Coimisiún Meabhair-Shláinte | Mental Health Commission

Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

UNITS 2, 3, 4, AND UNIT 8 (FLOOR 2), ST STEPHEN'S HOSPITAL

Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital, Sarsfield's Court, Glanmire, Co Cork

Date of Publication:
Thursday 01 April 2021

ID Number: AC0164

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
1 March 2020

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Hugh Scully, Acting General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
Noeleen Byrne, Lead Inspector
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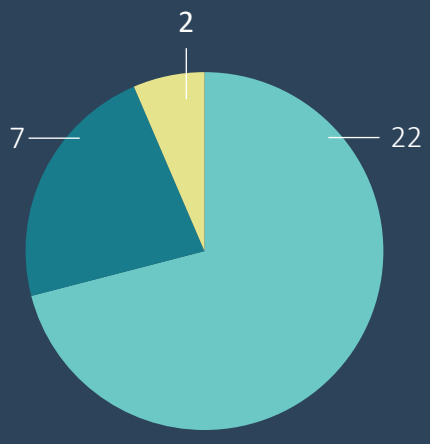
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
2 – 6 November 2020

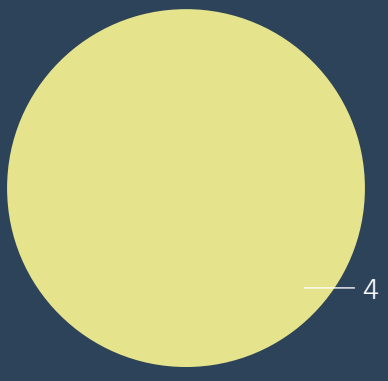
Previous Inspection Date:
3 – 6 September 2019

Inspection Type:
Announced Annual Inspection

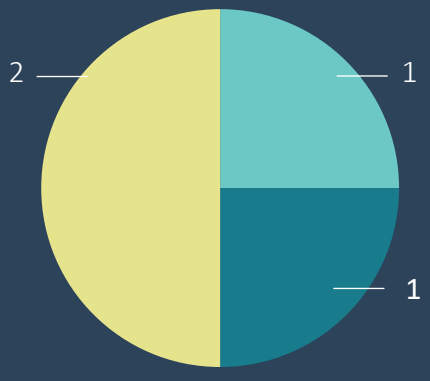
2020 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



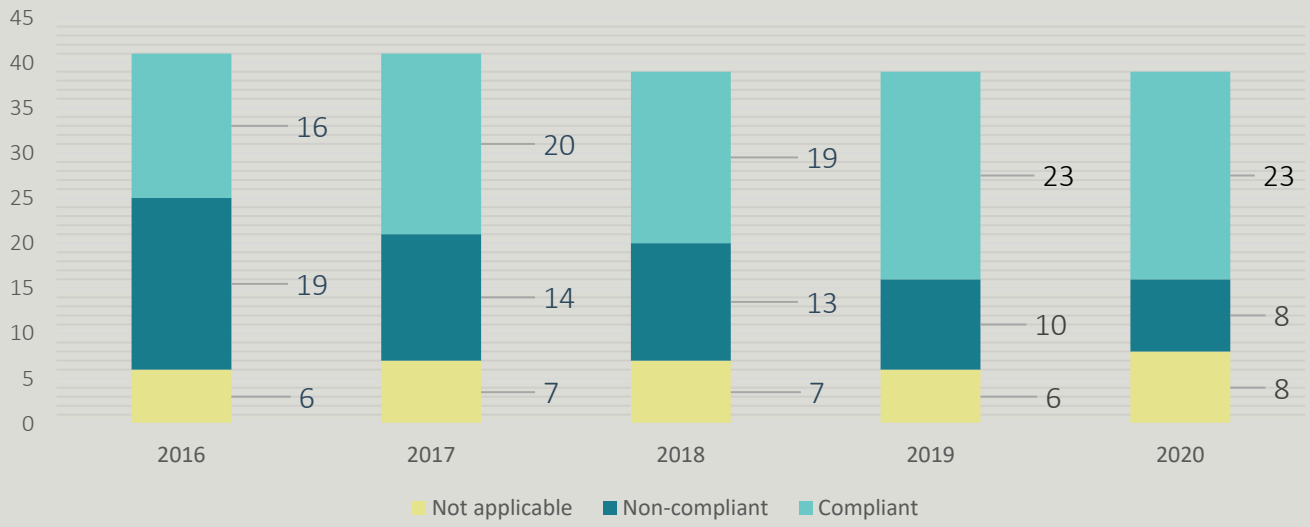
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2016 – 2020

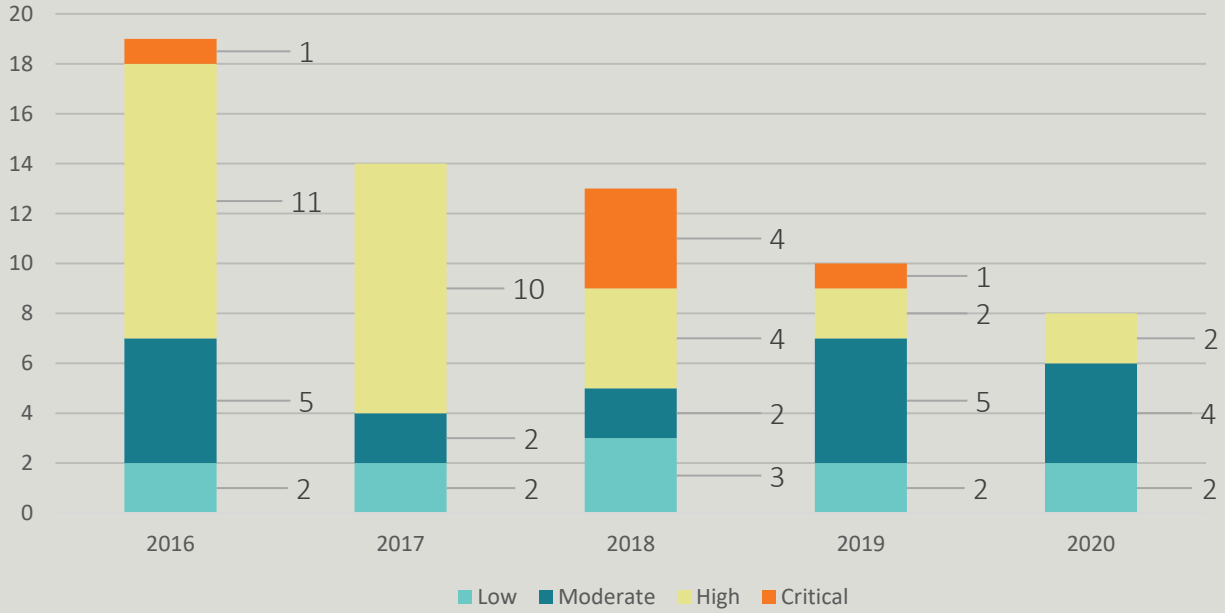
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2016 – 2020



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with regulations, rules and codes of practice.

In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

The approved centre was located seven kilometres from Cork city. It comprised of four buildings co-located within the 117-acre grounds at St. Stephen's Hospital. The approved centre had a total of 87 beds.

The North Cork area was served by three general adult sector teams (Fermoy and Mitchelstown, Mallow and Charleville, Kanturk and Newmarket). A Psychiatry of Later Life, and a Rehabilitation team, also admitted residents to the approved centre.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	46%	59%	60%	70%	74%
Regulations Rated Excellent	1	0	6	6	N/A

Conditions to registration

There were eight conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: *To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission. The approved centre shall appoint a named person with responsibility for monitoring and reporting on compliance with Regulation 15: Individual Care Plan.*

Finding on this inspection: The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 15: Individual Care Plan at the time of inspection.

Condition 2: *To ensure adherence to Regulation 22(3): Premises, the approved centre shall develop a costed, funded and time-bound plan to minimise ligatures in Unit 4. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on the implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 2 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Condition 3: *To ensure adherence to Regulation 22(3): Premises, the approved centre shall develop by 30 June 2020 a costed, funded and time-bound plan to minimise ligatures in Units 2, 3, and 8. The approved centre shall provide a progress update on the implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was in breach of Condition 3 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Condition 4*: To ensure adherence to Regulation 22(3): Premises the approved centre shall develop a costed, funded and time-bound plan to provide residents in Unit 8 direct access to an outdoor area. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 4 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Condition 5: *To ensure adherence to Regulation 22(1)(a) and 22(1)(c): Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 5 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Condition 6: *To ensure adherence to Regulation 22(2): Premises, the approved centre shall develop a costed, funded and time-bound plan to ensure all residents in all units have access to adequate toilet and bathing facilities. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 6 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Condition 7: *To ensure adherence to Regulation 26(4) and 26(5): Staffing, the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 7.

Condition 8: *To ensure a comprehensive risk management policy is implemented in the approved centre in adherence to Regulation 32(1) and (2), the approved centre shall maintain and update a risk register. The approved centre shall provide an update on the actions taken to mitigate risks to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 8 and the approved centre was non-compliant with Regulation 32: Risk Management at the time of inspection.

Safety in the approved centre

- There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Kitchen areas were clean.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre.
- Medication was ordered, prescribed and stored in a safe manner.
- Individual risk assessments were also completed on resident transfer and at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.

However:

- Ligature points were not minimised to the lowest practicable level throughout the approved centre.
- Rooms were centrally heated; however, pipe work and radiators were not guarded.
- Two medication prescription and administration records did not contain a record of all medications administered to one resident.
- Fire doors were held open by chairs in the approved centre and this had not been identified, assessed, treated, reported, monitored or documented within the risk register as a health and safety risk.

Appropriate care and treatment of residents

- Groups were run by nursing, social work, occupational therapy, and psychology disciplines, and an art therapist attended once a week. Therapeutic groups included a staying well group, cognitive

emotional behaviour therapy (CEBT) sessions, art therapy, yoga, relaxation, a cooking group, an 'understanding my care plan' group, and mindfulness colouring.
- The six monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, and a medication review. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

However:

- One general health assessment did not document the resident's body-mass index (BMI) or weight, while another general health assessment did not document the resident's waist circumference. The individual care plans (ICP) were not satisfactory:
  - Two ICPs did not identify appropriate goals for the resident.
  - One ICP did not identify the resources required to provide the care and treatment identified.
  - Two ICPs were not reviewed by the MDT weekly in consultation with the resident.
  - One ICP was not updated following the review by the MDT.

Respect for residents' privacy, dignity and autonomy

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident, and where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.

However, not all resident records were secure, up-to-date, and in good order due to loose pages and damaged, bulky folders.

Responsiveness to residents' needs

- Regular recreational activities included, art and art therapy, books, DVDs, TV, crafts, walking in grounds, and regular outings outside of the approved centre when national guidance in relation to COVID-19 restrictions permitted. Other activities included horticulture and gardening.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a choice of food at mealtimes.

However, one of two complaints made via the 'Your Service, Your Say' process had not been investigated promptly. This was recognised and acknowledged by the nominated person and actions had been taken to remedy this.

Governance of the approved centre

- St Stephen's Hospital was under the governance of North Cork Mental Health Services and within the overall governance of Cork Kerry Community Healthcare Organisation (CHO). There was also a Quality and Patient Safety Committee.
- The approved centre maintained a risk register which highlighted various clinical and health and safety risks.
- Multi-disciplinary training was provided by Nursing and Medical staff regarding the use of PPE and related infection control measures. Cross disciplinary training was held in modified Basic Life Support, AED and principles of airway management and utilising the frailty score to recognise a deteriorating patient in the context of COVID-19. Eight nurses were trained to swab for COVID-19. All units had made arrangements to isolate residents if they were suspected or confirmed as having COVID-19.
- The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE's 'Comment, Compliment or Complaint' process and resident community meetings.
- A clinical audit programme was developed with an annual audit plan and these audits formed part of the quality improvement in the approved centre.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A new outdoor space was developed for residents in Unit 8.
2. Art packs were developed for residents' use in each unit.
3. Dietitians and nurse therapy services have commenced a new educational group on healthy eating.
4. Information leaflets were enhanced to include visiting arrangements and structure of the service.
5. Unit 8 was refurbished to include new sitting rooms, showers and toilets.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located seven kilometres from Cork city in a picturesque valley outside the small village of Glanmire. The approved centre comprised of four buildings co-located within the 117-acre grounds at St. Stephen's Hospital. The hospital was originally built as a tuberculosis sanatorium in 1954, with each of the units facing a southerly direction, maximising sunlight into the wards. Each unit had an outside space for residents to sit. Until March 2020, residents from all four units attended the Valley View day centre which was also located on the grounds of St. Stephen's Hospital. Due to COVID-19 restrictions Valley View was closed at the time of the inspection.

The North Cork area was served by three general adult sector teams (Fermoy and Mitchelstown, Mallow and Charleville, Kanturk and Newmarket). A Psychiatry of Later Life, and a Rehabilitation team, also admitted residents to the approved centre. Each admitting team had responsibility for the care of their residents.

The approved centre had a total of 87 beds and comprised the following:

- Unit 2 – 25 beds for Psychiatry of Later Life.
- Unit 3 – 18 beds for the care of male residents with severe and enduring mental illness.
- Unit 4 – 19 beds for acute admissions within the North Lee area.
- Unit 8 (Floor 2) – in the main building, had 25 beds which provided care to residents with enduring mental illness and challenging behaviour.

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

Resident Profile	
Number of registered beds	***87***
Total number of residents	**51**
Number of detained patients	2
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	43
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

St Stephen's Hospital was under the governance of North Cork Mental Health Services and within the overall governance of Cork Kerry Community Healthcare Organisation (CHO). St Stephen's hospital had a monthly management meeting. At an organisational level, there was a monthly Cork Management team meeting.

There was also a Quality and Patient Safety Committee, which convened on a quarterly basis. Heads of Service or discipline attended all meetings.

Since 2018, the inspection team found that the state of the premises was a critical risk, principally due to the inadequate maintenance of the buildings and the limited showering facilities relative to the number of residents on Unit 8. Corrective action plans to address these issues were authored by the service; however, they were not implemented. Consequently, in 2019, the inspection team found no improvement concerning the premises. Funding for the development of new showering facilities on Unit 8 was approved, and the work has been completed. Work on the bathrooms in Unit 3 was underway at the time of the inspection. There were many ligature points that had not been minimised, however, plans were drafted for funding this work. An improved communications system with maintenance staff was note, however there were still numerous maintenance issues regarding the structural and decorative condition of the approved centre outstanding.

The approved centre maintained a risk register which highlighted various clinical and health and safety risks. Where required, the Risk and Patient Safety Advisor provided advice and support to the service in relation to risk management issues. The Mental Health Commission were notified of a number of falls and each one was investigated individually. The learning from each was documented however, there was no collective systematic approach to establishing if there was further learning about the environment or the age profile of the residents.

Multi-disciplinary training was provided by Nursing and Medical staff regarding the use of PPE and related infection control measures. Cross disciplinary training was held in modified Basic Life Support, AED and principles of airway management and utilising the frailty score to recognise a deteriorating patient in the context of COVID-19. Eight nurses were trained to swab for COVID-19. All units had made arrangements to isolate residents if they were suspected or confirmed as having COVID-19. Staff were encouraged to continue with general training and to access courses online.

The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE's 'Comment, Compliment or Complaint' process and resident community meetings. The Area Lead for Mental Health engagement was available by telephone and by telecall at times when access was limited, due to COVID-19 restrictions.

A clinical audit programme was developed with an annual audit plan and these audits formed part of the quality improvement in the approved centre. Each audit detailed the actions required to ensure compliance and improve quality.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 15: Individual Care Plan	✗	High	✗	High	✗	Critical	✗	Moderate	✗	Moderate
Regulation 19: General Health	✓		✗	High	✗	Moderate	✓		✗	Low
Regulation 22: Premises	✗	High	✗	High	✗	Critical	✗	Critical	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High	✓		✓		✗	Moderate	✗	Low
Regulation 27: Maintenance of Records	✗	Moderate	✗	High	✗	Moderate	✗	Low	✗	Moderate
Regulation 31: Complaints Procedures	✓		✓		✓		✓		✗	Moderate
Regulation 32: Risk Management	✗	Critical	✗	High	✗	Critical	✗	Moderate	✗	High
Code of Practice of the Use of Physical Restraint	✗	High	✓		✗	High	✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.

Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

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

The Irish Advocacy Network representative was not visiting due to COVID-19 but was available by phone. Residents were generally happy with the care and treatment they received, and that the food was very good. They attended and enjoyed the activities in the Valley View day centre up until March. Since then, they have been walking on the campus and activities were brought into each unit. Residents in Unit 4 wanted access to the internet as they have to source information about housing and other matters.

10 residents returned questionnaires. On a scale of 1-10 with 1 being poor and 10 being excellent three residents rated the overall experience of care and treatment at 10 out of 10, two at 9 out of 10, three at 8 out of 10 and three at 7 out of 10. Five residents (50%) said they were sometimes involved in setting goals for their individual care plan and five residents said they were sometimes able to discuss worries or concerns with a member of staff as soon as they needed to.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Registered Proprietor
- Clinical Director
- Area Director of Nursing
- Principle Psychologist
- Occupational Therapy Manager
- Principal Social Worker
- Assistant Director of Nursing x2
- Area Lead Mental Health Engagement
- Pharmacist
- Business Manager
- Dietitian Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The Safety Statement made available to the inspection was not the most up-to-date statement. The Registered Proprietor sent the most recent statement by return.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals and a source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in December 2018. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile, as well as self-directed activities such as television, books, board games, outdoor gardening, and a gym. Regular recreational activities included, art and art therapy, books, DVDs, TV, crafts, walking in grounds and regular outings outside of the approved centre when national guidance in relation to COVID-19 restrictions permitted. Other activities included horticulture and gardening.

Recreational activities varied between units depending on the resident likes and requests. Each unit had a defined member of staff from Valley View who encouraged and supported residents to partake in recreational pursuits. A new outdoor space had been specifically created for the residents in Unit 8, floor 2. This was a pleasant outdoor area with planters and seating adjacent to the ground floor corridor, located near the entrance to Valley View centre. Recreational activities were provided on weekdays and weekends.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in December 2018. At the time of inspection, visits to the approved centre had been suspended due to pandemic events, with the exception of visits for compassionate purposes or care for the dying. Visiting times were appropriate and reasonable. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Visiting rooms were suitable for children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to resident communication. The policy was last reviewed in December 2018. Residents had access to mail and phones unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The approved centre did not have Wi-Fi available for resident use; however, during COVID-19 pandemic events and the resulting visiting restrictions, residents were provided with smartphones for communication purposes if they did not have their own. Residents also had access to a cordless phone on the ward.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in December 2018 and included all requirements related to:

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

The resident search policy and procedure was communicated to all residents and relevant staff could articulate the search processes as set out in the policy. No searches had been conducted since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in December 2017. The clinical file of a resident who had died in the approved centre was examined during the inspection process. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs: this was documented in the resident's individual care plan. Religious and cultural practices were respected, insofar as was practicable, as was the dignity and privacy of the resident. Representatives, family, next of kin, and friends were involved, supported and accommodated during end of life care. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to resident communication. The policy was last reviewed in December 2018. Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinic file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

Appropriate goals for the resident were not identified in two of the ICPs reviewed. All ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. One of the ICPs did not identify the resources required to provide the care and treatment identified, while two of the ICPs were not reviewed by the MDT weekly, in consultation with the resident. One ICP had not been updated following the review, as indicated by the resident's changing needs, condition, circumstances, and goals.

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

a) **Two ICPs did not identify appropriate goals for the resident.**
b) **One ICP did not identify the resources required to provide the care and treatment identified.**
c) **Two ICPs were not reviewed by the MDT weekly in consultation with the resident.**
d) **One ICP was not updated following the review by the MDT.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to resident communication. The policy was last reviewed in August 2020. The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Groups were run by nursing, social work, occupational therapy, and psychology disciplines, and an art therapist attended once a week. Therapeutic groups included a staying well group, cognitive emotional behaviour therapy (CEBT) sessions, art therapy, yoga, relaxation, a cooking group, an 'understanding my care plan' group, and mindfulness colouring.

Therapeutic programmes were available on weekdays and the weekend. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in July 2020. The clinical file of one resident who had been transferred was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. As it was an emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral, including a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a medical emergencies policy, which was last reviewed in July 2020. The approved centre had an emergency trolley and staff had access at all times to an AED, both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Three clinical files were examined during the inspection process in relation to the provision of general health services. The six monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review. However, one general health assessment did not document the resident's body-mass index (BMI) or weight, while another general health assessment did not document the resident's waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, prolactin levels, and an electrocardiogram.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing, e.g. lab results. Residents could access national screening programmes according to age and gender, including bowel screening and retina check. A medication review was documented.

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

a) **One general health assessment did not document the resident's BMI or weight, 19(1).**
b) **One general health assessment did not document the resident's waist circumference, 19(1).**

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in December 2018. The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. Unit-specific booklets were also available to residents in addition to the general service booklet. The booklet was available in the required formats to support resident needs and information is clearly and simply written. It contained details of: housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and; residents' rights.

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Residents were called by their preferred name and the general demeanour of staff and the way in which they dressed and communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs and sought the resident's permission before entering their room, as appropriate.

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident, and where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy. Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre, and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics and the lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address the resident needs. The approved centre provided assisted devices and equipment to address resident needs, as well as suitable furnishings to support resident independence and comfort. Sufficient spaces were provided for residents to move about, including outdoor spaces. An outdoor space had been developed since the previous inspection for those residents in Unit 8 Floor 2, adjacent to valley view therapy centre.

Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre. However, ligature points were noted throughout each of the approved centre's units. The approved centre was not kept in a good state of repair externally and internally. The sluice room in Unit 2 was in poor repair and this had been identified by the approved centre. Additionally, the sitting room in Unit 2 was in need of painting, though preparation works for this had commenced at the time of inspection. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The

approved centre was clean, hygienic, and free from offensive odours and rooms were centrally heated, though pipework and radiators were not guarded. Current national infection control guidelines were followed.

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

a) **Ligature points were not minimised to the lowest practicable level (based on risk assessment) throughout the approved centre, and therefore the overall approved centre environment had not been developed and maintained with due regard to the specific needs of residents and patients, and the safety and wellbeing of residents, staff, and visitors, 22(3).**
b) **Rooms were centrally heated, however, pipe work and radiators were not guarded 22(3).**
c) **The approved centre had not been maintained in good structural and decorative condition, 22(1)(a).**

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

NON-COMPLIANT

Risk Rating LOW

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

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

INSPECTION FINDINGS

The approved centre a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in July 2020 and included:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication, and; a clear record of the date of discontinuation for each medication. Two MPARs, however, did not have a record of all medications administered to the resident. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the electronic signature of the medical practitioner for each entry.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition: this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

The approved centre was non-compliant with this regulation because two MPARs did not contain a record of all medications administered to the resident, 23(1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written Safety Statement for each unit, all of which were last reviewed in September 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to staffing. The policy was last reviewed in December 2018. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times. This was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) & 26(5) have been deferred until 2021.

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

Staff in Approved Centre		
Staff Grade	**Day**	**Night**
Assistant Director of Nursing Unit 2, 4 and 8	1 WTE (9-5)	
Clinical Nurse Manager 3	1	
Occupational Therapist	0.9	
Psychologist	2.5	
Dietitian	6 days per month	
Art Therapist, Clinical Nurse Specialist	0.5	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Unit 2	Clinical Nurse Manager 2	1 WTE (9-5)	
	Registered Psychiatric Nurse	3	2
	Multitask attendant (MTA)	1	1

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Unit 3	Assistant Director of Nursing	0.2 WTE (9-5)	
	Clinical Nurse Manager 2	1	
	Registered Psychiatric Nurse	3	2
	Multitask attendant (MTA)	1	1

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Unit 4	Clinical Nurse Manager 2	1 WTE (9-5)	1
	Registered Psychiatric Nurse	3	3
	Multitask attendant (MTA)	1	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Unit 8	Clinical Nurse Manager 2	1 WTE (9-5)	
	Registered Psychiatric Nurse	3	2
	Multitask attendant (MTA)	1	

In-reach to Approved Centre*			
	Staff Grade	**Day**	**Night**
	Consultant Psychiatrist	5	
	Non-Consultant Hospital Doctor	10	
	Social Workers	5	

Whole time equivalent (WTE)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in August 2020 and included:

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

Not all resident records were secure, up-to-date and in good order. Some files were observed to be bulky and frayed, allowing damage to occur to the bottom of the records. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were appropriately secured from loss or destruction and tampering and unauthorised access or use. However, not all resident records were in good order, as loose pages were observed. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was non-compliant with this regulation because not all resident records were secure, up-to-date, and in good order due to loose pages and damaged, bulky folders, 27(1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

All operating policies and procedures requiring a three-yearly review were reviewed appropriately.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process, including remote access to the tribunals. Staff attended Mental Health Tribunals and provided assistance as necessary when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in December 2018 and included the process for managing complaints, such as the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Not all complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. One of two complaints made via the 'Your Service, Your Say' process had not been investigated promptly. This was recognised and acknowledged by the nominated person and actions had been taken to remedy this and details of the appeals process had been made available to them.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan.

The approved centre was non-compliant with this regulation because one complaint had not been investigated promptly, 31(5).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had several of written policies in relation to risk management and incident management procedures. These included: the Risk Management policy, which was last reviewed in June 2018; the Risk Management – Non-Clinical policy, which was last reviewed in April 2019, and the Incident Reporting policy, which was last reviewed in February 2017. The combined policies addressed requirements of the *Judgement Support Framework*, including the following:

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

The policies did not address the process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre, including:

- Organisational risks.
- Capacity risks relating to the number of residents in the approved centre.
- Health and safety risks to the residents, staff, and visitors.
- Risks to the resident group during the provision of general care and services.

- Risks to individual residents during the delivery of individualised care.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. However, the risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Fire doors were held open by chairs in the approved centre and this had not been identified, assessed, treated, reported, monitored or documented within the risk register as a health and safety risk, as appropriate. Structural risks, including ligature points, had not been removed or effectively mitigated.

Individual risk assessments were completed prior to and during physical restraint and in conjunction with medication requirements or administration, and resident transfer and discharge. Risk assessments were also completed during admission, to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because the use of chairs to hold open fire doors had not been identified, assessed, treated, reported, monitored, and documented as a health and safety risk in within the risk register, as appropriate, 32(2)(a).

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with eight conditions to registration attached. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

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

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2020. The approved centre also had a policy on the use of physical restraint on a child, which was dated February 2020. Together, they addressed the following:

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector.

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

Evidence of Implementation: The clinical file of a resident that had been physically restrained whilst being admitted was examined on inspection. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment. Cultural and gender sensitivity were demonstrated.

The physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. A physical examination was completed approximately 20 minutes after the episode, however this was also the admission physical examination.

As soon as was practicable and with resident's consent, the resident's next of kin or representative was informed of the use of physical restraint and a record of the communication was documented in the clinical file. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. The completed clinical practice form had been placed in the resident's clinical file. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode.

There was no documentary evidence that the resident was afforded an opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable.

Additionally, there was no documentary evidence that the episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

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

a) **The episode of physical restraint was not reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode, 7.2.**
b) **There was no evidence that the resident had been afforded the opportunity to discuss the episode with members of the MDT involved in their care as soon as was practicable, 9.3.**

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

Discharge: The discharge policy, which was last reviewed in March 2020, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the resident's family member was involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged was examined. The discharge plan included the estimated date of discharge, a follow-up plan, and documented communication with the relevant general practitioner, primary care team, or community mental health team (CMHT). The discharge meeting was attended by the resident, their key worker, relevant members of the multi-disciplinary team (MDT), and their family, carer, or advocate.

The discharge assessment addressed the resident's psychiatric and psychological needs, a current mental state examination, and a comprehensive risk assessment and risk management plan. The discharge was coordinated by a key worker and a comprehensive discharge summary was sent within 14 days to the relevant general practitioner, primary care team, or CMHT that detailed the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, the names and contact details of key people for follow-up, and risk issues. A follow up appointment was arranged for the resident.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001614		**Two ICPs did not identify appropriate goals for the resident. One ICP did not identify the resources required to provide the care and treatment identified. Two ICPs were not reviewed by the MDT weekly in consultation with the resident. One ICP was not updated following the review by the MDT.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Further to the ICP training that took place for North Cork Mental Health Service staff via webinar on 05/10/20 and 01/12/20, all MDT staff will be notified of the need for the completion of all sections of the ICP for each resident. A programme of ongoing local training regarding best practice for ICPs will be ongoing.	All ICPs will be fully completed. Progress in relation to this matter will be monitored via the monthly ICP audits which are reported to the MHC on a quarterly basis.	Achievable and realistic	31/03/2021	All member of the NCMHS Local Management Team; Heads of Discipline; all MDT staff across all sector teams.
Preventative Action	Communication will issue to all MDT staff regarding the need to fully complete ICPs. Progress in relation to this matter will be monitored via the monthly ICP audits which are reported to	Monthly ICP audits will be discussed at MDT	This action is achievable and realistic.	30/04/2021	All member of the NCMHS Local Management Team; Heads of Discipline; all MDT staff across all sector teams.

	the MHC on a quarterly basis. This will serve to identify deficits in relation to ICPs promptly in order that they are addressed immediately.				

Regulation 19: General Health					
Reason ID : 10001618		One general health assessment did not document the resident's BMI or weight, 19(1). One general health assessment did not document the resident's waist circumference, 19(1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	All staff will again be informed of the need to ensure that the general health assessment is completed in full as part of the resident's individual care plan. The General Health Assessment currently in use will be review to consider how it may strengthen compliance with Regulation 19 in its use on both the Acute and Long Stay units.	A 3 monthly audit of admissions physicals and a 6 monthly audit of the general health assessment will be undertaken.	This action is achievable and realistic.	31/03/2021	Clinical Director, all Medical Staff; Assistant Director of Nursing, CNM II and the CNM II on duty in the relevant ward.
Preventative Action	The audit of admission physicals and the general health assessment will identify any deficits in the implementation of local policy in relation to Regulation 19 - General Health. The requirement of	A 3 monthly audit of admissions physicals and a 6 monthly audit of the general health assessment will be undertaken.	This action is achievable and realistic.	31/05/2021	Clinical Director, all Medical Staff; Assistant Director of Nursing, CNM II and the CNM II on duty in the relevant ward.

	Regulation 19 will also be addressed as part of NCHD induction programme.				

Regulation 22: Premises					
Reason ID : 10001621		**The approved centre had not been maintained in good structural and decorative condition, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Template developed for local reviews of various units. Template is for the local service complied by management to undertake and is colour coded to identify priorities across the units. Updated Memo issued to staff locally in relation to refinement of processes around maintenance requests for units	Template created to track and also allows escalation and de-escalation as required. Updated Memo issued to Units	Complete by end of February 2021	26/02/2021	Template - ADON, Area Administrator, HODs and Maintenance Department Memo - ADON
Preventative Action	Preventative maintenance plan being developed with Maintenance Department Maintenance program to be placed on Local Management Team agenda quarterly to monitor works plans	Template's in place for Urgent request's and also for maintenance projects. Formal meeting with maintenance officer monthly to review works and update on status across the St. Stephen's Campus.	Achievable - next local management team meeting has been scheduled for 4th March 2020	31/03/2021	Maintenance Officer and Area Administrator

		Minutes of these meetings will be available to the Commission at inspection. Maintenance program added to agenda for March, June, September and December.			
Reason ID : 10001622		**Rooms were centrally heated, however, pipe work and radiators were not guarded 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	As part of the General Ligature program currently being undertaken in the Hospital Campus All Radiators have been identified as areas requiring sealing off and pipework boxing out is also part of the program. Unit 3 is complete with Unit 4 next for completion. Unit 2 and Unit 8 Floor 2 will follow.	All exposed pipework to be boxed in. Radiators to be enclosed by suitable vented covers.	Unit 3 Complete and other units will follow in line with ligature works sequencing U4, U2 and U8Fl.2	31/05/2021	Maintenance Officer, Area Administrator in conjunction with ADON's for units.
Preventative Action	Preventative maintenance plan being developed with Maintenance department	Template's in place for urgent request's and also for maintenance projects. Formal	Next local management scheduled for 4th March 2021	31/05/2021	Area Administrator

	Maintenance program to be placed on Local Management Team Agenda quarterly to monitor works plans	meeting with maintenance officer monthly to review works and update on status across the St. Stephen's Campus. Minutes of these meetings will be available to the Commission at inspection. Maintenance program added to Agenda for March, June, September and December.			

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10001623		**Two MPARs did not contain a record of all medications administered to the resident, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Nursing staff will again be informed of the need to ensure that the full completion of MPARs is necessary to ensure a complete record of all medications administered is maintained at all times.	All MPARs will be fully completed when medications are administered to residents.	This action is achievable and realistic. Memo of 22/02/21 has been issued to address this deficit.	22/02/2021	ADON, CNM II and the CNM II on duty in the relevant ward.
Preventative Action	Nursing management will address this issue through internal written communication (Memo of 22/02/21), face to face conversations with the relevant nursing staff and the ongoing feedback of audit results in order to track progress on addressing this deficit	Audit results will be discussed at MDT	achievable and realistic	31/03/2021	All MPARs will be fully completed when medications are administered to residents.

Regulation 27: Maintenance of Records					
Reason ID : 10001624		**Not all resident records were secure, up-to-date, and in good order due to loose pages and damaged, bulky folders, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review of patient charts across units to be completed. Each ward to identify charts requiring immediate remedy. This will be advised to Staff Officer to co-ordinate/arrange repair. Chart repairs to be completed with agreed local policy for same. All staff to be re-advised in relation to same.	List of charts for repair to be forwarded by Wards to the ADON to be provided to Administration. Following repair charts to be labelled to clearly demonstrate the person who undertook the task and the date the task completed.	List of charts to be made available before 26th February 2021. Chart maintenance to commence 27th February 2021 and to be maintained on an ongoing basis. All charts should be assessed, reviewed and where required volumised at least 2 times per annum.	31/03/2021	CNM2's to forward list, ADON to supply to staff Officer and Administration to undertake.
Preventative Action	Records audit to be completed quarterly to assess patient charts and records within. Audit team to be from Administration and other MDT member	Records audits will be conducted quarterly and included in audit committee for performance review	Initial Records Audit to be completed before 31st March 2021.	30/04/2021	Staff Officer and MDT.

Regulation 31: Complaints Procedures					
Reason ID : 10001625		**One complaint had not been investigated promptly, 31(5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	This complaint has now been investigated and responded to.	Complaint Response Issued to the complainant.	Achieved	22/02/2021	Complaints Officer
Preventative Action	All complaints to be acknowledged and investigated in line with identified timelines in accordance with YSYS. For complaints where it is known that the complaint resolution will be outside the required response timelines a communication pathway to be agreed in relation to the complaint with the complainant to ensure they are fully appraised of the current status and ongoing process. Complaints progress to be updated in review at local management team meetings.	Additional staff have been trained on the complaints management system. This will allow systematic tracking of timelines to assist in response management. Complaints management system training completed December 2020. To commence for local management team meeting scheduled March 04th	achievable	31/03/2021	Complaints Officer / Area Administrator

Regulation 32: Risk Management Procedures					
Reason ID : 10001626		**The use of chairs to hold open fire doors had not been identified, assessed, treated, reported, monitored, and documented as a health and safety risk in within the risk register, as appropriate, 32(2)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff will again be informed of the need to ensure that the practice of retaining doors in the open position is not permitted under any circumstances.	No fire doors will be held open inappropriately on any ward.	Completed	22/02/2021	ADON
Preventative Action	The installation of the appropriate magnetic door release system that works with the unit fire alarm will be undertaken in Unit 8 Floor 2 Day Room and any other relevant doors across the Approved Centre. Fire training (Fire Evacuation Training and Fire Extinguisher Training) is ongoing and addresses the need to ensure that all fire doors and exits are kept clear at all times.	This action is measurable (when the work on the door in Unit 8 Floor 2 and other relevant doors is completed. Fire training is ongoing for all MDT staff.	achievable	31/05/2021	Area Admin and Estates All members of the NCMHS Local Management Team; Heads of Discipline; all MDT staff across all sector teams will encourage their staff to attend the relevant fire training.

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10001612		**The episode of physical restraint was not reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode, 7.2. There was no evidence that the resident had been afforded the opportunity to discuss the episode with members of the MDT involved in their care as soon as was practicable, 9.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Physical Restraint Booklet has been introduced. It addresses all of the key components of the Code of Practice relating to physical restraint. The full completion of the booklet and the relevant physical restraint documentation ensures that the episode of restraint will be reviewed by members of the MDT within the specified time frame and that the resident will be afforded a meaningful opportunity to discuss the episode of restraint. All nursing and medical staff have been	All episodes of restraint will be undertaken and completed in line with the Code of Practice. This matter is covered in the induction programme for all medical staff when they commence their placement in the Approved Centre.	This action is achievable and realistic. This action relating to the Memo has been completed on 22/02/2021 and the remaining elements of this CAPA will be ongoing	22/02/2021	All member of the NCMHS Local Management Team; Heads of Discipline; all MDT staff across all sector teams

	informed of the need to complete the booklet in full for every episode of restraint (Memo of 22/02/21				
Preventative Action	NCMHS Local Management Team will address this issue through internal written communication (Memo of 22/02/21), face to face conversations with the relevant MDT staff and the ongoing feedback of audit results in order to track progress on addressing this deficit	All episodes of restraint will be undertaken and completed in line with the Code of Practice.	This action is achievable and realistic. This action relating to the Memo has been completed on 22/02/2021 and the remaining elements of thsis CAPA will be ongoing	31/05/2021	All member of the NCMHS Local Management Team; Heads of Discipline; all MDT staff across all sector teams.

Appendix 2: Background to the inspection process

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

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

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

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

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

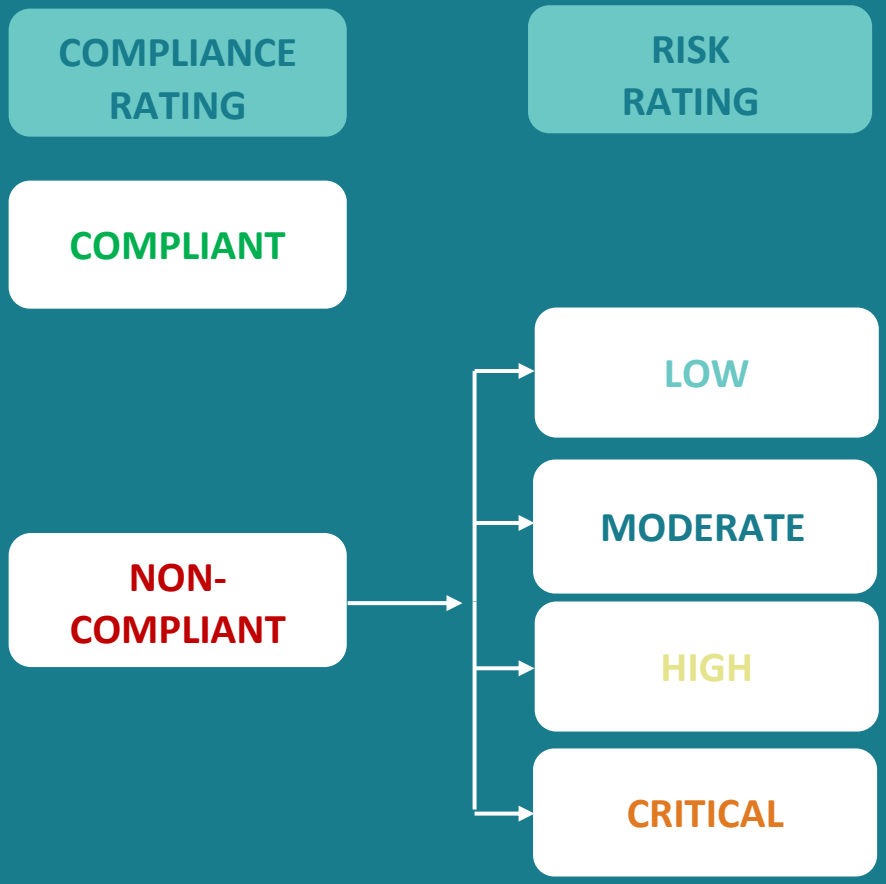
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



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

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

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

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