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

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

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

Sarsfield's Court, Glanmire, Co. Cork

Date of Publication:
Friday 17 September 2021

ID Number: AC0164

2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

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

Inspection Team:
Marianne Griffiths, Lead Inspector
Susan O'Neill
Karen McCrohan
Fergal Duffy

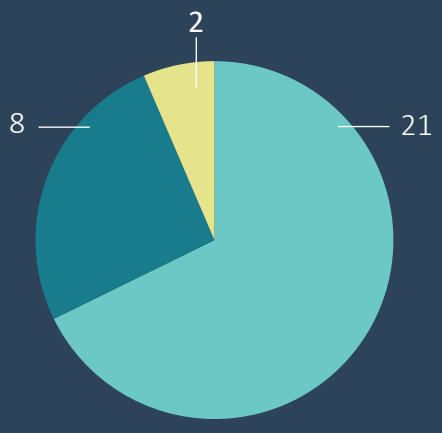
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
3 – 6 August 2021

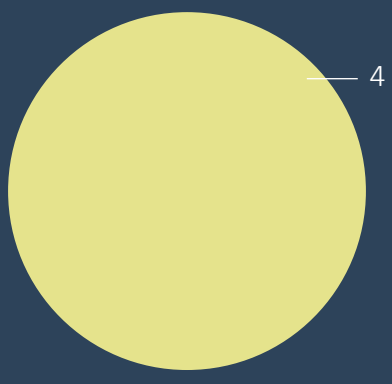
Previous Inspection date:
2 – 6 November 2020

Inspection Type:
Announced Annual Inspection

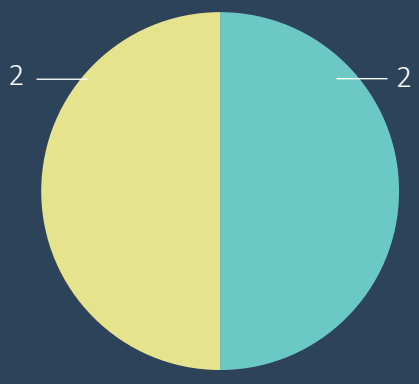
2021 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



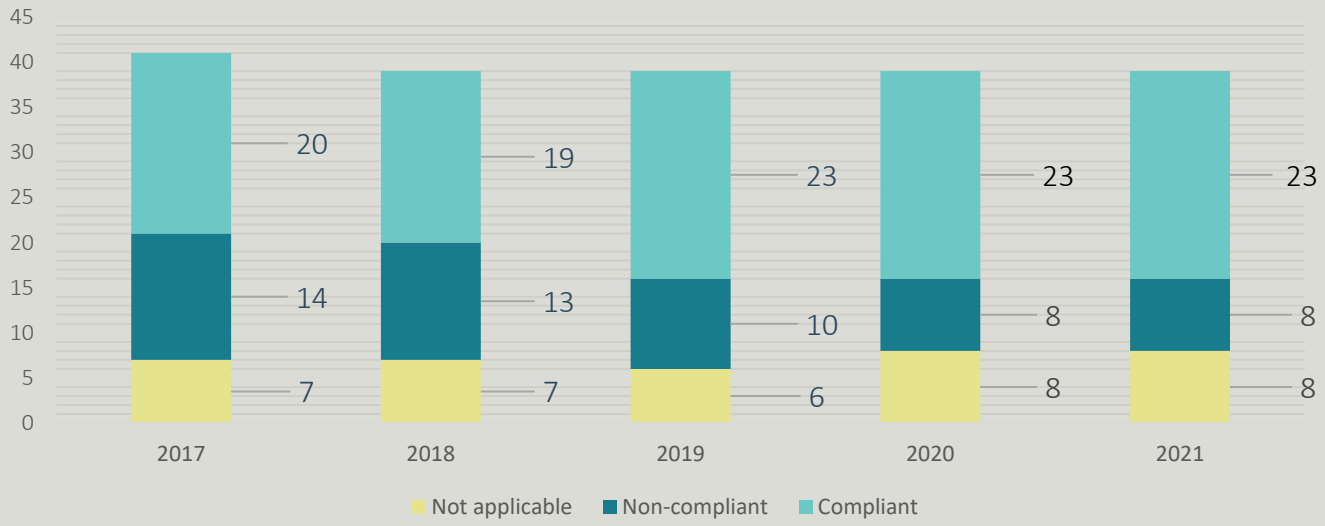
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2017 – 2021

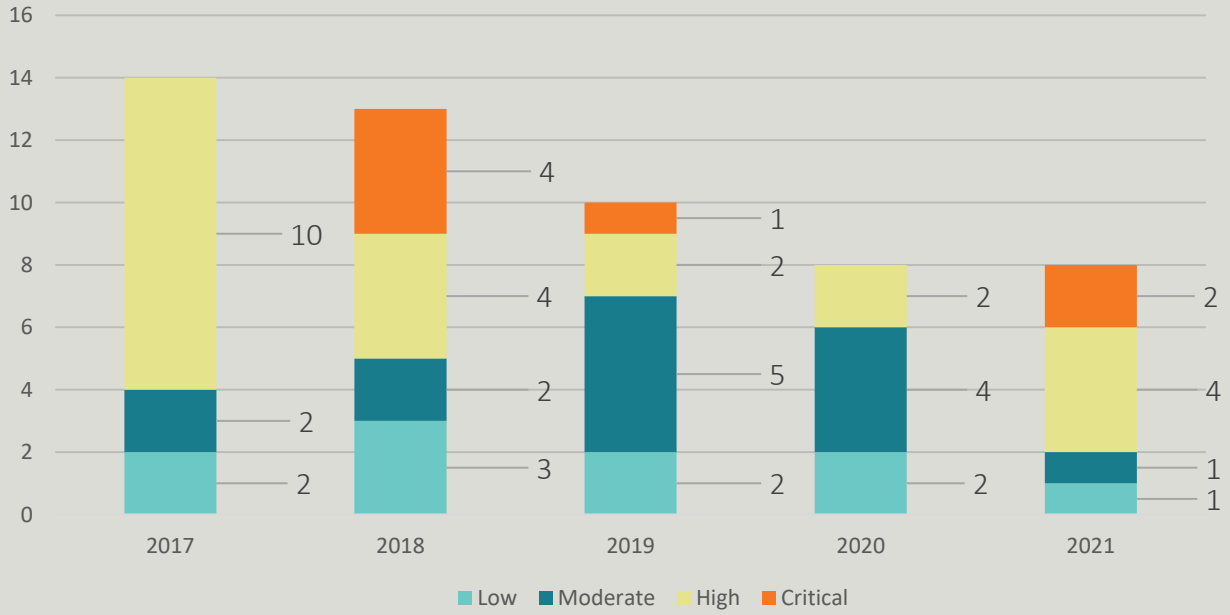
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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 2017 – 2021



Contents

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

St. Stephen's Hospital was located north of Cork City. The hospital was originally built as a tuberculosis sanatorium in the 1950s. Residents had access to the Valley View day centre which was also located on the grounds of St. Stephen's Hospital. The approved centre had a total of 87 beds.

Unit 4 was an admission unit, Unit 2 was a 25-bedded unit providing care and treatment to those under the Psychiatry of Later Life (POLL) team, Unit 3 contained 18 beds for male residents with severe and enduring mental illness. Unit 8 (Floor 2) was located in the main building. It had 25 beds and it provided care to residents with enduring mental illness.

Three general adult sector teams, a Psychiatry of Later Life, and a Rehabilitation team admitted residents to the approved centre.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	59%	60%	70%	74%	74%
Regulations Rated Excellent	0	6	6	N/A	N/A

The average rate of compliance across all approved centres in 2020 was 87%.

Conditions to registration

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

Conditions	Findings
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.*	Results of monthly audits were provided to the Mental Health Commission. There was a named person with responsibility for monitoring and reporting on compliance with Regulation 15: Individual Care Plan
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.*	The approved centre provides regular updates to the Mental Health Commission on the plan to reduce ligature anchor points. Ligature anchor points remain throughout the approved centre.
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.*	The approved centre provides regular updates to the Mental Health Commission on the plan to reduce ligature anchor points. Ligature anchor points remain throughout the approved centre.
The approved centre was not 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(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*	The approved centre provided progress updates to the Mental Health Commission.

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.	A programme of maintenance was not implemented throughout the approved centre. The inspection found numerous areas of poor maintenance as well as unmaintained fire doors.
The approved centre was in breach 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(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.*	The approved centre provided progress updates to the Mental Health Commission. Adequate toilets and bathrooms were made available for residents.
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 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.*	Medical and nursing staff were not all trained in the Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes. Due to COVID-19 Pandemic, the inspection of other regulatory requirements in relation to staff training 26(4) have been deferred until 2022.
The approved centre was in breach of Condition 6 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.	
Condition 7: *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.*	Updates on the actions taken to mitigate risks were provided to the Mental Health Commission. While there was a risk register, not all health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate; risks posed by the fire doors and windows had not been identified.
The approved centre was in breach of Condition 7 and the approved centre was non-compliant with Regulation 32: Risk Management Procedures at the time of inspection.	

Escalation and enforcement actions since last inspection

There were no escalation and enforcement actions at the time of the inspection.

Escalation and enforcement actions following this inspection

In response to the concerns regarding the care and treatment of residents in Unit 3 of St Stephen's Hospital the Commission took the following enforcement actions:

1. An Immediate Action Notice dated 12 August 2021.
2. A focused inspection of Unit 3 took place on Monday 16 August 2021.
3. A Regulatory Compliance Meeting took place on Thursday 26 August 2021.
4. A notice of a proposal to attach a condition to registration of St Stephen's Hospital issued on 3 September 2021.

Safety in the approved centre

We found that the approved centre did not fully operate safe practices to reduce the risk of harm.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- 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.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However:

- Ligature points were not minimized to the lowest practicable level, based on risk assessment and numerous ligature anchor points remained within the approved centre.
- There was an exposed metal radiator in one bathroom that was very hot to touch. There were other exposed radiators throughout the approved centre. As heating was centrally controlled, there was no means of thermoregulation built into the existing system and no method of controlling the heat of radiators.
- The approved centre was unable to provide documentation relating to fire inspections for the St. Stephen's campus.
- A fire door in one unit was not functioning correctly; it was wedged open with a piece of paper as the magnet used to connect it to the fire system was not working. This fire door did not have a seal around it, and therefore it was not functioning as a fire door.

- A fire door in another unit contained glass that was not insulated and therefore did not fulfil their function as fire doors.
- Windows on two of the units were in need of replacing; they were breakable and posed a risk to residents if they were to be hit with force.

Appropriate care and treatment of residents

We found that the provision of individual care plans and therapeutic services and programmes was variable across the approved centre.

- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

However:

- Individual care plans inspected were not of a satisfactory standard and had not been for a period of five years.
- The approved centre did not consistently ensure that each resident had access to an appropriate range of therapeutic services in accordance with their care plan.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre provided services in a way that did not always respect residents' privacy and dignity.

- Accommodation was in single rooms as well as dormitories of up to 6 beds. At the time of the inspection, the majority of residents were accommodated in dormitories of only 2 or 3 residents.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- 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 clean and hygienic.
- There was a visiting room where residents could meet their visitors in private.
- Physical restraint was carried out in compliance with the Code of Practice on the use of Physical Restraint.

However:

- Residents had insufficient storage space beside their beds for their personal effects and possessions. As a result, residents had to store their personal property in a locked property room where they could not retain control over these possessions.
- The general demeanour of a small number of staff and the way in which they addressed and communicated with residents was not appropriate at all times; this communication was observed to be dismissive on two occasions.
- Outdoor spaces provided for Unit 8 (Floor 2) were insufficient, with one picnic table was provided for potentially eleven residents.
- External walls, soffit and fascia were dirty and discoloured. The walls and skirting boards in some bedrooms were in need of painting. Paint was blistered on ceilings in some areas. Veranda areas of some units were unkempt and had weeds growing on them. There were tiles or floor coverings missing from some areas. Floor coverings in some showers had come loose.
- Not every area was well ventilated; bathrooms on two of the units had a distinct smell of urine. The designated sluice room and cleaning rooms were in need of refurbishment.
- The windows on some units were single glazed and there were gaps allowing draughts when in the closed position.
- There were no curtains on a bedroom window in one unit.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of residents.

- Recreational activities included art, books, games, DVDs, walks around the grounds and gardening.
- The approved centre had a bus and outings were organised for the residents.
- 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 comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

We found that there was a lack of effective and cohesive governance.

- The North Cork Senior Management Team met each month. The Quality and Patient Safety Committee met on a quarterly basis. These addressed issues arising in terms of risk management, the ongoing programme of audits and the processes around incident management including the conveying of a Serious Incident Management Teams as needed.

- The representative from the Irish Advocacy Network contacted the unit by phone or using allocated iPads to speak with residents because in-person visits to the unit were not permitted.

However:

- On the days of the inspection, industrial action meant that nursing management did not make themselves available to answer questions relating to clinical governance. Representatives from administrative management were available to answer questions and facilitate the inspection, but the approved centre did not nominate another clinical manager. It was not possible to get information about the staffing complement for the nursing team due to the ongoing industrial action.
- It was difficult for the inspection team to ascertain exactly what structures were in place regarding risk management. Clinical risk management was well documented within the clinical files and there was a system in place for the reporting, review and escalation of incidents but the processes in place for the review of the local risk register was unclear. Risks relating to fire safety were identified on the inspection.
- Despite repeated requests for a ligature audit to be provided to the inspection team, none was forthcoming.
- The nursing staff in Unit 3 were under the management of the North Lee services, whereas the other units in the hospital were staffed and managed by the North Cork Mental Health Services. This had resulted in lack of oversight of the unit, with consequent absence of recovery focused care.
- The Area Lead for Mental Health Engagement was a member of the North Cork Area Management team. The Lead did not attend these meetings on a regular basis; instead providing input into the management team as required. The Lead attended the approved centre approximately every six weeks.

COVID-19 response

There was an established Outbreak COVID Team who at the time of the inspection were meeting fortnightly. Depending on need, this group had previously met more often. The approved centre adopted the policies and protocols for the prevention and management of COVID-19 for acute and residential health care settings. At the time of inspection all visiting was suspended or restricted on compassionate grounds.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. An initiative to make Unit 4 more *Lesbian Gay Bisexual and Transgender* (LGBTQ) inclusive was rolled out by the nursing team. This included staff training in the area of LGBT rights taking guidance from the report: *Lesbian Gay Bisexual and Transgender Service Users: Guidance for Staff working in Mental Health Services*. Staff received training in working with LGBTQ+ service users and endeavoured to make the environment more inclusive by avoiding heteronormativity and promoting a non-judgemental LGBTQ+ friendly environment. This initiative also included the creation of a resource noticeboard which included information about various LGBT charities and help line numbers. Other resources pertaining to providing quality care and treatment to residents identifying as LGBTQ+ were maintained.

2. A new nursing admission and discharge checklist had been developed by the approved centre. This integrated a series of evidence-based risk assessments and allowed for the recording of residents data on admission and prior to discharge.

3. A Food and Nutritional analysis had been carried out in three of the continuing care wards on St. Stephen's Hospital. This project was completed by Dietician Service in conjunction with Catering and UCC.

4. Recovery training and Risk Process training had been delivered to staff.

5. Pharmacy initiatives regarding the storage of medication. These aimed to better facilitate storage of medication on trolleys and the upgrade of medication trolley design. Other pharmacy clinical initiatives delivered in St Stephen's Hospital included the development of two policies designed to support prescribers and nursing staff.

6. A research project had been carried out by the psychology team within the approved centre. this was entitled: "Exploring the effects of sedentary lifestyle among patients with severe and enduring mental illness".

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Stephen's Hospital was located north of Cork city in a valley setting outside the village of Glanmire. The approved centre comprised of four buildings co-located on 117-acre grounds at St. Stephen's Hospital. The scenery in which the approved centre was set was impressive. The hospital was originally built as a tuberculosis sanatorium in the 1950s. Residents from all four units had access to the Valley View day centre which was also located on the grounds of St. Stephen's Hospital.

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

Unit 2 was a 25 bedded unit providing care and treatment to those under the Psychiatry of Later Life (POLL) team. Unit 3 contained 18 beds and delivered care to male residents with severe and enduring mental illness. Unit 3 was sparsely decorated with meagre furnishings observed in the sitting room. Unit 4 had 19 beds and was the acute admissions unit for the North Lee area. Each of these units was located a single storey building and contained recently refurbished bathrooms.

Unit 8 (Floor 2) was located in the main building It had 25 beds and its remit was to provide care to residents with enduring mental illness. This unit was located on the first floor of a large, old building. Access to the outdoor area was via a lift and a long corridor. The outdoor area provided to the residents of Unit 8 Floor 2 consisted solely of one picnic table. Bathrooms in Unit 8 Floor 2 had been refurbished in the past year.

Due to the age of the buildings, the approved centre was somewhat unkempt in appearance and was in constant need of renovations. Accommodation was in single rooms as well as dormitories of up to 6 beds. At the time of the inspection the majority of residents were accommodated in dormitories of only 2 or 3 residents. The exception to this was the Unit 4 male dormitory; four residents were being cared for in this dormitory on the first day 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 in-reach responsibility for the care and treatment of their residents. In addition to this, each of the units had allocated nursing and occupational therapy staff.

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

Resident Profile	
Number of registered beds	***87***
Total number of residents	**55**
Number of detained patients	5
Number of wards of court	4
Number of children	0

Number of residents in the approved centre for more than 6 months	41
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

On the days of the inspection, industrial action meant that nursing management were unavailable to escort the team on the inspection of the premises or to answer questions relating to clinical governance. While representatives from administrative management were available to answer questions and facilitate the inspection, the approved centre did not opt to nominate another clinical manager in order to provide the in-depth information required by the inspection team to inform a description of the clinical governance structures of St. Stephen's Hospital.

Two management meetings took place on a regular basis. The North Cork Senior Management Team met each month. St. Stephen's Hospital was discussed at this meeting along with other services within the North Cork area. Standing items on the agenda included: a discussion of the risk register, acknowledgement of complaints received and the roll out of mandatory staff training. Plans for ongoing works to the premises were also discussed as were conditions attached to the approved centre registration with the Mental Health Commission. Other operational issues such as the roll out of Wi-Fi to the approved centre and a review of visiting guidelines were discussed. The results of a recent Infection Prevention and Control inspection on Unit 8 Floor 2 in terms of outstanding maintenance issues were outlined and addressed.

The Quality and Patient Safety Committee met on a quarterly basis. These meetings addressed issues arising in terms of risk management, the ongoing programme of audits and the processes around incident management including the conveying of a Serious Incident Management Teams as needed. The committee discussed issues arising from Mental Health Commission inspections and reports. The developments from policy and procedure group as well as service user feedback each featured as standing items within the minutes of these meetings.

The approved centre operated within a system of five consultant-led mental health teams. Each of these contained a full complement of medical staff. The psychology team was also fully staffed with the recruitment of a second staff grade post imminent for the Charleville / Mallow team. Occupational therapy input was delivered by staff allocated to each of the units. It was not possible to get information about the staffing complement for the nursing team due to the ongoing industrial action.

During the inspection, neither the registered proprietor nor the clinical director were available to speak with the inspectors due to the fact that they were on annual leave at this time. Similarly, the head of discipline for occupational therapy was not available, because they were also on leave. The acting clinical director spoke with the lead inspector. The head of discipline for psychology and for social work each spoke with the lead inspector in order to describe their teams' input into St. Stephen's Hospital and the provision of staff to each of the units.

Each head of discipline provided the Mental Health Commission with a completed questionnaire detailing their input into the governance structures of St. Stephen's Hospital. Management for the medical and

nursing teams were onsite each day. Heads of Discipline for the health and social care professionals had minimised their presence in St. Stephen's Hospital due to the COVID-19 outbreak. Each manager had regular contact with staff working in the approved centre. All had received training in the area of risk management. The quarterly Quality and Patient Safety meetings were cited as supporting quality improvement within the approved centre. Similarly, representation on the policy group and shared learning across the teams contributed to quality improvement. The main area of quality improvement pertaining to the premises consisted of the newly refurbished bathrooms in each of the units.

Strategic aims in relation to the approved centre included: full regulatory compliance with the Mental Health Act (2001), to continue to work towards providing a recovery oriented in-patient service to residents and to provide effective, evidence-based assessments and interventions to residents. Supervision arrangements were in line with the requirements of the various disciplines and included aspects of performance appraisal for staff.

In terms of risk management, it was difficult for the inspection team to ascertain exactly what structures were in place regarding risk management. Clinical risk management was well documented within the clinical files and there was a system in place for the reporting, review and escalation of incidents. Nonetheless, the processes in place for the review of the local risk register was unclear. Risks relating to fire safety were identified on the inspection. Despite repeated requests for a ligature audit to be provided to the inspection team, none was forthcoming.

Risks identified by each of the disciplines included: difficulty accessing mandatory training, the negative impact upon clinician-resident interactions as a result of online consultations instead of in-person sessions and the under-resource of social work on the rehabilitation and old age teams. Risk associated with the premises including the lack of en suite bedrooms, ongoing ligature risk and limited access to therapeutic space in Unit 4 were also identified. Actions to remedy these risks were proposed within the questionnaires.

The Area Lead for Mental Health Engagement was a member of the North Cork Area Management team. The Lead did not attend these meetings on a regular basis; instead providing input into the management team as required. The Lead attended the approved centre approximately every six weeks.

At the time of the inspection, the representative from the Irish Advocacy Network contacted the unit by phone or using allocated IPADS to speak with residents because in-person visits to the unit were not permitted. This was due to the COVID-19 pandemic restrictions. An interview with the advocate indicated that feedback to the advocate from the residents was less forthcoming because of the loss of in-person interaction. The advocate contacted the admission ward each week and the other every two to three weeks. Despite efforts on behalf of the advocate, residents from Unit 4 engaged only occasionally with the advocate with very little feedback coming from Units 2,3 and Unit 8 Floor 2.

Within their governance questionnaires, Heads of Discipline indicated an openness to service user engagement. All service users were encouraged to partake in the Individual Care Planning (ICP) process. Service user feedback was used to modify and improve therapeutic groups. The North Cork Open Forum provided the opportunity for residents to give feedback about their experience of St. Stephen's Hospital.

There was an established Outbreak COVID Team who at the time of the inspection were meeting fortnightly. Depending on need, this group had previously met more often. The approved centre adopted the policies and protocols for the prevention and management of COVID-19 for acute and residential health care settings. At the time of inspection all visiting was suspended or restricted on compassionate grounds.

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 2017 and 2021 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 8: Residents' Personal Property and Possessions	✗	Moderate	✓		✓		✓		✗	High
Regulation 15: Individual Care Plans	✗	High	✗	Critical	✗	Moderate	✗	Moderate	✗	Critical
Regulation 16: Therapeutic Services	✓		✓		✓		✓		✗	High
Regulation 21: Privacy	✗	High	✗	Critical	✗	High	✓		✗	High
Regulation 22: Premises	✗	High	✗	Critical	✗	Critical	✗	High	✗	High
Regulation 26: Staffing	✗	High	✗	High	✗	High	✓		✗	Moderate
Regulation 27: Maintenance of Records	✗	High	✗	Moderate	✗	Low	✗	Moderate	✗	Low
Regulation 32: Risk Management Procedures	✗	High	✗	Critical	✗	Moderate	✗	High	✗	Critical

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

5.1 Service-user feedback

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:

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- 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 inspection team spoke with two residents over the phone. Four questionnaires were returned to the inspectors. Comments received from the service user feedback included: 'nurses can lack empathy at times,' 'it is difficult to contact my doctor', 'there are too many people in the male ward' and 'there are not enough activities for me to do during the day.' A resident in Unit 8 Floor 2 stated that the ward could be cold at times.

In response to the questionnaire item: 'How often are you able to discuss worries or concerns with a member of staff?' Two respondents stated, 'always' and two indicated 'sometimes.' All respondents knew who their key worker was. Three out of four questionnaires indicated that residents could speak freely with family and friends with one ticking 'no' when asked about this. Two respondents stated that they had space for privacy, while two did not.

On questionnaire respondent was particularly appreciative of the hard work undertaken by nurses in St. Stephen's Hospital.

5.2 Advocacy

The approved centre had an advocacy service. The main demand for the advocacy service came from Unit 4, the Admission Ward.

The Inspector received a report from the Irish Advocacy Network (IAN) representative. This report stated that residents were complimentary about the nursing care that they received in Unit 4 describing the nurses as 'wonderful.' It stated that residents were of the opinion that the food served in St. Stephen's Hospital was of a very high quality and that residents enjoyed gardening activities including growing vegetables. Residents reported that were eager to have access to Wi-Fi in the approved centre. This was not in place at the time of the inspection.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Acting Clinical Director
- Principal Clinical Psychologist
- Senior Occupational Therapist
- Pharmacist
- Area Administrator
- Mental Health Engagement Lead

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. Representatives from the approved centre had no comments to make regarding the findings of the inspection team.

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: these included name, address, date of birth, hospital number and photo. 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. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations throughout the approved centre.

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. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared centrally and transported to the kitchen of each unit in temperature-controlled trolleys. The temperature was recorded prior to the serving of hot food in each unit and records of such were maintained. Food was served from temperature-controlled equipment. Hygiene was maintained to support food safety requirements. and food was stored appropriately. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

NON-COMPLIANT

Risk Rating HIGH

(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.

Residents' 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 was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident.

Residents were not consistently supported to manage their own property unless this posed a danger to the resident or others. Residents in one of the units had little or no storage space beside their beds; this meant that residents could store very few personal possessions or effects in the sleeping accommodation. Some wardrobes were extremely small and provided insufficient storage capacity; instead, the practice was that residents were encouraged to store their possessions including clothes in a separate locked property press.

The approved centre was non-compliant with this regulation because residents had insufficient storage space beside their beds for their personal effects and possessions. As a result, residents were obliged to store their personal property in a locked property room where they could not retain control over these possessions, 8 (5).

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 recreational activities appropriate to the resident group profile. The approved centre facilitated structured recreational activities on weekdays and during the weekend. Activities included: art, books, games, DVDs, walks around the grounds and gardening. The approved centre had a bus and outings were organised for the residents.

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 July 2020.

At the time of the inspection, visits to the approved centre were curtailed and in line with infection control measures and public health guidance. Outside of these restrictions reasonable times were identified during which a resident could receive visits and reasonable steps had been taken to ensure the safety of residents and visitors. Each unit had a separate visitors' room or visiting area where residents could meet visitors in private. The visitors' areas were suitable for children visiting a resident.

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 relating to communication, which was last reviewed in June 2021.

Residents had access to a mail, email and telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. At the time of the inspection Wi-Fi was not provided by the approved centre; residents used their own mobile phones in order to access the internet.

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 July 2020. The policy 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.
- Carrying out searches with the consent of a resident.
- Carrying out searches in the absence of consent.
- The finding of illicit substances during a search.

The resident search policy and procedure was communicated to all residents and staff could articulate the searching processes as set out in the policy. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

The clinical file of one resident who was searched was inspected. The resident’s consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search what was happening during the search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was conducted with due regard to the resident’s gender, dignity and privacy.

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 protocols for care of residents who were dying. The policy was last reviewed in July 2020.

The end of life care provided was appropriate to residents' physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, as were the privacy and dignity of the residents. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care.

The clinical file of a resident who had died was inspected. The death was managed in accordance with the resident's religious and cultural practices, with dignity and propriety and in a way that accommodated the resident's family, and next of kin.

All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating CRITICAL

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

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 clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Not all ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment; three out of five ICPs examined were developed only by nursing and medical staff. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident. The ICPs did not consistently include appropriate care and treatment required to meet the goals identified; three of the ICP examined did not include sufficient detail in terms of care and treatment to be provided.

Four of the five ICPs examined identified the resources required to provide the care and treatment identified, however one ICP did not contain appropriate resources. Instead, the use of the generic term 'MDT' as resource was documented.

Not all ICPs were reviewed by the MDT at least six monthly, in consultation with the resident. Three ICPs were found to have been reviewed by an MDT that comprised of medical and nursing staff only. Two out of five ICPs examined were not updated following 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) **Three individual care plans were not developed by the multi-disciplinary team, 15.**
b) **Three individual care plans did not adequately identify the care and treatment required to meet the goals identified, 15.**
c) **One individual care plan did not identify the resources required to provide the care and treatment, 15.**

d) **Two individual care plans were not reviewed by the multi-disciplinary team, 15.**
e) **Two individual care plans were not adequately updated following review by the multi-disciplinary team, 15.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

(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

Some therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. However, these programmes were not appropriate in all cases and did not consistently meet the needs of the residents.

Occupational therapy groups were provided within three of the four units. In one unit, the occupational therapy service was provided remotely only. This service was focused mostly upon one to one work and as a result no occupational therapy groups were in place.

The needs of the residents identified in the individual care plans (ICPs) were not consistently met by the provision of an appropriate range of therapeutic services. The approved centre did not consistently ensure that each resident had access to an appropriate range of therapeutic services in accordance with their care plan.

Psychology and social work input was available to residents as required, for one to one assessment and intervention work.

Some therapeutic services which were not provided internally such as art therapy were delivered by external providers.

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

a) **The occupational therapy input into one unit was solely provided on a remote basis and as a result no occupational therapy groups were delivered to residents, 16 (1).**
b) **Not all residents received an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16 (1).**
c) **Not all residents were in receipt of programmes and services directed towards restoring and maintaining optimum levels of physical and psychosocial functioning, 16 (2).**

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 a written policy and procedures on the transfer of residents. The policy was last reviewed in March 2021.

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. Information accompanied the resident upon transfer, to a named individual, including a letter of referral that contained a list of current medications and a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy. The policy on medical emergencies was last reviewed in July 2020.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Clinical files were examined in relation to provision of general health services during the inspection process. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. 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.

The clinical files of three residents who had been in the approved centre over six months were reviewed. The six monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, body mass-index and weight. For residents on anti-psychotic medication there had been an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG).

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes according to age and gender, including breast check, retina check as appropriate, cervical screening, and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written 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. The booklet was available in the required formats to support resident needs and information was 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

NON-COMPLIANT

Risk Rating HIGH

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. The general demeanour of staff and the way in which they addressed and communicated with residents was not appropriate at all times; this communication was observed to be dismissive on two occasions. Staff were discreet when discussing the resident's condition or treatment needs and sought the resident's permission before entering their bedrooms, 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. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because the general demeanour of staff and the manner in which they communicated with residents was not consistently appropriate, 21.

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. 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.

Sufficient spaces were provided for residents to move about within the units. However, outdoor spaces provided for Unit 8 (Floor 2) were insufficient: merely one picnic table was provided for potentially eleven residents. 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. Ligature points were not minimized to the lowest practicable level, based on risk assessment and numerous ligature anchor points remained within the approved centre.

The approved centre was not consistently kept in a good state of repair externally and internally; External walls, soffit and fascia were dirty and discoloured. The walls and skirting boards in some bedrooms were in need of painting. Paint was blistered on ceilings in some areas. Veranda areas of some units were unkempt and had weeds growing on them. There were tiles or floor coverings missing from some areas. Floor coverings in some showers had come loose.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. While major refurbishment works were completed, some minor snags were being remedied at the time of inspection. The approved centre was clean and hygienic. Not every

area was well ventilated; bathrooms on two of the units had a distinct smell of urine. Rooms were centrally heated. There was an exposed metal radiator in one bathroom that was very hot to touch. There were other exposed radiators throughout the approved centre. Residents were not able to control the heating in bedrooms. As heating was centrally controlled, there was no means of thermoregulation built into the existing system so there was no method of controlling the heat of radiators. Current national infection control guidelines were followed.

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. Three of the four units in the approved centre had a designated sluice room and cleaning room; however, all of these were in need of refurbishment. One unit did not have a sluice room at the time of the inspection. All resident bedrooms were appropriately sized to address the resident needs. The approved centre did not provide suitable furnishings to support resident independence and comfort. The wardrobe spaces on some units were of insufficient size to accommodate resident belongings. The windows on some units were single glazed and there were gaps allowing draughts when in the closed position. There were no curtains on a bedroom window in one unit. There was little decor on the walls of one unit.

The approved centre provided assisted devices and equipment to address resident needs.

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

a) The registered proprietor did not ensure that the approved centre was maintained in good structural and decorative condition because:
- **External walls, soffit and fascia were dirty and discoloured, 22(1) a.**
- **The walls and skirting boards in some bedrooms were in need of painting. Paint was blistered on ceilings in some areas, 22(1) a.**
- **The veranda areas of some units were unkept and had weeds growing on them, 22(1) a.**
- **There were tiles or floor coverings missing from some areas, 22(1) a.**
- **Floor coverings in some showers had come loose, 22(1) a.**
- **The sluice rooms on three units were in need of refurbishment, 22(1) a.**

b) The registered proprietor did not ensure that the approved centre was adequately ventilated. There were unpleasant odours in two bathrooms, 22(1) b.

c) The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings having regard to the number and mix of residents of the approved centre, because:
- **Curtains were missing from one bedroom, 22(2).**
- **Some wardrobes were too small to store residents belongings, 22(2).**
- **The furnishings in the outside space of one unit were inadequate for the number and mix of residents, 22(2).**
- **There was minimal décor on the walls of one unit, 22(2).**

d) The registered proprietor did not ensure that the overall environment was developed with due regards to the specific needs of the residents. This was because:
   - Ligatures were not minimised to the lowest possible level, based on risk assessment, 22(3).
   - There was an exposed metal radiator in one bathroom that was very hot to touch, 22(3).
   - One unit did not have a sluice room onsite, 22(3).
   - Windows on two of the units were single glazed and contained gaps, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

- 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.

Five Medication Prescription and Administration Record (MPAR) were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident, and a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the 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. Directions to crush medication were only accepted from the resident's medical practitioner with a documented reason as to why.

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 compliant with this regulation.

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 written operational policies and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last approved in July 2020. There was a site-specific Safety Statement that had been reviewed and updated as required.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating **MODERATE**

(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 which was last reviewed in December 2018, 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.

The approved centre had five multi-disciplinary teams (MDT). Staff on these teams worked within the approved centre on an in-reach basis in order to attend the MDT meetings and provide one to one assessments and interventions. They included medical, nursing, occupational therapy, social work, and psychology staff. These teams were fully staffed in terms of medical staff and health and social care professionals.

Each of the four units had an OT staff allocated to it. Three of these worked onsite and one worked remotely.

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.

Not all staff had up to date training with the Mental Health Act (2001). Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.

Staff Training Table		
Profession	Mental Health Act 2001	
Nursing (47)	45	90%
Medical (15)	14	93%
Occupational Therapist (3)	3	100%
Social Worker (1)	1	100%
Psychologist (1)	1	100%

The approved centre was non-compliant with this regulation because not all staff had up-to-date training in the Mental Health Act, 26 (5).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating LOW

(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 relating the creation of, access to, retention off and destruction of records. The policy was last reviewed in August 2020.

Resident records were secure, up-to-date, and in good order, and were physically stored together in a secure office. 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 maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Documentation of inspections relating to food safety and health and safety was presented as part of the inspection. However, the approved centre did not present documentation relating to fire inspections for the St. Stephen's campus.

The approved centre was non-compliant with this regulation because documentation relating to fire inspections was not maintained in the approved centre, 27 (3).

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 policies and procedures requiring a three-yearly review had been reviewed and updated as required.

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. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process. Resources and facilities were provided to support patients accessing Mental Health Tribunals remotely.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in December 2018 and included the process for managing complaints, including 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. This information was available within the resident information booklet and on noticeboards in the approved centre. 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. Each unit held its own minor complaints log. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. 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 actioned appropriately. All complaints (that were not minor) were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in July 2020. The policy on Incident Reporting was last reviewed in March 2020. Each unit had its own site specific Safety Statement.

The risk management policies and associated safety statements addressed all policy requirements, including:

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

Responsibilities were not allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was not identified and known by all staff. Risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. A fire door in one unit were not functioning correctly; one fire door was wedged open with a piece of paper as the magnet was not working. Fire doors in another unit contained glass that was not insulated

and therefore did not fulfil their function as fire doors. This fire door did not have a seal around it and was therefore not working as a fire door.

Not all health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate; risks posed by the fire doors and windows had not been identified. Structural risks, including ligature points, were not removed and remained a risk throughout the approved centre. The risks posed by identified ligature anchor points were not effectively mitigated; an up to date ligature audit was not available for the approved centre. Some old windows in the approved centre were in need of replacing; they were breakable and posed a risk to residents if they were to be hit with force.

Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Individual risk assessments were completed in conjunction with medication requirements or administration, and resident transfer and discharge. Individual risk assessments were also completed at 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.

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, 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:

a) **Responsibilities were not allocated at management level and throughout the approved centre to ensure their effective implementation, 32 (2) a.**
b) **The person with responsibility for risk management was not known by all staff, 32 (2) a.**
c) **A fire door in one unit was not functioning correctly; it was wedged open with a piece of paper as the magnet used to connect it to the fire system was not working. This fire door did not have a seal around it, and therefore it was not functioning as a fire door. This meant that there were not adequate precautions in place to control for the management of fire risk, 32 (b).**
d) **A fire door in another unit contained glass that was not insulated and therefore did not fulfil their function as fire doors. This meant that there were not adequate precautions in place to control for the management of fire risk, 32 (b).**

e) **Windows on two of the units were in need of replacing; they were breakable and posed a risk to residents if they were to be hit with force. The precautions in place to control for the specific risk of resident self-harm were not adequate, 32 (c, ii).**

f) **Ligature points remain in the approved centre. The precautions in place to control for the specific risk of resident self-harm were not adequate, 32 (c, ii).**

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. The certificate was displayed prominently in the administration building foyer and included the conditions to registration.

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

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

COMPLIANT

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 2021.
The policy covered:

- 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 which showed that all staff involved in physical restraint had read and understood the policy.

Evidence of Implementation: The clinical file of one resident who had been physically restrained was inspected. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident's unsafe behaviour.

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident's next of kin were informed about the physical restraint. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered medical practitioner (RMP), and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the resident within three hours after the start of the episode of physical restraint.

A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after episode.

The approved centre was compliant with this code of practice.

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:

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 June 2021, 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 was inspected in relation to the admission process. A key-worker system was in place. The admission was on the basis of a mental illness or mental disorder. The resident had received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, education, and dietary requirements. The resident received a full physical examination.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge plan included an estimated date of discharge, as well as a follow-up plan and a reference to early warning signs of relapse. A discharge meeting was held and attended by the resident, their key worker, and relevant members of the multi-disciplinary team (MDT).

A discharge assessment was completed: it addressed the resident's psychiatric and psychological needs, a current mental state examination, a comprehensive risk assessment, and a risk management plan. There

was appropriate MDT input into discharge planning. A preliminary discharge summary was issued within three days. A comprehensive discharge summary had been issued within fourteen days.

The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues and follow- up arrangements. Risk issues had also been included. A timely follow up appointment had been arranged.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 8: Residents' Personal Property and Possessions					
Reason ID : 10002358		The approved centre was non-compliant with this regulation because residents had insufficient storage space beside their beds for their personal effects and possessions. As a result, residents were obliged to store their personal property in a locked property room where they could not retain control over these possessions, 8 (5)			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	To support residents requiring additional personal storage additional temporary wardrobes and lockers will be provided to meet the residents immediate storage needs. Residents are encouraged to keep personal belonging in their bed space and use available storage.	All residents will have adequate storage for their personal belonging	This action is achievable and realistic.	30/11/2021	Nursing staff on Unit 3.
Preventative Action	A design team has been assigned to progress works in Unit 3 to include the design of wardrobes/lockers to provide sufficient storage for residents. The design team for the campus has been appointed and is in the process of developing tender documentation for a contractor to undertake the works required. Aligned with the tender process the design team will develop the required design specifications for the various elements	Residents will use storage provided to hold personal items near bed space.	This action is achievable and realistic	27/05/2022	Design team. Budget holders.

Regulation 15: Individual Care Plan					
Reason ID : 10002329		**Three individual care plans were not developed by the multi-disciplinary team, 15. Two individual care plans were not reviewed by the multi-disciplinary team, 15. Two individual care plans were not adequately updated following review by the multi-disciplinary team, 15.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Steering Group for ICPs in SSHC establish with its first meeting held on 9/9/2021. Following this meeting it was agreed that weekly audits of ICPs in Unit 4 (every 4 weeks for unit 2, 3 and 8 floor 2) commenced on 15/09/2021. Results of these audits will be sent weekly to the Consultants for each team,Cnm3,Clinical Director. All disciplines to partake in the audit process rota established. Steering group to meet every 4 weeks to discuss progress. All sections of the ICP to be completed. To achieve full MDT participation at ICP's a rotation of MDT members attending ICP's is to be arranged by each team. ICP champion to be identified within each team. The audits will commence with Medical and Nursing taking the lead followed by a rotation of remaining AHP's. Nominate champion to do audit within each team – but all team members responsible for full completion of ICPs. Following each weekly audit feedback will be given to individual teams by email from the individual responsible for completing the audit this will highlight areas of noncompliance needing improvement. The MHC audit template will be used. All disciplines to be included in rotation. It was agreed that the goal can be team/individual or both once it's done collaboratively. If the person responsible for	All ICPs will be fully completed. Progress in relation to this matter will be monitored by the weekly audits and reported to the MHC on a quarterly basis.	This action is achievable and realistic.	28/01/2022	All members of the NCMHS Local management team, Heads of discipline, all MDT members across all sector teams.

	completing the weekly audit is not available they must arrange another person to complete the audit in their absence. ICP flow chart re process of audit implementation was developed and circulated. Current ICP documentation reviewed and an agreed ICP template to be used. The use of the up-date sheet has ceased. Continuing care ICP meetings Continuing care ICP meetings are held every 6 months. Care plan meetings are attended by all MDT members. A member of the administration team co-ordinates and records the ICP meetings. Administration will contact each consultant by email or phone a month before ICP due date and she will organise a date and time with consultant to hold the ICP meetings. Administrator will then email consultant and all MDT members with date and time of each ICP meeting. The patients NOK will be contacted by letter and send a copy of letter with agenda to the nurses' station in each unit for their records.				
Preventative Action	ICP training dates for the campus were identified following a training needs analysis by [redacted] Registered Nurse Tutor. Dates of ICP Training: 4/10, 8/10,15/10,19/10/21/10,5/11. To date 61 staff have attended ICP training. An audit MDT participation in the ICP process for continuing care patients was completed in November 2021. Ongoing Feedback of all audit results will be circulated to relevant HODs and clinical leads with a view to rectifying any deficits.	All ICPs will be fully completed.	This action is achievable and realistic.	28/01/2022	All members of the NCMHS Local management team, Heads of discipline, all MDT members across all sector teams.

Reason ID : 10002330		Three individual care plans did not adequately identify the care and treatment required to meet the goals identified, 15. One individual care plan did not identify the resources required to provide the care and treatment, 15.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	ICP training dates for the campus were identified following a training needs analysis by [redacted] Registered Nurse Tutor. Dates of ICP Training: 4/10, 8/10,15/10,19/10/21/10,5/11. To date 61 staff have attended ICP training. Weekly audits of ICPs in Unit 4 (every 4 weeks for unit 2, 3 and 8 floor 2) commenced on 15/09/2021. Training included the need to identify the care and treatment required to meet the identified goals and resources required to provide the care and treatment.	All ICPs are fully completed identifying patient goals and resources required.	This action is achievable and realistic.	28/01/2022	All members of the NCMHS Local management team, Heads of discipline, all MDT members across all sector teams
Preventative Action	An audit of MDT participation in the ICP process for continuing care patients was completed in November 2021. Ongoing Feedback of all audit results will be circulated to relevant HODs and clinical leads with a view to rectifying any deficits.	All ICPs are fully completed identifying patient goals and resources required	This action is achievable and realistic.	30/11/2022	All members of the NCMHS Local management team, Heads of discipline, all MDT members across all sector teams

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10002338		**The occupational therapy input into one unit was solely provided on a remote basis and as a result no occupational therapy groups were delivered to residents, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Occupational Therapist dedicated to this unit had been working from home on the advice of the Occupational Health Dept. She had attempted to provide a remote service whilst working from home. This OT has now commenced maternity leave and another OT is now providing the OT service to Unit 2 in person and according to IPC guidelines	1.5 days per week of OT will be provided to Unit 2	This is achievable and is now in place.	12/11/2021	OT Manager
Preventative Action	The Occupational Therapy Department provides an individual and group intervention programme to residents across all units of the St Stephens Campus including Unit 2, Unit 3, Unit 4 and Unit 8 Floor 2. Each unit has a dedicated OT with protected time allocated to each unit	OT patient input will be recorded in the patient file as per ICP's	This is achievable and is now in place.	12/11/2021	OT Manager.
Reason ID : 10002339		**Not all residents received an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Nurse Activities Based Service completed Rehabilitative assessment in conjunction with the CNM2 and Nursing staff of Unit 3 to address needs / requirements of service users. A range of activities is available in Unit 3 and at Valley View Day Centre which is situated on the grounds of the campus. The below list outlines some of the options available to service users, and the Nurse Based Activities Service will endeavour to include more meaningful activities which are personal to each service user. • Gardening group • Polytunnel Activities •	Therauptic services will reflect ICP goals and resources required.	This is achievable and realistic.	31/03/2021	All members of the NCMHS Local management team, Heads of discipline, all MDT members.

	Playing pool • Physical Exercise and walking group • Social Integration Group • Cognitive Activities • Current Affairs • Music • Social Outing • Creative writing • Community Meetings • Understanding My Care Plan • Seasonal Events – Events will be organised such as Christmas parties, Easter Celebration, Summer party to reflect the changes of the year and the social customs surrounding them. • Anxiety Management/relaxation groups Residents on all units attend Valley View for individual and group therapies. • Art Group Clients can access this group to express themselves through art. Each client accessing this group has individual art packs where they have access and ownership over their individual art supplies. This group gives clients a medium to express themselves in a different way. Some of the clients showcase their abilities annually in the "Reflections through Art Exhibition". Evidence of this can be seen hanging throughout the unit itself. The clients attend the exhibition opening in the Airport Terminal Cork yearly. Group size: 4-7. Recreational Room to remain open at all times for residents to access. The Occupational Therapy Department provides an individual and group intervention programme to residents across all units of the St Stephens Campus including Unit 2, Unit 3, Unit 4 and Unit 8 Floor 2. Each unit has a dedicated OT with protected time allocated to each unit The groups currently being delivered by the OT Dept include; • Current affairs • Creative Music • Social Outings • Craft Groups • Physical Activity Groups • Music				

	appreciation • Reminiscence • Self-care/ beauty Therapy • Cooking • Relaxation • Walking • Gardening The occupational therapy department also provides a seating assessment and review service for residents across the units. Each occupational therapist also delivers 1:1 intervention where included as part of a residents ICP				
Preventative Action	Unit 3 steering group to meet regularly to monitor progress and review activities. Activities will change frequently depending on the needs and wishes of the service users in Unit 3 in conjunction with resident's needs, ICPs and MDT discussion. All Staff to document all activities offered and attended by residents. Documentation will reflect	Therauptic services will reflect ICP goals and resources required.	This is achievable and realistic.	31/03/2022	Members of the unit 3 steering group. Heads of discipline and relevant MDT members.
Reason ID : 10002340		**Not all residents were in receipt of programmes and services directed towards restoring and maintaining optimum levels of physical and psychosocial functioning, 16 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Unit 3 MDT steering group convened on the 21/9/21. Full MDT assessments were completed on all residents by the following disciplines – Medical, Nursing, CNS Art Therapy, Nurse Therapist, Pharmacy, Occupational Therapy, Social Work, Psychology , Dietician. Individualised recovery orientated recommendations for each resident were made following these assessments. The responsibility for the implementation of these recommendations rests with the relevant discipline. Psychology – The centre psychologist is continuing to provide individual assessment and intervention to residents in Unit 3 where/when requested as well as Units 2, 4, and	All copies of these reports were submitted to the MHC.	It is achievable.	31/03/2022	All MDT members.

	8 (floor2). Collaboration with other AHP's is also ongoing regarding multidisciplinary input to these units. A review of the therauptic services and programs took place and new program of therauptic activities was agreed following a meeting on the 28/9/21. The Psychologist attached to the centre is part of this review group and contributes both to the development and delivery of therapeutic interventions for clients within the centre. Social Work- The Social Work Dept provides both individual and group intervention to residents across Unit 2, Unit 3 and Unit 8 Floor 2, of the St Stephens Campus. The Social worker attached to SSC works 0.4 WTE and is available to Unit 2, Unit 3 and Unit 8 Floor 2, Mondays and Fridays. There is currently a recovery focused group being facilitated by a social worker on unit 3 every Monday morning, focusing on relationships and identity + self-esteem. The social worker also delivers 1:1 intervention when requested through the referral process. The social worker also attends the Residents ICP meeting where possible and ensures her apologies are given and noted when unable to attend same The Occupational Therapy Department provides an individual and group intervention programme to residents across all units of the St Stephens Campus including Unit 2, Unit 3, Unit 4 and Unit 8 Floor 2. Each unit has a dedicated OT with protected time allocated to each unit				
Preventative Action	Unit 3 steering group to meet regularly to monitor and review progress. Both the steering group members and MDT members working	Services and programmes directed towards	It is achievable.	31/03/2022	All MDT members.

	together are fully committed to enhancing the user experience for residents of Unit 3. The welfare and associated programmes is central to the ongoing care of residents physical and mental health needs.	restoring and maintaining optimum levels of physical and psychosocial functioning			

Regulation 21: Privacy					
Reason ID : 10002350		The general demeanour of staff and the manner in which they communicated with residents was not consistently appropriate, 21.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	1.The philosophy of care would be would be brought to the attention of staff. This would act as a unifying act, focusing staff on what is expected from them at all times. 2.Each line manager will have meetings with staff outlining what is expected of them.	1.Philosophy of Care to be placed in the unit. 2.The minutes of these minutes will demonstrate the extent of these interactions	1-4. It is achievable	23/12/2021	Heads of Disciplines
Preventative Action	1.All staff working across the campus will be asked to complete recovery training. 2.All staff in Unit 8 floor 2 and Unit 3 will be asked to complete Brief Solution Focused Therapy training to enable a recovery focused ethos on campus. 3.All staff in Unit 8 floor 2 and Unit 3 will be asked to complete Positive Behaviour Support training to enable an evidence based and recovery orientated model of care to support service users who present with behaviours that challenge. 4.A rehabilitative care pathway between units to be developed by hospital management.	1.It is measurable by viewing the attendance list 2.It is measurable by viewing the attendance list and practice development initiatives afterwards 3.It is measurable by viewing the attendance list and practice development initiatives afterwards 4. It is measurable by the development of a rehabilitative care pathway	1-4: It is achievable	30/06/2022	1.Heads of Disciplines 2.All staff supported by Heads of Disciplines and NCMHS Local Management Team. 3.Heads of Disciplines 4.Heads of Disciplines

Regulation 22: Premises					
Reason ID : 10002346		**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. Minutes of these meetings will be available to the Commission at inspection. Maintenance program added to agenda for March, June, September and December.	Achievable - next local management team meeting has been scheduled for 4th March 2020	31/03/2021	Maintenance Officer and Area Administrator
Reason ID : 10002347		**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 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. Minutes of these meetings will be available to the Commission at inspection. Maintenance program added to Agenda for March, June, September and December.	Next local management scheduled for 4th March 2021	31/05/2021	Area Administrator
Reason ID : 10002364		**The registered proprietor did not ensure that the approved centre was maintained in good structural and decorative condition because: - External walls, soffit and fascia were dirty and discoloured, 22(1) a. - The walls and skirting boards in some bedrooms were in need of painting. Paint was blistered on ceilings in some areas, 22(1) a. - The veranda areas of some units were unkept and had weeds growing on them, 22(1) a. - There were tiles or floor**			

		coverings missing from some areas, 22(1) a. - Floor coverings in some showers had come loose, 22(1) a. - The sluice rooms on three units were in need of refurbishment, 22(1) a.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A refurbishments works program is underway across all the units. Works are phased and sequenced in conjunction with availability of supplies in addition to service needs. Weeds on veranda areas have been cleared. Flooring material surveys were required across the units and this has been completed. Flooring repairs/patches have been undertaken where possible. In areas/rooms requiring substantial repairs will be replaced in conjunction with the overall refurbishment program for the units. A number of shower rooms have been completed made over creating patient wet rooms. The design team are engaged with specifying the finish for the sluice rooms prior to commencement. This works program is ongoing across the various units.	Weekly meetings between the site teams Estates and the service continue. These meetings measure the previous week's performance and assist with future planning works.	This is an achievable and realistic action noting that operational in a live environment brings challenges and careful planning.	31/03/2022	Estates, contractors and Mental Health Services.
Preventative Action	The service introduced a local facilities walk-through program which is cross-functional with MDT members and estates representatives. The maintenance department plan on introducing an automated electronic maintenance request system which capture, expedite and track requests. The system will also allow generation of reports for services. St Stephen's Hospital Campus has been identified as pilot site for the project	Cross functional group reviews occur bi-monthly with records available. Introduction of pilot maintenance system planned for early in 2022	This is both achievable and realistic	29/04/2022	Estates and MDT members.
Reason ID : 10002365		**The registered proprietor did not ensure that the approved centre was adequately ventilated. There were unpleasant odours in two bathrooms, 22(1) b.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Bathrooms across the Approved centre are in the process of being upgraded. To date six bathrooms have been upgraded. In some bathrooms immediate interim works are planned to replace stained and damaged flooring.	Six bathrooms have been completed. Weekly meetings between the site teams Estates and the service continue. These meetings measure the previous week's performance and assist with future planning works.	Six Bathrooms are complete and it is achievable and realistic to complete the remaining.	23/12/2021	Estates, contractors and Mental Health Services.
Preventative Action	Detailed designs are required for a number of bathrooms across the approved centre. This is to ensure that the final design incorporates all elements and effectively deals with odours. The ability to fresh air purge rooms will be included.	Detailed specifications will be developed to enable the contractor procure and provide a fully complaint certified finished room.	This is both achievable and realistic.	30/09/2022	Estates, contractors and Mental Health Services.
Reason ID : 10002366		**The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings having regard to the number and mix of residents of the approved centre, because: - Curtains were missing from one bedroom, 22(2). - Some wardrobes were too small to store residents belongings, 22(2). - The furnishings in the outside space of one unit were inadequate for the number and mix of residents, 22(2). - There was minimal décor on the walls of one unit, 22(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New rails fitted and curtains replaced from missing bedroom, additional wardrobes to be provided as an interim measure with new wardrobes to be fitted upon design team specification.	Curtain refitting completed and also additional wardrobes provided as required.	Complete	29/10/2021	Local maintenance and Housekeeping

Preventative Action	Additional external furniture to be ordered for the outside space once external painting is complete. As wall hangings are an identified ligature point these had been removed. These pictures will be replaced by use of film printed pictures to increase the décor on the walls. Art therapy will also support decoration on the walls with patient supported art.	External furniture selected. Art Therapy progressing designs for wall décor.	This is both achievable and realistic	31/03/2022	Design team and NCMHS Local management team.
Reason ID : 10002367		**The registered proprietor did not ensure that the overall environment was developed with due regards to the specific needs of the residents. This was because: - Ligatures were not minimised to the lowest possible level, based on risk assessment, 22(3). - There was an exposed metal radiator in one bathroom that was very hot to touch, 22(3). - One unit did not have a sluice room onsite, 22(3). - Windows on two of the units were single glazed and contained gaps, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of inspection refurbishment works were ongoing. Ligature audits have been completed for all units across the campus with an action plan being developed to reduce or eliminate out the risk item. A full design team is in place to support the process. The addition of a sluice room for U8FI2 is being progressed with the design team and a suitable room has been identified. Damaged window panes were remedied.	Ligature Audits completed for units across the campus with a design team selected and appointed. Weekly site meetings to manage the refurbishment program	This is both achievable and realistic.	25/02/2022	Design Team, Estates team supported by the Site management team including service stakeholders.
Preventative Action	The appointment of the design team will support the overall refurbishment program for the campus with the design team selecting suitable methods and processes for addressing deficiencies across the units. Detailed designs with specifications will ensure certified and compliant solutions.	Detailed development of specifications, and certification of works and materials. Weekly site meetings monitor progress of the project.	This is both achievable and realistic.	30/09/2021	Design Team, Estates team supported by Mental Health Services.

Regulation 26: Staffing					
Reason ID : 10002357		**Not all staff had up-to-date training in the Mental Health Act, 26 (5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff training to be reviewed by HOD and identify staff who need to complete MHA training. Deadline of 30/11/21021 emailed to all staff who need to completed MHA training	Review training logs.	Achievable.	30/11/2021	All members of the NCMHS Local management team, Heads of discipline.
Preventative Action	All HOD to review training logs regularly and add training as a standing agenda item at the LMT meeting	On Agenda Item of LMT meetings.	Achievable and Realistic	23/12/2021	All members of the NCMHS Local management team, Heads of discipline.

Regulation 27: Maintenance of Records					
Reason ID : 10002348		**Documentation relating to fire inspection reports was not maintained in the approved centre, 27(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire inspection reports and associated documentation was not held centrally but was dispersed across the campus making it more difficult to provide assurances. Annual fire prevention audit was undertaken 09/11/2022 and a review meeting is scheduled with the service once the report is available.	Fire prevention audit completed for St Stephen's Campus 09/11/21.	This is achievable and realistic	23/12/2022	Fire prevention officer, estates, ADON and Area Administrator.
Preventative Action	The Approved centre will put together a composite Fire inspection documentation folder held centrally and managed by the Area Administrator.	New Composite documentation log will be compiled.	This is achievable and realistic	28/01/2022	Area Administrator

Regulation 32: Risk Management Procedures					
Reason ID : 10002351		**A fire door in one unit was not functioning correctly; it was wedged open with a piece of paper as the magnet used to connect it to the fire system was not working. This fire door did not have a seal around it, and therefore it was not functioning as a fire door. This meant that there were not adequate precautions in place to control for the management of fire risk, 32 (b). A fire door in another unit contained glass that was not insulated and therefore did not fulfil their function as fire doors. This meant that there were not adequate precautions in place to control for the management of fire risk, 32 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The nonconforming items identified were remedied during the inspection process. The door release was repaired and the fire protection seals were replaced on the doors. Both the Fire and Safety Officer and Maintenance officer met with the inspectors to review the identified issues. A fire prevention audit has also been undertaken on the units.	Magnetic release repaired, fire seals replaced. Fire prevention audit completed	This is both achievable and realistic	28/01/2022	Fire prevention officer and Area Administrator supported by the Estates and maintenance departments
Preventative Action	The appointment of the design team will support the overall refurbishment program for the campus with the design team selecting suitable methods and processes for addressing deficiencies across the units. Detailed designs with specifications will ensure certified and compliant solutions.	Detailed development of specifications, and certification of works and materials. Weekly site meetings monitor progress of the project.	This is an achievable and realistic action noting that operational in a live environment brings challenges and careful planning.	30/09/2022	Design Team, Estates team supported by Mental Health Services.
Reason ID : 10002353		**Windows on two of the units were in need of replacing; they were breakable and posed a risk to residents if they were to be hit with force. The precautions in place to control for the specific risk of resident self harm were not adequate, 32 (c, ii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Windows identified as having a cracks caused by the metal expansion and contraction have had	Glazing replaced on identified windows	Complete	31/10/2022	Maintenance team

	the glazing replaced with a non shatter Perspex finish.				
Preventative Action	Suitable replacement of windows is included in the overall design scheme for the units. The construction material of the window frames requires a considered detailed design in addition to the planning of the replacement process based on the complexity of the elevation of the unit. Access is limited and will require detailed health & safety assessments and method statements.	Detailed development of specifications, and certification of works and materials. Weekly site meetings monitor progress of the project.	This is both achievable and realistic	30/09/2022	Design Team, Estates team supported by Mental Health Services.
Reason ID : 10002354		**Ligature points remain in the approved centre. The precautions in place to control for the specific risk of resident self harm were not adequate, 32 (c, ii.)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Updated Ligature Audits completed for all units across the campus. The Ligature review group was cross functional and used the revised Manchester Audit tool. The Audits results will support and inform the design team in proposing solutions to address the identified solutions. Additional Nursing staff added to the Unit 4 team to assist management of risk within the unit.	Ligature Audits complete, Design team appointed, refurbishment works ongoing, weekly site meetings and additional staff added to U4.	This is both achievable and realistic not without complexities as operating in a live environment and ensuring a safe works are while respecting the patient and resident needs.	23/12/2021	Design Team, Estates team supported by the Site management team including service stakeholders.
Preventative Action	Detailed designs are required for some of the remaining works around ligatures. The design team has been appointed and have reviewed the units on campus. Design specific considerations are being considered by the design team who are also reviewing a scheduling and associated works plan given the complex operating environment and within the parameters of Covid and staffing numbers and skills mix on site.	Weekly site meetings for the refurbishment works in conjunction to the various design team elements to provide certification and compliance with works completed.	This is both achievable and realistic not without complexities as operating in a live environment and ensuring a safe works are while respecting the	30/09/2022	Design Team, Estates team supported by the Site management team including service stakeholders.

			patient and resident needs.		
Reason ID : 10002355		**Responsibilities were not allocated at management level and throughout the approved centre to ensure their effective implementation, 32 (2) a**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	[redacted], as Clinical Director, has clinical responsibility for the St. Stephen's campus, including Unit 2, 3, 4 and 8 Floor 2. The Assistant Director of Nursing (ADON) for St. Stephens Health Campus has responsibility all units including Unit 3 and Valley View and participates in the North Cork Local Management Structure including the Management Team, QPS and Risk meetings and is based on site. Each Unit nursing staff is led by the CNM2 and respective CNM3. A single consultant has been appointed to Unit 3 and Unit 2 to provide clinic leadership to the MDT. All AHP (Allied Health Professional) Heads of Discipline are part of the local management team will continue to liaise on a regular basis with respective senior clinicians on campus in terms of providing governance and individual support to patients across the Approved centre.	Viewing minutes of local management, SIMT, QPS meetings.	Complete and Achieved.	31/10/2022	All members of the NCMHS Local management team, Heads of discipline, all MDT members across all sector teams
Preventative Action	On-going engagement with staff and the management team to ensure effective implementation of responsibilities. Governance arrangements to be placed on the LMT agenda to retain a focus on the change and assist in managing the transition. Regular LMT meetings and senior nurse management meetings to be held.	Viewing minutes of Local management team meetings and senior nurse management team meetings.	Achievable.	25/02/2022	All members of the NCMHS Local management team, Heads of discipline and senior nurse managers.
Reason ID : 10002356		**The person with responsibility for risk management was not known by all staff, 32 (2) a.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The policy on risk management was circulated to all staff identifying the person responsible for Risk Management	It is measurable by asking staff who has responsibility for risk management. Memo to circulate to all staff advising of staff with responsibility for risk management	It is achievable.	23/12/2021	Each Line Manage
Preventative Action	All staff are made aware of current up to date policies and all staff members must sign that they have read and understood all policies.	Check policy sign off sheet.	It is achievable.	31/03/2022	Each Line Manager

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.

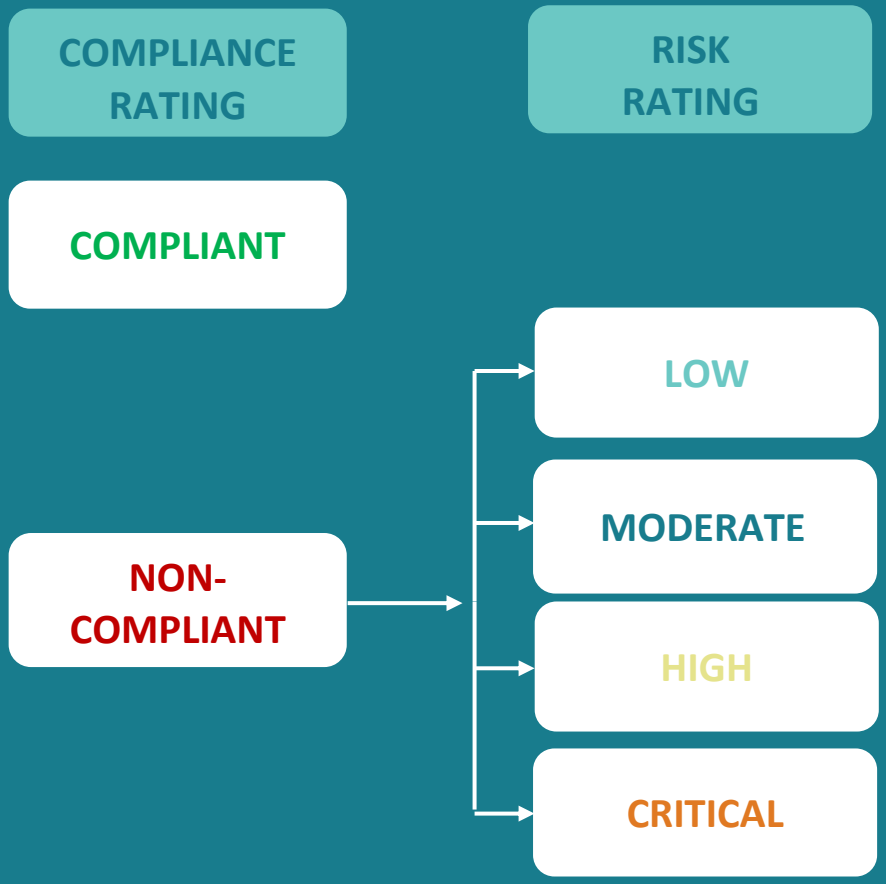
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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