Selskar House, Farnogue Residential Healthcare Unit

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mental health commission

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

SELSKAR HOUSE, FARNOGUE RESIDENTIAL HEALTHCARE UNIT

Old Hospital Road, Wexford

Date of Publication: 5th March 2024

ID Number: AC0155

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Psychiatry of later life

Conditions Attached:
None

Most Recent Registration Date:
2 May 2022

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Anne Donaghey, Head of Services, CHO 5 Mental Health Services

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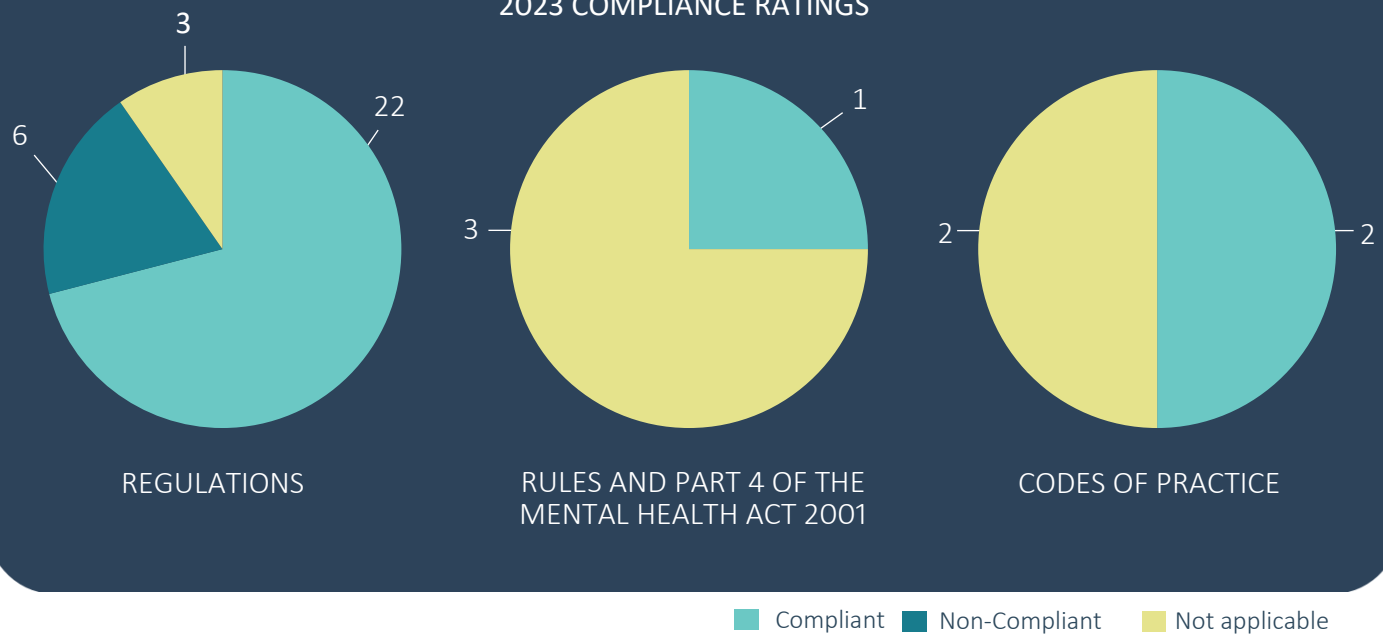
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
18 – 20 July 2023

Previous Inspection date:
1 – 4 March 2022

Inspection Type:
Announced Annual Inspection

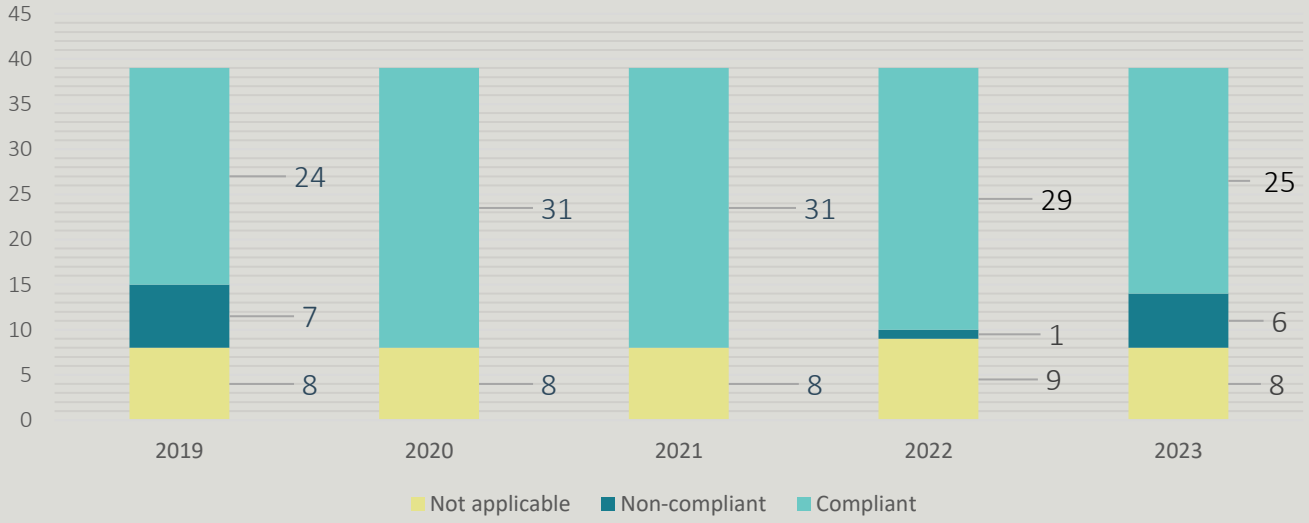
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

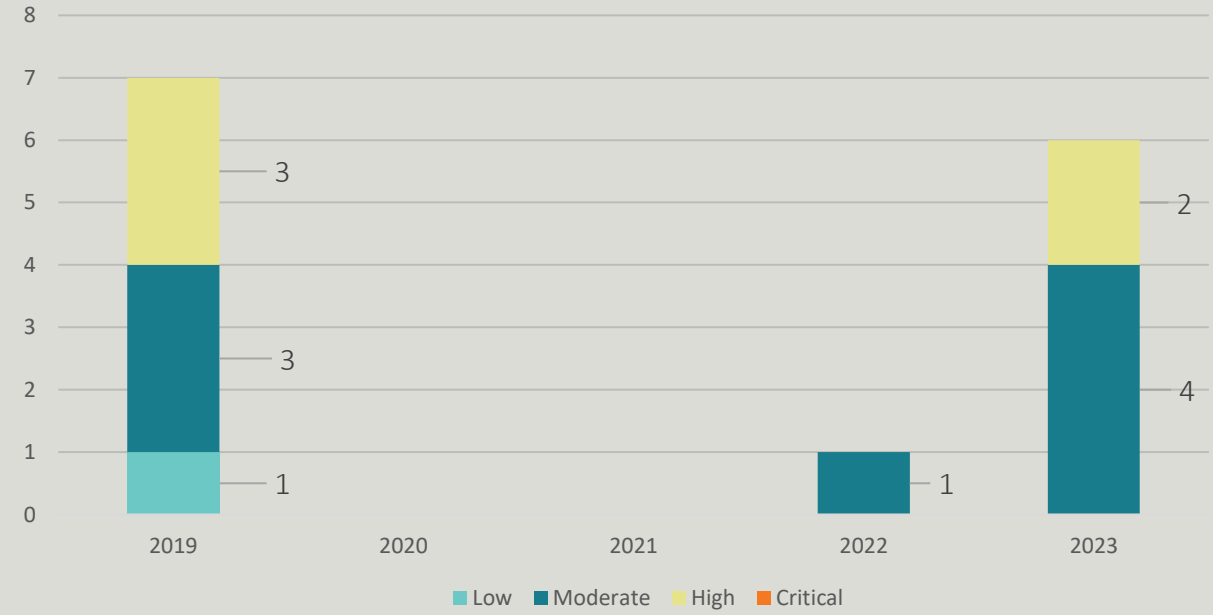
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

Selskar House provided psychiatry of later life services (POLL). It was a modern, purpose-built facility which first opened in 2014, was square in design and located near to Wexford General Hospital. It had a bed capacity of 20, and at the time of the inspection accommodated 20 residents in single en suite rooms. The registered proprietor was the Health Service Executive (HSE). Residents were admitted from the Wexford county and were all under the care of the Psychiatry of Later Life team.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	77%	100%	100%	97%	81%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*05/07/2023*	*Immediate Action Notice (IAN) has been issued to the approved centre as a result of a notified Serious Reportable Event.*	*To date the approved centre submitted a series of assurances in relation to the safety of residents. The MHC continues to liaise with the approved centre.*
Regulatory compliance meeting	*07/07/2023*	*Regulatory Compliance Meeting was held with the representatives of the approved centre in relation to the submitted Serious Reportable Event.*	*At the Regulatory Compliance Meeting the approved centre provided the MHC with immediate assurances and the MHC continues to follow up on this matter through the IAN.*

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** All staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Infection control*****:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Food safety:*** A high standard of hygiene was not maintained in relation to the storage of food, as approved centre staff were storing their lunch bags in the kitchen fridge.
- ***Medication safety:*** While the storing and administration of medication was carried out in a safe manner, the ordering and prescribing in relation to crushed medications was not. There was not enough evidence to indicate that the approved centre consulted with a pharmacist about the type of preparation to be used when crushed medications were prescribed.
- ***Risk Management:*** The approved centre had a number of deficits in relation to their risk management processes:
  a) Clinical risks, relating to food and drinks being available in an unlocked fridge to residents on modified diets (residents on these diets could potentially be at risk of choking) were not identified, assessed, treated, reported and monitored.
  b) Clinical risks relating to residents not having seating assessments (residents could potentially have clinical risks of respiratory dysfunction, posture risks, digestive tract issues etc) were not assessed, treated, reported and monitored.
  c) Health and safety risks, relating to scaffolding outside residents' windows, were not identified, assessed, treated and monitored.
  d) Ligature points, were not effectively removed or mitigated.

Appropriate care and treatment of residents

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

- ***Appropriateness of environment:*** The layout and the decoration of Selskar House was of a good standard and met the needs of the residents.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines. There was also a General Practitioner that attended the approved centre daily.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. There was evidence of significant engagement with residents in respect of their ICP. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, a psychologist, and a dietitian. There was also a social worker and occupational therapist on the team. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line with residents' individual care plan.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Therapeutic interventions:*** Residents had an unmet need of a seating assessment service: this service was not available to residents at the time of the inspection, which meant that the physical and psychosocial functioning of a resident could not be optimal.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** At the time of the inspection Selskar House accommodated 20 residents in single rooms which all had en suite bathroom facilities.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents'

names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialising.

- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Mechanical restraint and physical restraint were used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained by mechanical means and by physical means, including information on attempts to reduce or eliminate the use of restraint for that person. The approved centre was compliant with the Rules Governing Mechanical Restraint and the Code of Practice on Physical Restraint. Seclusion was not used in the approved centre.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Maintenance of records:*** Resident clinical file records were found not to be kept in good order. Loose pages, loose dividers, an absent index sheet, torn poly pockets, and folded over pages were present in clinical files. Resident records were not easy to retrieve: records were not maintained in a logical sequence.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. There was a prayer room and all residents' faiths were facilitated could be accommodated on an individual needs basis.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Included one-to-one and group basis, including TV, books, board games, newspapers, music, hand massage, painting, arts and crafts, movies, jigsaws, cards, reminiscence, walking and outings, beauty therapy, nail painting, hair styling and gardening.

- ***Residents' feedback:*** Two residents provided feedback, and feedback from these residents was positive and very complementary of the care and treatment provided.

However: ***Residents' feedback:*** The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was under the governance of the Waterford/Wexford Mental Health Services and within the overall governance of the South-East Community Healthcare Organisation (CHO). There was no clear governance structure for supervision/line management of catering staff in Selskar House.
- ***Leadership:*** The approved centre was represented at two monthly meetings which took place at CHO level – the Executive Management Committee (EMT) and the Quality and Safety Executive Committee (QSEC). The local management meeting for Selskar House, the Quality and Patient Safety Committee (QPSC), also met on a monthly basis. Service user input into the approved centre was enhanced by the Area Lead for Mental Health Engagement who had input into the approved centre governance processes.
- ***Clinical governance:*** There were areas of good clinical governance: Individual care planning processes were good, general health care provided met the needs of the residents and there was evidence in the files of multi-disciplinary team working. Audits were carried out, although a more robust auditing programme is required to capture where there were deficits in regulatory compliance.
- ***Restrictive practices reduction:*** In line with the Mental Health's Commission commencement of the newer version of restrictive practices requirements which came into effect January 2023, the service had developed and implemented a policy on the reduction of restrictive practice. The registered proprietor had appointed a senior manager responsible for the approved centre's reduction in restrictive practice. The approved centre was compliant with the Rule Governing Mechanical Restraint and the Code of Practice on Physical Restraint.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. There was a local risk register. Risk management was addressed at each of the monthly governance meetings with risks escalated appropriately.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. A number of *Quality Initiative Improvements* had taken place since the last inspection including the erection of a shed for use by horticultural and woodwork groups. *(Please refer to section 2.0 of this report for more information on quality initiatives*).
- ***Policies:*** The approved centre's policies were up-to-date.
- ***Staff training:*** All staff had received mandatory training.
- ***Complaints:*** There was a robust complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.

- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** The approved centre had an advocacy service. The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 95% over the last four years. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risk: Medication safety:*** There was no proof that the approved centre consulted with a pharmacist about the type of preparation to be used when crushed medications were prescribed.
- ***Risk Management:*** The approved centre had a number of deficits in relation to their risk management processes:
  -*Clinical risks:* relating to food and drinks being available in an unlocked fridge to residents on modified diets were not identified, assessed, treated, reported and monitored. Clinical risks relating to residents not having seating assessments were not assessed, treated, reported and monitored.
  -*Health and safety risks:* relating to scaffolding outside residents' windows, were not identified, assessed, treated and monitored.
  -*Risk: Ligature points:* were not effectively removed or mitigated.
- ***Clinical governance:*** There was an area where clinical governance needed improvement: the maintenance of records documentation was inadequate.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A display unit with information about the approved centre and activities was installed in each resident's bedroom.

2. A shed, for use by the horticultural and woodwork groups, was erected.

3. A large touch screen tablet, which would allow residents to watch movies, listen to music and look up information, was purchased.

4. Song workshops, story telling, folklore, and pet farm visits were provided by horticultural and musical facilitators.

5. A programme of music and movement for residents took place over a period of 12 weeks.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Selskar House was a modern, purpose-built facility which first opened in 2014. It was situated on the ground floor of the Farnogue Residential Healthcare Unit, which was shared with a nursing home on the upper floor. It was located near to Wexford General Hospital. Access to the approved centre was gained via a keypad secured entrance. Selskar House accommodated 20 residents in single rooms which all had en suite bathroom facilities. The approved centre had two 10-bedded wards and each included a day room/dining room, a nursing office, and a clinical room.

Therapeutic groups took place in a separate therapies room. The approved centre was square in shape, and it was spacious and bright. All bedrooms opened onto an outside area. However, at the time of the inspection, scaffolding erected to repair the building restricted residents in two bedrooms from accessing the outdoors directly.

Residents also had access to a small, internal courtyard as well as a large, enclosed garden area. Supervised access to the garden was facilitated by the nursing team as appropriate. Visits were also accommodated in the garden. An oratory was situated on the ground floor of Farnogue Residential Healthcare Unit and this was accessible to residents of the approved centre.

Residents were admitted from the Wexford county and were all under the care of the Psychiatry of Later Life team.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**20**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the governance of the Waterford/Wexford Mental Health Services and within the overall governance of the South-East Community Healthcare Organisation (CHO). The approved

centre was represented at two monthly meetings which took place at CHO level – the Executive Management Committee (EMT) and the Quality and Safety Executive Committee (QSEC).

The local management meeting for Selskar House, the Quality and Patient Safety Committee (QPSC), also met on a monthly basis. Issues pertaining to health and safety, staff training, and compliance for the approved centre were all discussed at this meeting. At the time of the inspection, arrangements were being made to remove scaffolding following the completion of works to the premises. The audit programme was also addressed at these meetings.

The QSEC included standing items on their agenda such as: regulation and compliance for all four approved centres within the CHO, discussions about the system of monitoring (including clinical audit and continuous quality development), the input of the Mental Health Engagement and Recovery Team and the introduction of individual care plan (ICP) champions to improve ICPs. The committee also examined any issues escalated from local QPSC meetings and any items that emerged for discussion from the Policy and Procedure review group.

The Executive Management team met to discuss service plans, staffing, finances, performance including key performance indicators (KPI), quality improvement and matters that were escalated from QSEC meetings. Equally, matters that were discussed during the inspection were brought to the attention of QSEC. The Head of Service responded swiftly to areas of concern raised during the inspection. These included that there was no clear governance structure for supervision/line management of catering staff in Selskar House. Hot food was prepared at St. John's Hospital and delivered to Selskar House in hot food trolleys. Healthcare Assistants (HCA) served the food to residents and prepared sandwiches, light meals, and snacks. HCAs were in the line management of nursing which is appropriate for other duties. A risk assessment was accepted by the QSEC committee and appropriate structures and oversight for food preparation and storage was listed for discussion.

Similarly, medication was supplied by Wexford General Hospital and while the pharmacist was always available to give advice they did not attend Selskar House. Pharmacists did not audit the prescribing or the administration and storage of medication.

Risk management was addressed at each of the monthly governance meetings with risks escalated appropriately. The approved centre had an established process for the identification of risks and the reporting of incidents. Risks were identified by each of the heads of discipline for nursing, medical and occupational therapy, as well as by representatives of the heads of discipline for social work and psychology. These risks included difficulties in terms of recruitments and retention of staff. Controls had been implemented by each department for all risks identified. Risks were identified to the local risk register as required.

A robust system of multi-disciplinary clinical audit was in place within the approved centre. The results of these audits, as well as the findings of the Mental Health Commission annual reports, were discussed at the monthly meetings (EMT, QSEC and QPSC) along with action plans to address areas requiring improvement.

Staff from all disciplines had completed the required mandatory training as set out by the Mental health Commission: Basic Life Support, Therapeutic Management of Aggression and Violence, Fire Safety, and the Mental Health Act 2001.

Service user input into the approved centre was enhanced by the Area Lead for Mental Health Engagement who had input into the approved centre governance processes. Resident community meetings, suggestion boxes, and engagement with the complaints process were each utilised in order to maximise resident feedback to management.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 6: Food Safety	✓		✓		✓		✓		✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✓		✓		✓		✓		✗	High
Regulation 22: Premises	✗	High	✓		✓		✗	Moderate	✗	Moderate
Regulation 23: Ordering, Prescribing, storing and Administration of Medication	✓		✓		✓		✓		✗	High
Regulation 27: Maintenance of Records	✗	Moderate	✓		✓		✓		✗	Moderate
Regulation 32: Risk Management Procedures	✗	Moderate	✓		✓		✓		✗	High

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.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, 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.
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. To that end, the inspection team engage with residents in a number of different ways:

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

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

One resident attended an interview with the inspectors and one resident completed a questionnaire. Feedback from residents was positive and very complementary of the care and treatment provided.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

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:

- Registered Proprietor
- Executive Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing X2 (ADON)
- Regulatory Compliance Support (ADON)
- Clinical Nurse Manager II x 2
- Risk Advisor
- Occupational Therapist
- Complaints Officer

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two appropriate resident identifiers before administering medications, undertaking medical investigations, and providing other healthcare services. Identifiers included resident photograph, name, and date of birth. 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. The majority of food was cooked in St. John's hospital and delivered to the approved centre. Residents had at least two choices for meals.

A source of safe, fresh drinking water was available at all times in the approved centre. For residents with special dietary requirements, their 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

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Hygiene was not maintained to support food safety requirements. Staff were placing their lunch in the fridge and these were placed in lunch bags that possibly had been sitting on unclean surfaces. Staff not trained in food safety were entering the kitchen and preparing drinks for their own lunch. The kitchen was also open to all staff at night. These practices were inconsistent with best practice for food safety and hygiene.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that a high standard of hygiene was maintained in relation to the storage of food, as staff were storing lunch bags in the kitchen fridge, 6 (1)(C).

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 an ample supply of male and female emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practises. Emergency clothing comprised of sweaters, leggings, underwear, and pyjamas. There was an emergency clothing supply monitoring sheet which was signed by staff when any clothing was used. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2021.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities, including safes and lockers were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile. Recreational activities were scheduled over seven days, twice per day at 10:30 am and 3.30 pm.

Activities were available to residents on a one-to-one and group basis, including TV, books, board games, newspapers, music, hand massage, painting, arts and crafts, movies, jigsaws, cards, reminiscence, walking and outings, beauty therapy, nail painting, hair styling and gardening.

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 practise religion were facilitated within the approved centre insofar as was practicable. There was a prayer room and all residents' faiths were facilitated.

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 written policies and procedures in relation to visits. The policy was last reviewed in July 2022. At the time of inspection, visiting times were flexible, appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Residents could meet visitors in a private visiting area: there was a quiet room and residents could also use their bedroom to receive visitors, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting area was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had written policies and procedures in relation to communication. The policy was last reviewed in January 2021. Residents in the approved centre had access to postal mail, internet including e-mail and telephone, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was a reasonable cause to believe the communication may 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 policy and procedures on the conducting of searches. The policy was last reviewed in June 2021, and included all requirements related to:

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

No searches took place in the approved centre since the last inspection, and compliance for this regulation was assessed on the basis of policy alone.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. This policy was last reviewed in September 2020. The clinical file of one resident who passed away since the last inspection was reviewed on inspection.

The end-of-life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs. This was documented in the resident's individual care plan. Religious and cultural practices were respected. The privacy and dignity of the resident was protected, and the resident was given a single room within the approved centre during the provision of end-of-life care. Representatives, family, next of kin, and friends were involved, supported and accommodated during end-of-life care.

All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

Ten 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. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment. 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 and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT at least six-monthly, in consultation with the resident and their family representative. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

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

The therapeutic services and programmes provided by the approved centre met the assessed needs of all residents is line with their individual care plans. A therapeutic group programme was delivered in blocks of weeks which changed to facilitate the changing needs and preferences of the residents. Therapeutic groups included music, cognitive stimulation (which was co-facilitated with a psychology assistant and occupational therapist (OT)), art, garden, nature, horticulture, sensory, yoga and movement specialist groups. The therapy dog visited weekly and residents visited pet farms.

The therapeutic services and programmes provided within the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A music exploration officer facilitated music concerts, instrument and singing and performance sessions. A horticulturist facilitated a horticulture group which involved planting and sowing seeds.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre did not arrange for the service to be provided by an approved, qualified health professional in an appropriate location. A seating assessment service, to assess residents' seating and postural needs and to recommend a seating solution was not available to residents at the time of the inspection.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that a therapeutic service that was not provided in the approved centre, was provided by an approved qualified professional in an appropriate location: as a seating assessment service was not available to residents at the time of the inspection, 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 in relation to transfers. The policy was last reviewed in August 2022. The clinical file of one resident who had been transferred from the approved centre to a different healthcare facility was inspected. Full and complete written information for the resident was transferred to the receiving facility when they moved there, 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 was last reviewed in April 2021.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). 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 five 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, the six-monthly form documented that 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.

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 March 2021.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support residents' needs. The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team (MDT).

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to personal space, and appropriately sized communal rooms were provided. Rooms were ventilated. There was suitable and sufficient heating throughout the approved centre, and residents' bedrooms had an individual temperature controller which controlled the underfloor heating.

Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. The communal area had large windows for daylight to radiate into the rooms. There was sufficient artificial lighting for night reading.

Appropriate signage and sensory aids were provided to support residents in finding their way around the approved centre, and each room had the residents first name displayed. Sufficient spaces were provided for residents to move about, including outdoor spaces. Each resident had their own en suite bedroom.

Hazards were minimised. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

The approved centre had a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Current national infection control guidelines were followed. The centre was clean and hygienic. The approved centre, was kept in a good state of repair inside and outside.

There was a sufficient number of toilets and showers in the approved centre, which included an assisted toilet. The approved centre had a designated sluice room and two cleaning rooms. All resident bedrooms were appropriately sized, and suitable furnishings were provided to support resident independence and comfort. The approved centre provided assisted devices and equipment to address resident needs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre was maintained with due regard to the safety and wellbeing of the residents. Ligature points were not minimised to the lowest practicable level based on risk assessment, 22 (3).

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

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in October 2021. The policy included:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; 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. The approved centre did not have appropriate and suitable practices relating to the ordering and prescribing of crushed medications, as there was insufficient evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed.

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. Schedule 2 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the ordering and prescribing of crushed medications, as there was insufficient evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed, 23 (1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in July 2022.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in February 2023, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staffing were sufficient to meet resident needs. The approved centre had one multi-disciplinary team. This included psychiatry, nursing, occupational therapy, social work, and psychology staff. There was also a General Practitioner that attended the approved centre daily.

All healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The following is a table of staff showing the numbers and percentages of staff trained in the four mandatory training topics:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (17)	17	100%	17	100%	17	100%	17	100%
Consultant Psychiatrist (1)	1	100%	1	100%	1	100%	1	100%
Medical (1)	1	100%	1	100%	1	100%	1	100%

Occupational Therapist (2)	2	1200%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The Maintenance of Records policy was last reviewed in June 2021.

Resident records were not found to be kept in good order. Loose pages and loose dividers were present in clinical files. Clinical file pages were turned up and torn poly-pockets were present. Pages were folded over within documents in individual poly pockets, and there was no index sheet present in one clinical file.

Not all records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. Residents records were not developed and maintained in a logical sequence: an individual care plan was found to be filed with a mechanical restraint booklet, and a referral and correspondence were kept in the wrong place in the clinical note section of a file. Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorised access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

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

a) **The registered proprietor did not ensure that the residents' clinical files were maintained in good order, as clinical files contained loose pages and loose dividers, one index sheet was absent, poly pockets were torn, and pages were folded over, 27 (1).**

b) **The registered proprietor did not ensure that all records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. Residents records were not maintained in a logical sequence, 27 (1).**

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented hard copy 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 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 June 2021 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 and available for dealing with all complaints who was based in the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon after. 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. 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; however, no complaints had been made since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in April 2022. The risk management policy addressed all requirements. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks.

Clinical risks relating to food and drinks being available to residents on modified diets were not identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. These food and drinks were in an unlocked fridge in the day room and residents on modified diets could potentially choke on this food and drink if consumed. The clinical risks associated with residents not receiving seating assessments included, possible, respiratory dysfunction, digestive tract issues, posture, reduced mobility and the possibility that pressure areas may develop were not assessed, treated, reported or monitored.

Structural risks, including ligature points, were not removed, or effectively mitigated. Works to the premises were on-going at the time of the inspection. Risks to residents while the works were ongoing were not reduced. Residents' bedrooms were open to a scaffolding site during the works. This scaffolding was a health and safety risk which the approved centre did not assess, treat, report, and monitor in accordance with the relevant legislation. The garden had been fenced off but residents could still access hazardous and ligature risks.

Individual risk assessments were completed prior to mechanical restraint and physical restraint, and in conjunction with medication requirements or administration, and resident transfer and discharge. Risk

assessments were also completed during admission, to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

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

a) **Clinical risks, relating to food and drinks being available in an unlocked fridge to residents on modified diets were not identified, assessed, treated, reported and monitored, 32 (1).**
b) **Clinical risks relating to residents not having seating assessments were not assessed, treated, reported and monitored, 32 (1).**
c) **Health and safety risks, relating to scaffolding outside residents' windows, were not identified, assessed, treated and monitored, 32 (1).**
d) **Structural risks, including ligature points, were not effectively removed or mitigated, 32 (1).**

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 at the reception area of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Evidence of Implementation: Four episodes of mechanical restraint were reviewed during the inspection process. Mechanical restraint was only used to address an identified clinical need and/or risk. Mechanical restraint was only used when less restrictive alternatives were deemed unsuitable. Each episode was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist on their behalf. A risk assessment of the safety and suitability of mechanical restraint was undertaken, and it specified the monitoring arrangements and frequency to be implemented during its use. The MDT developed a plan of care for each person restrained by mechanical means, including information on attempts to reduce or eliminate the use of restraint for that person.

Each clinical file contained a contemporaneous record that specified the following: that there was an enduring risk of harm to the self or others, that less restrictive alternatives were implemented without success, the type of mechanical restraint, the situation in which mechanical restraint was being applied, the duration of the restraint, the duration of the order, and the review date. The approved centre notified the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the correct format, and within the timeframes set by the Mental Health Commission.

Clinical Governance: The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of mechanical restraint.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 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.

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

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 (PR). The policy had been reviewed annually and was dated December 2022. It addressed the following:

- The provision of information to the person which included information about the person's rights, presented in accessible language and format; information regarding who can initiate and who may carry out PR; information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of PR.
- Policies and procedures regarding staff training including the following:
  - Who will receive training based on the identified needs of persons who are restrained and staff
  - The areas to be addressed within the training programme, which included training in:
    The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques); alternatives to PR; trauma-informed care; cultural competence, human rights, including the legal principles of restrictive interventions; positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic, and the monitoring of the safety of the person during and after the PR.
    The identification of appropriately qualified person (s) to give the training.
  - The mandatory nature of training for those involved in PR.

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

- Details of how the approved centre aimed to reduce, or where possible eliminate, the use of PR within the approved centre, including its use of positive behaviour support.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. All staff who participated or may participate in the use of physical restraint had received appropriate training in the use of physical restraint and in the related policies and procedures regarding staff training. All staff who participated or may participate in the use of physical restraint had received training in cultural competence, and in the positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic. A record of attendance at physical restraint training was maintained by the approved centre.

Monitoring: Was not applicable nor inspected at the time of the inspection as the annual report had not yet occurred – a year had not passed.

Evidence of Implementation: The clinical files of three persons who had been physically restrained since the last inspection, were examined on inspection. PR was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy on physical restraint. The physical restraint order confirmed that there were no other less restrictive ways available to manage each person's presentation. The consultant psychiatrist (CP) or the duty consultant was notified as soon as was practicable and this was recorded in the clinical files. The RMP completed a medical examination of each of the persons (a physical examination) no later than two hours after the episodes of PR. The orders for PR lasted a maximum of 10 minutes.

The Clinical Practice Form (CPF) was signed by the CP within 24 hours. The persons were informed of reasons for, likely duration of, and circumstances leading to discontinuation of PR unless the information may have been prejudicial to the residents' mental health, well-being, or emotional condition.

In all episodes of physical restraint, as soon as was practicable, and as it was the person's wish in accordance with their individual care plan, the person's representative was informed of the person's restraint and a record of this communication was placed in the clinical file. The Mental Health Commission (MHC) was notified through the Comprehensive Information System (CIS) of the start time and date, and the end time and date of each episode of PR in the format specified by the MHC, within three days of the restraint.

A same sex staff member was present at all times during the episodes of PR. In the three episodes of physical restraint the person was continuously assessed throughout the use of restraint to ensure the person's safety and this was documented. In all three episodes of physical restraint the person's head and neck were supported where necessary. In all three episodes of physical restraint the person's airway and breathing were not compromised.

The person who lead the physical restraint ended it. The time, date, and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended.

An in-person debrief with the person who was restrained followed two of the three episodes of PR. The person refused to engage in the de-brief in one episode of physical restraint. This debrief was person-centred and gave each person the opportunity to discuss the PR with members of the multi-disciplinary team (MDT) involved in the person's care and treatment as part of a structured debrief process.

The debrief included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. The debrief included a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future, such as preferences in relation to which restrictive intervention they would not like to be used. The person's individual care plan was updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward. There was a record of all attendees who were present at the debrief, this was recorded in the clinical files.

The episodes of PR were recorded on the clinical practice forms located in the clinical file. The episodes of PR were reviewed by members of the MDT within five working days from the date of the restraint. The review covered everything required to be covered. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

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

Admission: The admission policy, which was last reviewed in November 2022, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in August 2022, included all of the policy-related criteria for this code of practice.

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

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

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

Evidence of Implementation:
Admission: The clinical file of one resident who was admitted to the approved centre was reviewed on inspection. A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the following: presenting problem; past psychiatric history, family history, medical history, current and historic medication, where relevant, social and housing circumstances, current mental health state, risk assessment, full physical examination, and other relevant information. The resident's family member, carer, or advocate was involved in the admission process, with the resident's consent.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.
Discharge: No resident had been discharged since the last inspection.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 06: Food Safety					
Reason ID : 10004363		**The registered proprietor did not ensure that a high standard of hygiene was maintained in relation to the storage of food, as staff were storing lunch bags in the kitchen fridge, 6 (1)(C).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff lunch bags removed from kitchen fridge on the 18th July 2023 in presence of the inspection team	Observed by ADON for the unit and MHC Inspection Team on 18/07/2023	Achieved	18/07/2023	Unit Clinical Nurse Managers
Preventative Action	All staff lunches now stored in a separate fridge in the staff room. This will be monitored regularly by Selskar Assistant Director of Nursing, Compliance Support Assistant Director of Nursing and through audit schedule for 2024.	This will be monitored regularly by Selskar ADON and Compliance Support ADON and through audit schedule for 2024. Most recent audit for Reg.6 completed on 15/01/2024 and achieved 100% compliance. Audit tool attached.	It is achievable and realistic	29/01/2024	Clinical Nurse Managers and Assistant Director of Nursing for Selskar

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10004364		**The registered proprietor did not ensure that a therapeutic service that was not provided in the approved centre, was provided by an approved qualified professional in an appropriate location: as a seating assessment service was not available to residents at the time of the inspection, 16 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of the inspection there were 5 residents in chairs, 3 of those residents had already been assessed. External vendor has now been sought and is now in place for assessments .	Completed assessment/ prescription documentation available in relevant individual health care records	Achievable & Realistic	29/01/2024	Head of Service and General Manager to ensure that external vendor to provide specialist seating assessments
Preventative Action	Outstanding seating assessments were completed by seating specialist vendor on Sat 6th January 2024	Completed assessment/ prescription documentation available in relevant individual health care records	Achievable and realistic	29/01/2024	Head of Service and General Manager to ensure external vendor is in place to provide specialist seating assessments. This will be monitored regularly by Selskar ADON and Compliance Support ADON through audit schedule for 2024.

Regulation 22: Premises					
Reason ID : 10004365		**The registered proprietor did not ensure that the approved centre was maintained with due regard to the safety and wellbeing of the residents. Ligature points were not minimised to the lowest practicable level based on risk assessment, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	(A) Scaffolding and protective Perspex hoardings were all removed from courtyard area on 27/07/2023 ; this work was necessary to mitigate a structural health & safety risk. This work was closely assessed, monitored and completed in the most efficient and timely manner possible; whilst the service was cognisant of the health and safety of the residents at all times. (B) Elastic band on bin in activities room was removed in the presence of inspectors on 18.07/2023. It is the practice of the approved centre and	(A)Scaffolding no longer in place as above this work was necessary to mitigate a structural health and safety risk (B) Elastic Band no longer on the bin in activities room (C) ADON for approved centre and technical services staff will observe and monitor on unit walkrounds	(A) and (B) achieved on 27/07/2023 and 18/07/2023 respectively, residents are never in activities space unsupervised this was the practice and time of the inspection and continues to be the practice (C) is ongoing as part of maintenance schedule	29/01/2024	(A) Head of Service-QSEC and QPSC (B) All approved centre staff accessing activities room with Selskar residents when supervising the residents and Assistant Director of Nursing for Selskar to monitor that bin remains elastic band free

	this continues that on the occasions when Selskar residents access the activities room they are supervised at all times by approved centre staff. Selskar residents cannot access the activities room unsupervised. (C) All bedroom windows are fitted with safety restrictor device which limits the opening to less than 2 inches, the latches are regularly monitored by technical services with ADON for approved centre and faulty/broken ones repaired when necessary. Windows/ latches are on maintenance schedule for the approved centre.				
Preventative Action	(B) Elastic band on bin in activities room was removed in the presence of inspectors on	ADON for approved centre and technical services staff will observe and monitor on unit walkrounds	(B) and (C) Achievable and realistic	29/01/2024	ADON for approved centre and technical services staff

	18.07/2023. It is the practice of the approved centre and this continues that on the occasions when Selskar residents access the activities room they are supervised at all times by approved centre staff. Selskar residents cannot access the activities room unsupervised. (C) All bedroom windows are fitted with safety restrictor device which limits the opening to less than 2 inches, the latches are regularly monitored by technical services with ADON for approved centre and faulty/broken ones repaired when necessary. Windows/ latches are on maintenance schedule for the approved centre.				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10004372		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the ordering and prescribing of crushed medications, as there was insufficient evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Agenda Item for February 2024 QSEC Meeting for a discussion on the input of a pharmacist into the approved centre and escalate to EMT following QSEC for discussion. Access to pharmacist has been noted on Selskar Risk Register. Minutes of the QSEC &/EMT Minutes will be uploaded to CIS for review by MHC once ratified by end of April 2024. Documentary evidence of consultation with Pharamacist at Wexford General Hospital was provided to Inspection Team at time of the	Outcome can be measured following outcome of QSEC and EMT meetings this is a budgetary issue and staffing issue in light of HSE recruitment pause	Outcome can be measured following outcome of QSEC and EMT meetings this is a budgetary issue and staffing issue in light of HSE recruitment pause	30/04/2024	Head of Service- EMT-QSEC governance structures

	inspection please see attached documents.				
Preventative Action	Agenda Item for February 2024 QSEC Meeting for a discussion on the input of a pharmacist into the approved centre and escalate to EMT following QSEC for discussion. Access to pharmacist has been noted on Selskar Risk Register. Minutes of the QSEC &/EMT Minutes will be uploaded to CIS for review by MHC once ratified by end of April 2024. Documentary evidence of consultation with Pharamacist at Wexford General Hospital was provided to Inspection Team at time of the inspection please see attached documents.	Outcome can be measured following outcome of QSEC and EMT meetings this is a budgetary issue and staffing issue in light of HSE recruitment pause	Outcome can be measured following outcome of QSEC and EMT meetings this is a budgetary issue and staffing issue in light of HSE recruitment pause	30/04/2024	Head of Service- EMT- QSEC governance structures

Regulation 27: Maintenance of Records					
Reason ID : 10004366		**The registered proprietor did not ensure that the residents' clinical files were maintained in good order, as clinical files contained loose pages and loose dividers, one index sheet was absent, poly pockets were torn, and pages were folded over, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All 20 residents healthcare records were reviewed, tidied and put into logical sequence and audit of all 20 health care records was completed by end of the allowed inspection period which was COB 24/07/2023. Photographic evidence as well as completed 100% compliant audit tool was sent to lead inspector Noeleen Byrne on 24/07/23	Audit completed 24/07/23 achieved 100% compliance	Achieved 24/07/23	24/07/2023	ADON For Selskar
Preventative Action	Administrative support has been put in place for purposes of Reg. 27 Maintenance of Records in the approved centre. This will be monitored regularly by ADON	Audit Schedule for 2024 next audit due by end of Feb 2024	Achievable and Realistic	29/02/2024	ADON for Selskar ADON for Compliance Support all staff of the approved centre

	for unit and Compliance Support ADON through audit schedule for 2024.				
Reason ID : 10004367		**The registered proprietor did not ensure that all records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. Residents records were not maintained in a logical sequence, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All 20 residents healthcare records were reviewed, tidied and put into logical sequence and audit of all 20 health care records was completed by end of the allowed inspection period which was COB 24/07/2023. Photographic evidence as well as completed 100% compliant audit tool was sent to lead inspector Noeleen Byrne on 24/07/23	Audited 24/07/2024 achieved 100% Compliance	Achieved	24/07/2023	ADON for Selskar ADON for compliance all approved centre staff
Preventative Action	Administrative support has been put in place for purposes of Reg. 27 Maintenance of Records in the approved centre. This	Audit Schedule 2024 next audit due by end of Feb 2024	Achievable and realistic	29/02/2024	ADONs for Selskar and Compliance Support, all staff of the approved centre and admin support

	will be monitored regularly by ADON for unit and Compliance Support ADON through audit schedule for 2024.				

Regulation 32: Risk Management Procedures					
Reason ID : 10004368		**Clinical risks, relating to food and drinks being available in an unlocked fridge to residents on modified diets were not identified, assessed, treated, reported and monitored, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The unlocked fridge referred to in draft report was removed immediately in the presence of the inspection team, the fridge is now located in the clinical room for safe storage of all nutritional drinks, supplements etc. The temperature of fridge in clinical room is monitored daily	Will be monitored as part of 2024 Audit Schedule	Achievable and Realistic	18/07/2023	ADON for Selskar and Clinical Nurse Managers
Preventative Action	The unlocked fridge referred to in draft report was removed immediately in the presence of the inspection team, the fridge is now located in the clinical room for safe storage of all nutritional drinks, supplements etc. The temperature of fridge in clinical room is monitored daily	Monitered as part of 2024 Audit Schedule next audit due by end of Feb 2024	Achievable and realistic	29/02/2024	ADON for Selskar and Clinical Nurse Managers

Reason ID : 10004369		Clinical risks relating to residents not having seating assessments were not assessed, treated, reported and monitored, 32 (1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of the inspection there were 5 residents in chairs, 3 of those residents had already been assessed and seating prescription evidence was available to the inspection team at time of inspection. Approval of assessments for the other two residents had been sought from GM and external vendor has now been secured.	Completion of all seating specialist assessments in a timely manner. Documentary evidence and prescription evidence is individuals health care records	Achievable and realistic	06/01/2024	Head of Service and General Manager to ensure external vendor to provide specialist seating assessments
Preventative Action	Seating Specialist vendor secured all outstanding seating assessments completed 06/01/24	Completion of all seating specialist assessments in a timely manner. Documentary evidence and prescription evidence is individuals health care records	Achievable and realistic	06/01/2024	Head of Service and General Manager to ensure external vendor to provide specialist seating assessments
Reason ID : 10004370		**Health and safety risks, relating to scaffolding outside residents' windows, were not identified, assessed, treated and monitored, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Scaffolding and protective Perspex hoardings were all removed from courtyard area on 27/07/2023; this work was necessary to mitigate a structural health & safety risk. This work was closely assessed, monitored and completed in the most efficient and timely manner possible; whilst the service was cognisant of the health and safety of the residents at all times.	Achieved as scaffolding removed on 27/07/2023	Achieved	27/07/2023	HOS-EMT-QSEC-QPSC Governance Structures
Preventative Action	ACHIEVED Scaffolding and protective Perspex hoardings were all removed from courtyard area on 27/07/2023; this work was necessary to mitigate a structural health & safety risk. This work was closely assessed, monitored and completed in the most efficient and	ACHIEVED	ACHIEVED	27/07/2024	ACHIEVED

	timely manner possible; whilst the service was cognisant of the health and safety of the residents at all times.				
Reason ID : 10004371		**Structural risks, including ligature points, were not effectively removed or mitigated, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	(A) Scaffolding and protective Perspex hoardings were all removed from courtyard area on 27/07/2023; this work was necessary to mitigate a structural health & safety risk. This work was closely assessed, monitored and completed in the most efficient and timely manner possible; whilst the service was cognisant of the health and safety of the residents at all times. (B) Elastic band removed from bin of activities room in presence of inspectors 19/07/23. It is the practice of	(A) Achieved scaffolding romoved (B) Achieved Selskar residents do not access activities room unsupervised. Elastic band on bin removed 18/07/23	Achieved	31/07/2023	(A) HOS -EMT-QSEC-QPSC Governance Structures (B) ADON for Selskar and all approved centre staff

	the approved centre that Selskar residents cannot access the activities room unsupervised on the occassions when Selskar residents utilise activities room they are supervised by staff for approved centre at all times.				
Preventative Action	(A) ACHIEVED Scaffolding and protective Perspex hoardings were all removed from courtyard area on 27/07/2023; this work was necessary to mitigate a structural health & safety risk. This work was closely assessed, monitored and completed in the most efficient and timely manner possible; whilst the service was cognisant of the health and safety of the residents at all times. (B)Elastic band removed from bin of	Ongoing observation and checks of bins to ensure elastic free	Achievable and realistic	15/01/2024	(A) Achieved (B) Ongoing monitering by approved centre ADON and all approved centre staff that bins remain elastic free

	activities room in presence of inspectors 19/07/23. It is the practice of the approved centre that Selskar residents cannot access the activities room unsupervised on the occassions when Selskar residents utilise activities room they are supervised by staff for approved centre at all times.				

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.

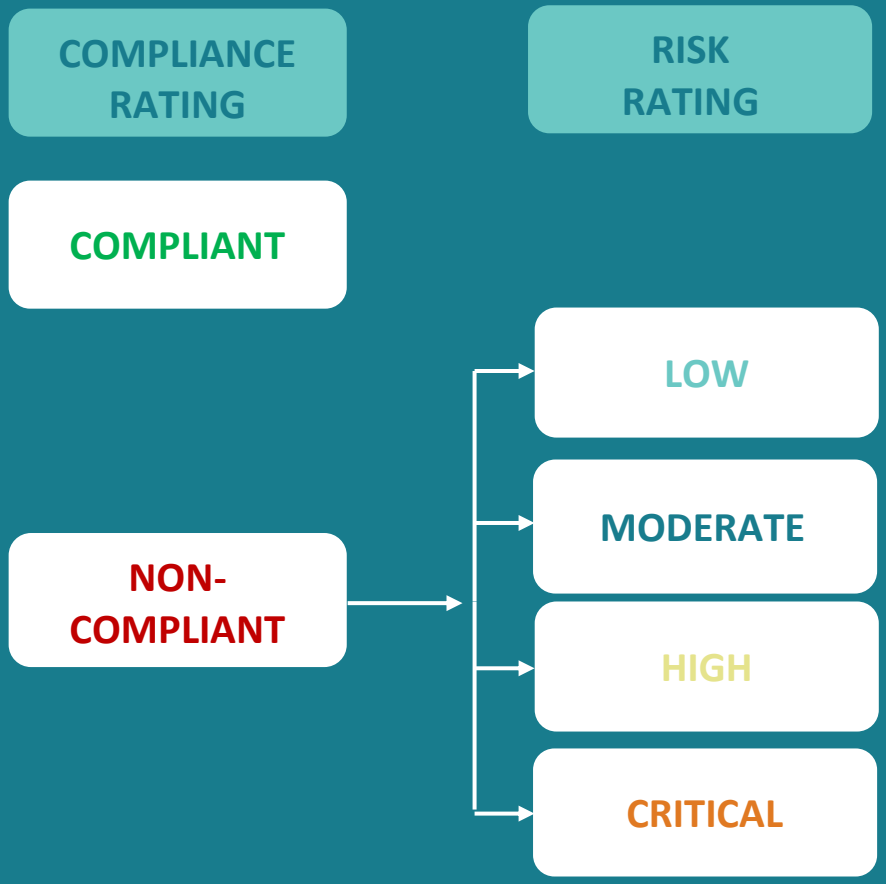
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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