports.

Training and Education: Staff had read the policies and, when interviewed, they were able to articulate the processes for complying with this code.

Monitoring: A governance process was in place to review all deaths occurring and to review incidents reported on an on-going basis.

Evidence of Implementation: There had been no deaths within the approved centre since the last inspection. There was an incident reporting system in place which utilised a standardised reporting form. This form was made available to the inspectors. Six-monthly summaries of all incidents occurring was provided to the MHC.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

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

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

Inspection Findings

The approved centre did not admit persons with an intellectual disability and mental illness and, therefore; this code was not applicable.

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

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

Inspection Findings

Processes: The approved centre had a written policy relating to the provision of Electro-Convulsive Therapy (ECT) to residents which was shared with the overall service. The policy outlined a set of processes which were compliant with the rules. The policy was in date and was reviewed annually. The policy included protocols for dealing with emergencies. ECT was not provided in St. Edmundsbury's Hospital (SEH) and residents receiving ECT were transferred to St. Patrick's University Hospital (SPUH) as day patients.

Training and Education: Staff who were involved in the pre-ECT assessment process had been trained and this was documented. Staff had signed the policy indicating that they had read and understood it. Staff interviewed were able to articulate the processes which occurred in the approved centre relating to ECT.

Monitoring: ECT was not provided in the approved centre and monitoring processes which did occur related to SPUH.

Evidence of Implementation: ECT was not provided in the approved centre. One resident at the time of the inspection was receiving ECT in SPUH. Review of the documentation indicated that all the requirements of this code were observed in the provision of ECT. Pre- and Post-ECT reviews were documented and the clinical file accompanied the resident to SPUH.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

6.6 Admission, Transfer and Discharge

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

Inspection Findings

Processes:

Admission: The approved centre had a written policy on admission which outlined processes for both urgent referrals and self-referrals. The policy outlined processes and defined roles and responsibilities for the assessment of residents both prior to admission and at the time of admission. Procedures for pre-admission communication with primary care or community mental health teams were outlined. The policy outlined processes required in the documentation of all admissions to protect privacy and confidentiality and to ensure that consent for any processes is obtained.

Transfer: There was a policy in place covering transfer, including transfer of an involuntary patient. The policy included processes for emergency transfer and for risk assessment in relation to the transfer process. The roles and responsibilities of staff were outlined.

Discharge: The approved centre had a written policy on discharge which was in date and approved. The policy outlined processes involved in discharge, including arrangements for the continuity of treatment on discharge. The policy incorporated protocols for the discharge of homeless persons and older persons. Provision for appropriate follow-up arrangements was include in the processes. A separate policy outlined processes for managing discharge against medical advice.

Training and Education: Staff had signed the relevant polices to confirm that they had read and understood them. Staff were able to articulate the processes involved in admission, transfer, and discharge.

Monitoring: There were audits available on each of the processes. These audits were analysed to identify opportunities for improvement in the particular process.

Evidence of Implementation:

Admission: The approved centre was compliant with the various regulations necessary to ensure compliance with this code. All admissions were for the treatment of mental disorder and all records were in a single file. Decision to admit was made by a registered medical practitioner and all assessments, including risk assessment, associated with the admission process were documented in the clinical file. All residents had a key worker assigned. Where appropriate and with the consent of the resident there was documented family involvement in the admission process.

Transfer: The approved centre was compliant with Regulation 18 – Transfer of Residents. No current resident had been transferred elsewhere for treatment. Due to operational factors residents requiring assessment or treatment elsewhere were discharged and re-admitted.

Discharge: The clinical files of a number of recent discharges were reviewed. In all cases the decision to discharge was made by the responsible consultant. A discharge plan was in place as part of the Individual Care Plan (ICP) and the resident was a participant in this process. A discharge plan was documented and this incorporated a follow-up plan, risk issues, and communication with community services.

There was evidence that that a discharge planning meeting, attended by the resident and the MDT, had occurred. A comprehensive assessment was documented prior to discharge and residents were given at least two days' notice of discharge. A comprehensive discharge summary was forwarded to the referral source and a copy retained on file. Where appropriate a resident's family were involved in the discharge process. Timely follow-up arrangements were documented.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	