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An Coillín

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

AN COILLÍN

Westport Road, Castlebar, Co Mayo

Date of Publication:
16 September 2025

ID Number: AC0080

2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay

Conditions Attached:
None

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson

Inspection Team:
Damien Lanigan, Lead Inspector
Aoife Gallaher
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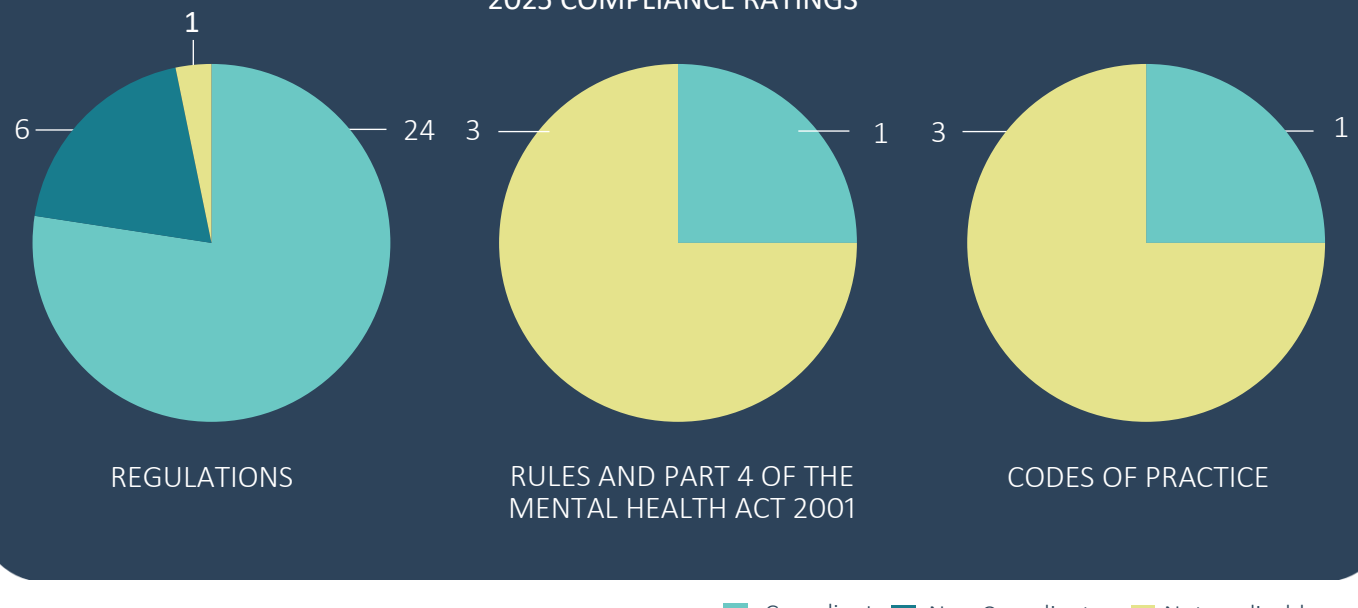
Inspection Date:
11 – 14 March 2025

Previous Inspection date:
25 – 28 June 2024

The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Type:
Unannounced Annual Inspection

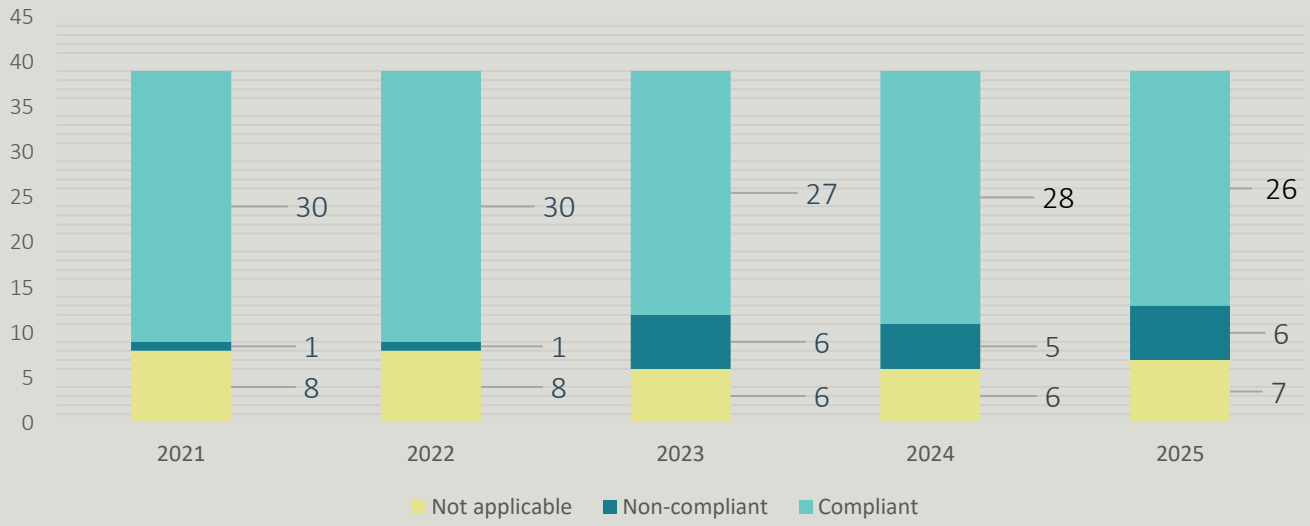
2025 COMPLIANCE RATINGS



RATINGS SUMMARY 2021 – 2025

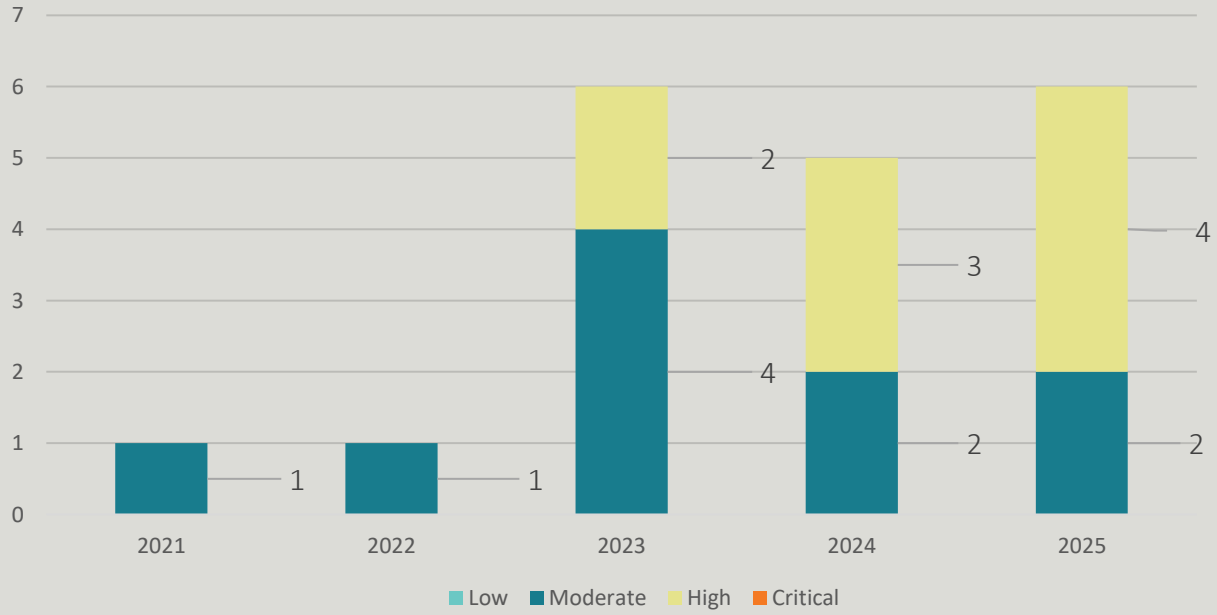
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2021 – 2025



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 2021 – 2025



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Professor James V Lucey

Description of Approved Centre

An Coillín was an approved centre that is registered with the Mental Health Commission for the provision of continuing mental health care. All residents received care and treatment from the Rehabilitation and Recovery multi-disciplinary team.

The approved centre was a single storey building, registered for eighteen beds. Residents were accommodated in a combination of single en suite bedrooms and shared rooms of up to four beds. Resident activity areas included a day room, a dining room, an activities room, an occupational therapy kitchen, an oratory, a visitor's room, and an enclosed garden. Whilst some improvements to the common areas in the premises had happened since the last inspection, the overall approved centre environment continued to need significant renovation and refurbishment.

Inspector of Mental Health Services Summary

An Coillín approved centre is located within the campus of former St. Mary's Psychiatric Hospital in Castlebar. The residents of the approved centre are cared for by one multi-disciplinary team (MDT) with a speciality of mental health rehabilitation. The approved centre is registered to accommodate 18 residents. The approved centre had no conditions attached to its registration.

The inspection was unannounced and occurred over four days. The inspection report reflects findings of the inspection over this period only. The inspection process was very well co-ordinated and prepared for by the staff and management in the approved centre.

This year the inspection team found six areas of non-compliance with minimum standards. Some of these areas were new and some were reoccurring since last year's inspection. The lack of a psychologist at the approved centre continues to be an issue directly impacting resident care. The local management team were restricted by the national recruitment policy and the fact that the psychology post has now been delimited, the impact of which is that the therapeutic needs of the residents were not met. Other areas of concern are that the areas within the approved centre are in a poor state of repair and that risks identified during the 2024 inspection are still apparent this year.

The inspection team observed that the approved centre had a skilled cohesive team, very invested in the resident care, who were caring and committed to the delivery of very good care and treatment in collaboration with the residents. The care delivered was aimed towards the residents living their lives in a meaningful way.

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

Resident Profile	
Number of registered beds	***18***
Total number of residents	**18**
Number of detained patients	5
Number of wards of court	5
Number of residents under the Assisted Decision Making Act	0
Number of children	0
Number of residents in the approved centre for more than 6 months	17
Number of patients on Section 26 leave for more than 2 weeks	0

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	97%	97%	82%	88%	81%

Conditions of registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

Please note, the information below in relation to the good practices and quality initiatives are as described by the service and provided to the inspection team.

The following quality initiatives were identified on this inspection:

- **Regulation 5: Food and Nutrition**
  - The service created an "Eating for a healthy heart" leaflet which identified ways in which residents could improve their cardiovascular health through food and included a visual guide of cardio protective food portions.

- **Regulation 9: Recreational Activities**
  - Occupational therapy staff provided each resident with individualised weekly activity schedules in their bedroom, which were specific to their interests.
  - The Castlebar Training Centre was facilitating chair yoga which was available for residents in An Coillín.
  - A Health Service Executive (HSE) employed musician visited An Coillín on a weekly basis and conducted a music group and there had been a very positive response from the residents to this initiative.

- **Regulation 19: General Health**
  - The approved centre promoted positive physical and mental health, and psychological wellbeing through general and targeted health promotion and preventive mechanisms. An Coillín partnered with health promotion campaigns such as Quit West team – A service provided by the HSE Health Promotion and Improvement team to support those who are stopping smoking and Healthy Ireland - whose goal is to prevent chronic disease by encouraging healthy lifestyle behaviours and creating healthier environments for the health benefit of the residents.
  - The physiotherapist in the approved centre co-facilitated a weekly boxing fitness group on the unit.

- **Regulation 27: Maintenance of Records**
  - An Coillín had established processes to identify areas for improvement in record management with weekly checks and annual audits. It also operated an electronic tracking record management system to enhance efficiency and traceability of clinical records.

- **Regulation 29: Operating Policies and Procedures**
  - The Rehab and Recovery team had developed a standard operational policy for the multi-disciplinary team. The policy detailed how the Rehabilitation and Recovery Team operates.

The purpose of the policy was to outline a specialised rehabilitation care pathway for people with complex mental health illness within Mayo, ensuring they had access to high quality mental health services and evidence-based interventions centred on clearly identified needs and service user preferences.

- **Regulation 31: Complaints Procedures**
    - Monthly residents' meetings were conducted at An Coillín where feedback from residents was encouraged and valued. Minutes of these meetings were recorded with actions, and these were followed up with residents, either at next meeting or in person. An Coillín also invited service users, families and friends to provide feedback during their resident's meetings & anonymously through the use of a suggestion box.

3.0 Governance

An Coillín was governed by the Mayo Mental Health Services (MMHS), which was part of the wider Community Healthcare West (CHW) region of Galway, Mayo, and Roscommon. The CHW region was in the process of changing over to the new Health Service Executive (HSE) Health Region-west and north-west and the Integrated Healthcare Area of Mayo, at the time of the inspection.

In the meantime, governance and oversight of MMHS remained with two core forums: the MMHS Area Management Team (AMT) meeting and the MMHS Quality and Patient Safety Committee (QPSC) meeting. Both meetings were scheduled monthly. The head of service chaired the MMHS QPSC meetings, which were attended by HSE managers, clinical leads, managers of health and social care disciplines, risk advisors, health and safety representatives, and senior administrators. The ECD chaired the MMHS AMT, which were attended by the head of service, HSE managers, clinical leads, managers of health and social care disciplines and senior administrators.

Sub-committees such as the Health and Safety Committee, the Policies, Procedures, Protocols and Guidelines (PPPG) Steering Group, the Drugs and Therapeutics Committee, the Infection Prevention Control Committee and the Multi-disciplinary Team Operational Group reported to the AMT and QPSC meetings. The Therapeutic Services and Programmes and Recreational Activity Group met bi-monthly and provided updates to the Operational Group. A multi-disciplinary approach was fostered within governance structures and clinical care, and an ethos of continuous quality improvement was evident. A Placement Committee Group met monthly to discuss bed management and the relocating of residents into the community where applicable.

Locally, the Multi-disciplinary Team Operational Group met monthly and monitored and updated the approved centre's risk register. This group also discussed matters relating to staff training, the reduction of restrictive practices within the approved centre and issues relating to health and safety. The Quality and Patient Safety Committee met monthly and monitored and maintained the Area Mayo Mental Health Services risk register. Minutes of these meetings documented discussion and review of any serious incidents that had taken place within the service. Complaints were also reviewed at this meeting.

Responsibilities for risk management were allocated at management level and throughout the approved centre to ensure effective implementation. There was a quality and patient safety advisor available to the approved centre and the person with overall responsibility for risk was identified and known by all staff. The approved centre had a local risk register and defined pathways for escalation and de-escalation of risks to and from QPSC and the AMT as appropriate. The risk register contained health and safety risks, clinical risks, corporate and operational risks. However, on inspection not all health and safety risks were identified, assessed, treated, reported or monitored on the risk register. Fire safety in the approved centre was compromised due to a failure to cumulatively consider the impact of the deficits in fire safety. Fire doors in the approved centre were not regularly reviewed on a structured and scheduled basis which did not allow for damaged fire doors to be identified and reported.

Fire training levels among staff were low with the type of training offered insufficient due to it having only an online component available to staff at the time of inspection. This was due to a change in the provider of fire safety training and the resulting gap in training provision. Fire training was not documented on the approved centers' training plan demonstrating a lack of planning of the in-person element of fire training for staff. A practice of wedging open fire doors was observed in the approved centre with plastic wedges, bins and chairs holding open fire doors. Governance of the fire safety processes was not effective and as a result there were not comprehensive risk management procedures in place to manage fire risk.

Any individual resident related risks were discussed by their treating team as required. Incidents were recorded and risk-rated on the National Incident Management System (NIMS) and were reviewed as appropriate to identify any trends or patterns occurring in the service. Serious Reportable Incidents (SRE's) were discussed and investigated by the Serious Incident Management Team (SIMT). There were clearly defined processes and procedures for learning from any near misses or incidents occurring in the approved centre. A program of auditing was conducted to assess compliance with regulatory standards and drive service improvements.

Organisational structures of leadership and the lines of authority and accountability were clearly identifiable within the approved centre. Governance questionnaires from each discipline provided the inspection team with information about their governance structures. Each head of discipline outlined clear strategic goals for the service and the systems that were in place to monitor goal attainment. Clinical supervision was provided for medical staff and the health and social care professional groups. There was evidence of appropriate line management supervision structures in place within each department.

The approved centre was not adequately staffed; the numbers and skill mix of the staffing were not sufficient to meet the residents' assessed needs. Heads of discipline reported staffing shortages. This included nursing and psychology which directly impacted on the provision of care and the therapeutic services and programmes received at the approved centre. The HSE recruitment practices impacted on the recruitment for vacant posts at the centre. Processes by local and area management to try to address these vacancies including applying through the national derogation scheme to approve recruitment had proved to be unsuccessful with the vacant psychology post being delimited by the HSE. Deficits in therapeutic psychology services were identified on resident care plans in An Coillín during this inspection. Risks identified to the provision of therapeutic services to residents due to staff shortages were documented on the local and area risk registers however appeared beyond the approved centres management control due to the HSE's Pay and Numbers Strategy in July 2024 which resulted in the approved centres psychology post being decommissioned. Nursing vacancies were managed using redeployment of staff from other areas of MMHS, overtime and agency staffing. All managers of health and social care disciplines said they were prioritising the approved centre in so far as practicable.

Resident input in governance and quality improvement processes was facilitated throughout the service. Resident community meetings and suggestion boxes provided residents with the forum to voice requests, suggestions and concerns. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service. Advocacy was provided weekly at the approved centre. The advocacy contact details were displayed within the approved centre. The process of making complaints and the Complaints Officer contact details were displayed within the approved centre and in the resident

information booklet. Complaints were dealt with by the staff in the approved centre and were documented with clear actions and outcomes detailed in a timely manner or in accordance with the approved centre's policy. The residents also benefited from input of a peer support worker and an Area Lead for Mental Health Engagement who attended management meetings relevant to the approved centre

There was a notable absence of restrictive practice use in An Coillín. Physical restraint was not used since the last inspection and centre did not use mechanical restraint. There were policies in place for the use of restrictive practices and a policy for the reduction of the use of restrictive practices. There was an oversight and review committee which met every three months to review any episodes of restrictive practice should they occur. A report was provided to the registered proprietor following each meeting.

4.0 Compliance

4.1 Compliant areas on this inspection

Please refer to **Appendix 2** for further guidance for compliance in relation to these regulations, rules and codes of practice.

Regulation/Rule/Act/Code		2025
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed Circuit Television	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 30: Mental Health Tribunals	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Part 4 Consent to Treatment	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

4.2 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 2021 and 2025 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2021		2022		2023		2024		2025	
Regulation 15: Individual Care Plan	✓		✓		✗	Moderate	✓		✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	Moderate	✗	High	✗	High
Regulation 22: Premises	✗	Moderate	✗	Moderate	✗	High	✗	High	✗	High
Regulation 23: Medication	✓		✓		✓		✓		✗	Moderate
Regulation 26: Staffing	✓		✓		✗	Moderate	✗	Moderate	✗	High
Regulation 32: Risk Management Procedures	✓		✓		✗	High	✗	High	✗	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.

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre had not admitted any children 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.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice 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.

Two residents availed of the opportunity to meet with the inspection team during the inspection and six completed questionnaires were also received from residents during the inspection.

Of the six completed questionnaires, five respondents indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood and one indicated no to the question. Four respondents indicated that they always received information on their diagnosis, care and treatment in a way that they understood, and two respondents indicated sometimes to this question. Five respondents indicated that they found the information useful, and one indicated partially to this question.

All six respondents indicated that they understood what their care plan was. Four indicated that they were always involved in setting goals for their individual care plans while one indicated sometimes to this question, and one did not want information on their careplan. Five of the six of the respondents indicated that they knew their multi-disciplinary team members, with all six indicating that they knew their keyworkers.

Five respondents indicated that they were always able to discuss worries or concerns with a member of staff with one indicating sometimes to the question. All six respondents felt there was enough leisure activities in the approved centre and all six respondents felt there was enough group activities and talking therapies available. All six respondents indicated that they were happy with how staff spoke with them. Five of the six felt their privacy and dignity was respected and one did not.

All six respondents indicated that they could communicate freely with family, friends and the advocate. Five of the six respondents indicated that they always felt safe in the approved centre, and one indicated sometimes to this question. Four respondents indicated that they were always able to give feedback to staff, and to make a complaint when they were not satisfied with any part of their stay and two indicated sometimes to this question.

General comments by the residents included that the access to the activities and therapeutic groups were good and that they enjoyed the food provided. They felt safe and happy in the approved centre and those in single bedrooms enjoyed the privacy it provided.

On a scale of 1-10, with 1 being poor and 10 being excellent for their overall experience of care and treatment at the approved centre. One resident rated it 7 out of 10, two residents rated it 8 out of 10, and one rated it at 9 out of 10, and two rated it at a 10 out of 10.

5.2 Advocacy

The approved centre had an advocacy service, and the inspectors received a report from the Peer Advocacy in Mental Health representative. Their report included the following:

Residents reported enjoying recreational and therapy groups such as baking, art, music, arts and crafts, cooking, gardening, exercise and walking. Residents reported they liked having the freedom to “come and go” from the unit. Residents reported appreciating one to one time with staff to support them with activities like shopping and personal care. They report that they enjoy the garden and outdoor space and that they appreciate the comfortable chairs and the large screen TV in the sitting room. They said that they like having visitors and getting to visit family.

The report stated residents enjoyed organised trips to local amenities with the support of staff and the peer support worker. Resident said that they appreciate the care given at the approved centre and how staff will facilitate their needs including access to mass, seasonal celebration days and support with accessing necessary health appointments and care.

Areas for improvement outlined in the report included that residents would like to have more single rooms in the approved centre so they can have quiet spaces for themselves and that when building works are happening at the centre that noise and disruption to residents should be kept at a minimum.

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
- General Manager/Business Manager
- Area Director of Nursing
- Occupational Therapy Manager
- Occupational Therapist
- Psychology Manager
- Principal Social Worker
- Area Lead for Mental Health Engagement
- Nurse Practice Development Coordinator
- Regulatory Compliance Advisor
- Acting Assistant Director of Nursing
- Clinical Nurse Manager 3
- Consultant
- Pharmacist
- Dietetics Manager
- Maintenance Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

*Please see **Section 4.1: Compliant areas on this inspection** for the list of compliant Regulations on this inspection.*

*Please see **Section 4.2: Non-compliant areas on this inspection** for the list of non-compliant regulations on this inspection.*

*Please see **Section 4.3: Areas that were not applicable on this inspection** for the list of regulations that were not applicable on this inspection.*

Regulation 15: Individual Care Plan

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). The Individual Care Plans (ICPs) addressed the resident's goals, mental health care and treatment needs based on a multi-disciplinary team assessment of the person and where practicable, in consultation with them. The ICPs were identifiable and uninterrupted. ICPs were not amalgamated with progress notes.

The ICPs were developed by the MDT following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, as appropriate. The ICPs identified appropriate goals for the resident, in addition to the care and treatment required to meet those goals and responsibilities. The ICPs were reviewed by the MDT in consultation with the resident; every six months for residents in this continuing care facility. Following this review, the ICPs were updated contemporaneously in accordance with best practice to reflect any changes to the goals, treatment, care, and required resources as per the assessed needs of the resident.

Two residents ICPs identified a need for psychology assessments by the MDT team. No referral or follow up in the progress notes or care plans were evident. There was a vacant psychology post at approved centre. A process existed where psychology referrals were to be sent to principal psychologist in these cases, however, this did not happen. In response to the inspection findings, a written protocol to address how psychology referrals could be escalated to psychology manager was developed by the service during the inspection to remedy this gap in resources. This protocol aims to ensure to access to psychology services for residents in An Coillín.

The approved centre was non-compliant with this regulation because two individual care plans where psychology was identified as a need, were not followed up and did not address the psychology resources required to provide the care and treatment identified.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre did not provide therapeutic services that were appropriate and met the assessed needs documented in residents' individual care plans. The approved centre did not have a psychologist allocated to the unit. There was a vacant psychology post since March 2022. Two individual care plans identified the need for psychology assessment; however, the appropriate therapeutic service was not provided to meet the assessed need.

The therapeutic programme was provided by the occupational therapist and occupational therapy assistant. The social work involved both individual and group work. The therapeutic groups which took place included the following: gardening, walking, beauty and spa, lunchtime cookery, an 'Action group' which was a weekly gym group, smoothie making, and a baking group. A physiotherapist facilitated a boxercise group once a week, a musician and art therapist also attended weekly. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location such as Dietetics and speech and language therapy which were accessed on a referral basis.

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

a) **The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan. Two individual care plans identified the need for psychology assessment; however, the appropriate therapeutic service was not provided to meet the assessed needs, 16(1).**
b) **The registered proprietor did not ensure that services provided were directed towards restoring and maintaining optimal levels of psychosocial functioning of residents due to the limited availability of psychology services within the approved centre, 16(2).**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms and bedrooms were provided. There was suitable and sufficient heating in day areas and bedrooms. Rooms were centrally heated. Rooms were well ventilated. All private and communal areas were adequately sized and furnished to remove excessive noise. The lighting in communal rooms suited the needs of residents and staff. It is sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support residents in finding their way around the approved centre.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Based on risk assessment, ligature points have been minimised to the lowest possible level where practical. All bathroom, shower, toilet and single bedroom locks had an override function. There was a sufficient number of toilets and showers for residents in the approved centre, and at least one assisted toilet. The approved centre had dedicated sluice and cleaning rooms, as appropriate.

Hazards were not minimised at the approved centre, specifically there were uneven paving blocks in the outdoor garden area due to tree roots raising up out of the ground, which constituted a trip hazard. This was identified during the 2024 inspection and safety cones were put in place by the maintenance department then. However, during the inspection, these cones were found to be ineffective in controlling or mitigating the trip hazard risk and did not cordon off all areas of uneven paving blocks in the garden.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. However, despite this the approved centre was not kept in a good state of repair. Flooring within the approved centre, in the communal corridors had been renovated to a high standard and had greatly improved those areas. Flooring in residents' bedrooms and bathrooms, however, were in a poor condition and was worn and potted and in need of renovation. There was a plan in place to do address these areas of flooring. The en suite bathrooms in resident bedrooms evidenced damaged shower screens, broken tiles, decommissioned rusted toilet brush holders and flooring that was lifting and damaged. Intumescent strips on corridor fire doors were missing, impacting the doors function to protect against fire and or smoke spreading in the event of a fire.

The approved centre was not clean, hygienic and free from offensive odours. There was a cleaning schedule in place, however the inside of windows was marked, cobwebs were evident on window openings of shower rooms, a grab rail within a bathroom had a dried stain running along the bar, a door frame had staining around the wooden frame by the handle of the bedroom door. A mattress in a resident bedroom had a dried stain present. Graffiti was evident on the back of a male toilet cubicle. The assisted

bathroom radiator had staining on and behind the radiator. In some bathrooms, decommissioned toilet brush holder were used as a bin with tissue inside and cobwebs were evident and were not cleaned.
The smell of smoke was evident along the corridor and in residents' rooms and beside the day room. Residents were not permitted to smoke in their rooms, however, the placement of an ashtray within the egress space to the garden was prompting residents to smoke in this space. The smoking area had cigarette butts on the ground and ash. As a result, the smell of smoke was lingering within the approved centre. This also resulted in the emergency exit doors and emergency exit signage being covered in a layer of residue from the smoke.

The approved centre provided enough toilets and showers for residents, with at least one assisted toilet. The approved centre provided suitable furnishings to support resident independence and comfort, including non-weight bearing clips to assist in hanging up clothing were placed in bedrooms following the last inspection; however, they had been removed in some instances. The approved centre provided assisted devices and equipment to address resident needs. Current national infection control guidelines were followed.

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

a) **The approved centre was not clean, hygienic and free from offensive odours; the inside of windows were marked, cobwebs were evident on window openings of shower rooms, a grab rail within a bathroom had a dried stain running along the bar, a door frame had staining around the wooden frame by the handle of the bedroom door. A mattress in a resident bedroom was noted to have a dried stain present. Graffiti was evident on the back of a male toilet cubicle. The assisted bathroom radiator had staining on and behind the radiator. In some bathrooms, decommissioned toilet brush holder were used as a bin with tissue inside and cobwebs were evident and were not cleaned. The smell of smoke was evident along the corridor and in residents' rooms and beside the day room. Residents smoking within the egress space to the garden resulted in the smell of smoke lingering within the approved centre. The smoking area had cigarette butts on the ground and ash. This also resulted in the emergency exit doors and emergency signage being covered in a layer of residue from the smoke, 22(1).**
b) **The approved centre was not kept in a good state of repair internally; en suite bathrooms evidenced damaged shower screens, broken shower tiles, cigarette burns evident on flooring and decommission steel toilet brush holders that were rusted. Flooring in resident's bedrooms and bathrooms was worn and potted, 22(1).**
c) **Hazards were not minimised at the approved centre; there were uneven paving blocks due to tree roots rising up in the in the outdoor garden area which constituted a trip hazard, 22(3).**
d) **Intumescent strips on corridor fire doors were missing, impacting the doors function to protect against fire and or smoke spreading in the event of a fire, 22(3).**

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

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in June 2023 and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPARs contained a detailed record of a medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident had none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.
However, in the case of one resident's MPAR, a record of all medications administered to that resident was not recorded or a reason why the medications was not administered, was not recorded, on 21 separate occasions.

All entries in the MPAR's were legible with a signature of the medical practitioner for each entry. 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.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified.

The approved centre was non-compliant with this regulation because in one of five Medication Prescription and Administration Records inspected, a record of all medications administered to the resident was not documented on 21 occasions, 23(1).

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

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

There was one multi-disciplinary specialist rehabilitation and recovery team for the approved centre. This included medical, nursing, social work, and occupational therapy staff. There were specialist mental health pharmacists that attended all MDT meetings. General health services such as physiotherapy and speech and language therapy were available via a referral processes.

An appropriately qualified staff member was on duty and in charge at all times and this was documented. The numbers and skill mix of staffing in the approved centre was not sufficient to meet resident assessed needs. There was no psychologist in the approved centre since the psychologist post became vacant in March 2022. The HSE recruitment practices impacted on the recruitment for vacant posts at the centre. Processes by local and area management to try to address these vacancies including applying through the national derogation scheme to approve recruitment had proved to be unsuccessful with the vacant psychology post being delimited by the HSE.

There was an annual training plan broken down into quarters which included a process for booking training places, monitoring and recording of attendance, and updating the staff training records. However, the staff training records showed that not all staff had completed mandatory training in Basic Life Support, Fire Safety, Management of Violence and Aggression and Safeguarding. All mandated persons in the approved centre were trained in Children First. Those who were due to recertify, were booked in as part of the approved centres training plan.

The training plan did not include fire training at the time of inspection and numbers trained were at a low level due to a number of staffs certification expiring in February 2025. This shortfall in training was addressed during the inspection by the approved centre, and a plan put in place to have staff complete the online portion of the fire training. A new service provider of fire training had recently commenced at the centre also who would be providing the in person element of the fire training to staff.

The following is a table of staff showing the numbers and percentages of staff trained in the mandatory training topics at the time of inspection:

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing	27	96%	10	36%	28	100%	28	100%	28	100%	26	93%
Medical	3	100%	3	100%	2	67%	3	100%	3	100%	3	100%
Occupational Therapist	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker	0	0 %	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian	1	100%	1	100%	1	100%	1	100%	N/A	N/A	1	100%
Pharmacist	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Peer Support	2	100%	2	100%	2	100%	1	50%	2	100%	2	100%

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

a) **The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre, there was no psychologist in the approved centre since the psychologist post became vacant in March 2022, 26(2).**

b) **The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, in that all staff were not trained in Basic Life Support, Fire Safety, Management of Violence and Aggression and Safeguarding, 26(4).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a series of written operational policies and procedures in relation to risk management. The risk management policy was last reviewed in October 2022. The risk management policy addressed all requirements including:

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

Responsibilities were 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. Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. The health and safety risks associated with the trip hazards in the garden were not removed or effectively mitigated.

The approved centres risk management policy was not fully implemented throughout the approved centre as two fire doors were observed to be wedged open which compromised fire safety and integrity of fire compartments. Fire doors were missing intumescent strips that would reduce effectiveness of the fire doors and there was also no structured or scheduled monitoring of the internal fire doors to identify potential issues. Fire training was not part of the annual training plan for staff with only 36% of nursing staff having completed fire training at the time of inspection. Fire training was offered in an online format and the training plan lacked a planned in person practical element.

While clinical, and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate, health and safety risks relating to fire safety deficits found on inspection were not identified, assessed, treated and monitored within the risk register.

Individual risk assessments were completed in conjunction with admission, medication requirements or administration, and at resident transfer and resident discharge. Multi-disciplinary teams were involved in the development, implementation and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children within the approved centre were appropriate and implemented as required.

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

a) **The registered proprietor did not ensure that the approved centres risk management policy was implemented throughout the approved centre in that fire doors were missing intumescent strips and wedged open and not all staff had completed fire safety training, 32(1).**
b) **Health and safety risks relating to fire safety; including, fire doors being wedged open, missing intumescent strips on fire doors and a lack of monitoring of the fire doors on a scheduled basis, low numbers of staff trained in fire training and the type of training offered were not identified, treated and monitored within the risk register, 32(1).**
c) **The risk management procedures to manage trip hazards at the approved centre did not actively reduce the identified risks to the lowest practicable level of risk, 32(1).**

8.0 Inspection Findings – Rules

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

*None of the rules were applicable on this inspection. Please see **Section 4.3: Areas that were not applicable on this inspection**.*

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 compliant on inspection. Please see **Section 4.1: Compliant areas on this inspection**.*

10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51(1)(b)(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.

*Please see **Section 4.1: Compliant areas on this inspection** for the list of compliant codes of practice on this inspection.*

*Please see **Section 4.3: Areas that were not applicable on this inspection** for the list of codes of practice that were not applicable on this inspection.*

Appendix 1: Corrective and Preventative Action Plan (CAPA)*

*CAPAs submitted by the registered proprietor nominee were requested and approved by the Mental Health Commission and incorporated in this inspection report. CAPAs are included in the report *verbatim* as received from the registered proprietor nominee.

Regulation 15: Individual Care Plan					
Reason ID : 10006419		**Two individual care plans where psychology was identified as a need, were not followed up and did not address the psychology resources required to provide the care and treatment identified.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The psychology post within An Coillin has been vacant since March 2022 and was subsequently decommissioned in 2024 under the Pay and numbers strategy. In the absence of a psychology post within An Coillin and as an interim measure a psychology Referral Protocol has been developed (attached) which outlines the process for referring residents for psychological input. Through the implementation of	Quarterly audit of ICPs. Weekly MDT reviews.	Yes	13/03/2025	Principal Psychologist Manager.

	this protocol, psychology resources were identified in relation to the two Individual Care Plans with a view to providing the care and treatment for the individuals.				
Preventative Action	As an interim measure, the psychology referral protocol ensures a clear standardised approach to accessing psychological services in response to identified needs. However, this is not sustainable in the longer term. The lack of a psychologist within An Coillin has been identified as a risk and placed on the An Coillin Risk Register. Continued efforts have been made by Psychology Management and MMHS to recommission the psychology post and	Quarterly audit of ICPs. Weekly MDT reviews	Yes	13/03/2025	Principal Psychologist Manager.

	a further business case seeking re-instalment of the post will be submitted under the 2026 Estimates programme.				

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10006420		**The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan. Two individual care plans identified the need for psychology assessment; however, the appropriate therapeutic service was not provided to meet the assessed needs, 16(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	As noted above, the psychology post within An Coillin has been vacant since March 2022 and was subsequently decommissioned in 2024 under the Pay and Numbers strategy. In the absence of a psychology post within An Coillin and as an interim measure, a Psychology Referral Protocol has been developed (attached) which outlines the process for referring residents for psychological input. Psychology resources have been identified in relation to the two service users with a view to providing	Quarterly audits of ICPs Weekly MDT reviews.	Yes	13/03/2025	Principal Psychologist Manager .

	appropriate care and treatment.				
Preventative Action	The Psychology Referral Protocol, as an interim measure ensures a clear standardised approach to accessing psychological services in response to identified needs, however this process is not sustainable in the longer term. The lack of a psychologist within An Coillin has been identified as a risk and placed on the Risk Register in An Coillin. Continued efforts have been made by Psychology management and MMHS to recommission the psychology post and a further business case seeking re-instatement of the post will be submitted under the 2026 estimates process.	Quarterly reviews. Weekly MDT reviews.	Yes	13/03/2025	Principal Psychologist Manager.

Reason ID : 10006421		The registered proprietor did not ensure that services provided were directed towards restoring and maintaining optimal levels of psychosocial functioning of residents due to the limited availability of psychology services within the approved centre, 16(2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Despite advertising and upgrading the psychology post within An Coillin, it has been vacant since March 2022 and was subsequently decommissioned in2024 under the Pay and Numbers strategy. In the absence of a psychology post within An Coillin and as an interim measure, a Psychology Referral Protocol has been developed (attached) which outlines the process for referring residents for psychological input.	Quarterly ICP reviews. Weekly MDT reviews.	Yes	13/03/2025	Principal Psychologist Manager.
Preventative Action	The lack of a psychologist within An Coillin has been identified as a risk and has been placed on the risk register in An Coillin. Continued	Quarterly ICP reviews. Weekly MDT reviews.	Yes	13/03/2025	Principal psychologist Manager.

	efforts have been made by psychology management and MMHS to recommission the psychology post and a further business case seeking re-instatement of the post will be submitted under the 2026 Estimates process.				

Regulation 22: Premises					
Reason ID : 10006422		**The approved centre was not clean, hygienic and free from offensive odours; the inside of windows were marked, cobwebs were evident on window openings of shower rooms, a grab rail within a bathroom had a dried stain running along the bar, a door frame had staining around the wooden frame by the handle of the bedroom door. A mattress in a resident bedroom was noted to have a dried stain present. Graffiti was evident on the back of a male toilet cubicle. The assisted bathroom radiator had staining on and behind the radiator. In some bathrooms, decommissioned toilet brush holder were used as a bin with tissue inside and cobwebs were evident and were not cleaned. The smell of smoke was evident along the corridor and in residents' rooms and beside the day room. Residents smoking within the egress space to the garden resulted in the smell of smoke lingering within the approved centre. The smoking area had cigarette butts on the ground and ash. This also resulted in the emergency exit doors and emergency signage being covered in a layer of residue from the smoke, 22(1).**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Marked windows, Cobwebs on Window openings, grab rail in bathroom, stained door frame, graffiti on back of male toilet door, the assisted bathroom radiator were actioned and cleaned by the contracted cleaners by 18th March 2025 Decommissioned toilet brush holders were logged with Maintenance Dept and have been removed.	All items listed inspected by Contract Cleaners Site Manager and IPCN on 18th March 2025 to ensure tasks completed effectively	yes	18/03/2025	Area Director of Nursing, IPCN, Business Manager, Maintenance Manager.

Preventative Action	Monthly Environmental Hygiene Audits Completed by Contracted cleaning site manager, area Manager and IPCN. The Environmental Hygiene audit tool was updated in April to more accurately reflect the environment. Within two weeks of the formal Environmental Hygiene audit being completed a walk around of the Unit is conducted by the Contract Cleaning site manager and the IPCN An Environmental Hygiene checklist was introduced on 1st April 2025. This highlights if an area is unable to be cleaned for any reason. This provides a process of accountability for staff. Emergency doors and signage covered in a residue	Monthly audits occur unannounced on different dates of the month Ensure follow up on any items that were actioned during Audit process This ensures that if any area has not been cleaned the area is identified and the reason why it has not been cleaned. Also used as a tool to identify if cleaning schedules are working appropriately.	yes	01/04/2025	Area Director of Nursing, IPCN, Business Manager, Maintenance Manager.

	of smoke have been cleaned and cigarette and ash removed and the area cleaned. Residents are encouraged not to smoke in the premises and in particular within the egress space. Residents are offered smoking cessation programme at each physical health review.				
Reason ID : 10006423		**The approved centre was not kept in a good state of repair internally; en suite bathrooms evidenced damaged shower screens, broken shower tiles, cigarette burns evident on flooring and decommission steel toilet brush holders that were rusted. Flooring in resident's bedrooms and bathrooms was worn and potted, 22(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Costings are being sought for upgrade works on the WCs and Bedrooms including flooring. Toilet brush holders have been replaced.	Quarterly review of maintenance audit with Maintenance Manager, Nurse Manager and Infection Control.	yes	01/01/2026	Maintenance Manager, Business Manager, Area Director of Nursing.
Preventative Action	WCs, Bedrooms and floor covering, costings are being sought for upgrade works. Annual Audit of Reg 22 Premises with quarterly	Quarterly review of maintenance audit with Maintenance Manager, Nurse Manager and Infection Control.	yes	01/01/2026	Maintenance Manager, Business Manager, Area Director of Nursing.

	reviews and updates involving all key stakeholders. Daily walk around by nurse management and any deterioration reported to maintenance.				
Reason ID : 10006424		**Hazards were not minimised at the approved centre; there were uneven paving blocks due to tree roots rising up in the in the outdoor garden area which constituted a trip hazard, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Tree surgeon has been contacted to remove trees to allow further repair works to be carried out.	Quarterly maintenance audit review by Maintenance Manager.	yes	01/01/2026	Maintenance Manager, Business Manager, Area Director of Nursing.
Preventative Action	A barrier has been put in place to prevent residents and staff from accessing the hazard area.	Quarterly maintenance audit review by maintenance manager.	yes	01/01/2026	Maintenance Manager, Business Manager, Area Director of Nursing.
Reason ID : 10006425		**Intumescent strips on corridor fire doors were missing, impacting the doors function to protect against fire and or smoke spreading in the event of a fire, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire Door Intumescent strips have been replaced. Specialist fire door contractors attending site to carry out survey on all doors.	Fire register checked and filled on a weekly basis.	Yes	01/04/2025	Maintenance Manager, Business Manager
Preventative Action	Proposed that contractors will carry out a fire survey on a	Fire register checked and filled weekly.	yes	01/01/2026	Maintenance Manager , Business Manager

	quarterly or biannual basis. A process is in place to appoint these contractors.				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10006428		**In one of five Medication Prescription and Administration Records inspected, a record of all medications administered to the resident was not documented on 21 occasions, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Medication management training carried out by all staff involved. Medication prescription administration record audit completed by both Nursing and Pharmacist. Frequency of audit increased to weekly following inspection, for 6 weeks and due to improvements in findings of audit MPAR's audit currently carried out fortnightly.	MPAR's audits	yes	01/07/2025	Area Director of Nursing, Pharmacist.
Preventative Action	All staff made aware of necessity of accurate medication documentation. Fortnightly audits.	MPAR's Audits	yes	01/07/2025	Area Director of Nursing, Pharmacist.

Regulation 26: Staffing					
Reason ID : 10006426		**The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre, there was no psychologist in the approved centre since the psychologist post became vacant in March 2022, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff grade psychology post was advertised on the HSE national staff grade psychology panel. It was unable to be filled due to lack of expression of interest. The post was then upgraded to a Principal Specialist Psychology post. This was done in an effort to fill the post, address the psychology needs in An Coillin and help meet the governance requirements for psychology within the Mayo Mental Health Services (MMHS). This was approved and was with the recruitment service, however it has been affected by the	Annual audit of Reg 16 and ongoing monitoring by Area Management Team	Extremely challenging due to the embargo approx. 50% of 2023 posts in psychology in MMHS are currently unfilled	13/03/2025	Principal Psychologist & Business Manager

	recruitment embargo. The post of Principal Psychologist Specialist based in An Coillin was escalated for consideration for derogation from the recruitment pause a number of times most recently Sept 2024. On the 18th Oct 2024 HR informed MMHS that as this post was vacated in March 2022 and this post is now decommissioned. A request had been made to the Head of Service that this post would be recommissioned as a priority. In the interim, psychology cross cover has been provided where possible. This has included providing group psychological interventions to maximise the number of residents that				

	could be seen by psychology. Psychology cross cover also included completion of assessments, interventions and consultation on cases since the initial post was vacated. A psychology Referral Protocol was subsequently developed (attached) which outlines the process for referring residents for psychological input and ensures a clear standardised approach to accessing psychological services in response to identified needs. The identified risk is on the An Coillin Risk Register.				
Preventative Action	As an interim measure, a Psychology Referral Protocol has been developed and implemented by the	Annual audit of Reg 26 and ongoing monitoring by Area Management Team	Extremely challenging due to the embargo approx. 50% of 2023 posts in psychology in MMHS are currently unfilled.	31/08/2025	Principal Psychologist & Business Manager

	Psychology Manager to ensure a clear standardised approach to accessing psychological services in response to identified needs. Continued efforts have been made by Psychology Management and MMHS to recommission the psychology post and a further business case seeking re-instatement of the post will be submitted under the 2026 Estimates process.				
Reason ID : 10006427		**The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, in that all staff were not trained in Basic Life Support, Fire Safety, Management of Violence and Aggression and Safeguarding, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1: Currently 90% of all staff are trained in Basic Life support (BLS). The training calendar for Sept-Dec 2025 is currently being devised by	Ongoing monitoring of staff training records.	Yes	31/12/2025	Area Director of Nursing. Principal Psychologist Manager, OT Manager, SW Manager.

	NPDC and will be circulated to all staff in the next 2 weeks. Staff that require BLS training will be booked in for same at the earliest available date. 2: Management of Violence and aggression. Currently 92% of all staff have completed this training. A plan is in place to recommence a training schedule in September 2025. The training calendar for Sept-Dec 2025 is currently being devised by NPDC and will be circulated to all staff in the next 2 weeks. Staff that require updated training in Therapeutic Management of Violence Aggression will be booked in for same at the earliest available date. 3: Fire Safety: 100% of all staff have completed				

	online fire safety training. Fire safety face to face training is planned for July 21st and 22nd, 9th and 10th September, 17th and 18th September, 1st 3rd and 10th October. 4: Safeguarding: 100% of all staff have completed this training and the remaining staff are being encouraged to complete the training.				
Preventative Action	Ongoing monitoring of staff training records. Heads of Department will ensure all staff complete training when it is due.	Ongoing monitoring of staff training records.	yes	31/12/2025	Area Director of Nursing. Principal Psychologist Manager, OT Manager, SW Manager.

Regulation 32: Risk Management Procedures					
Reason ID : 10006413		**The registered proprietor did not ensure that the approved centres risk management policy was implemented throughout the approved centre in that fire doors were missing intumescent strips and wedged open and not all staff had completed fire safety training, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1: Fire Door intumescent strips have been replaced. 2: Wedges removed and all staff instructed not to have any obstruction to the working of the fire doors. 3: 100% of all staff have completed online fire training. Fire safety face to face training planned for 21st and 22nd July, 9th and 10th September, 17th and 18th September, 1st 3rd and 10th October. 69% of Nursing staff have completed the face to face fire training to date. Risk assessment completed and on An Coillin Risk Register	An Coillin Fire register checked and filled weekly.	Yes	01/11/2025	Maintenance Manager, Area Director of Nursing, Principal Psychologist Manager, OT Manager, SW Manager.

Preventative Action	Specialist fire door contractors attending site to carryout survey on all doors. Process is in place to appoint contractors to carry out regular surveys on all fire doors. Risk register is reviewed on a monthly basis at the Operational group meeting in An Coillin. Continue with fire training programme.	Fire register checked and filled weekly.	Yes	01/11/2025	Maintenance Manager, Area Director of Nursing. Principal Psychologist Manager, OT Manager, SW Manager.
Reason ID : 10006414		**Health and safety risks relating to fire safety; including, fire doors being wedged open, missing intumescent strips on fire doors and a lack of monitoring of the fire doors on a scheduled basis, low numbers of staff trained in fire training and the type of training offered were not identified, treated and monitored within the risk register, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1: Fire Door intumescent strips have been replaced. 2: Wedges have been removed and Staff have been instructed to be vigilant in relation to obstructions to the fire doors. 3: 100% of all staff have completed online fire training. Fire safety face to face training	Risk register is reviewed on a monthly basis at the Operational group meeting in An Coillin. Fire register checked and filled weekly.	Yes	01/11/2025	Business Manager, Area Director of Nursing. Maintenance Manager, Principal Psychologist Manager, OT Manager, SW Manager.

	planned for 21st and 22nd July, 9th and 10th September, 17th and 18th September, 1st 3rd and 10th October. 69% of Nursing staff have completed the face to face fire training to date. Fire drills carried out on a monthly basis. 4: Health and Safety risk relating to fire have been identified, treated and will be monitored within the risk register.				
Preventative Action	Specialist fire door contractors attending site to carryout survey on all fire doors. Process is in place to appoint contractors to carry out regular surveys on all fire doors.	Risk register is reviewed on a monthly basis at the Operational group meeting in An Coillin. Fire register checked and filled weekly.	Yes	01/11/2025	Business Manager, Area Director of Nursing, Maintenance Manager.
Reason ID : 10006415		**The risk management procedures to manage trip hazards at the approved centre did not actively reduce the identified risks to the lowest practicable level of risk, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A tree surgeon has been contacted to remove the tree in order that the	Quarterly review and updated premises audit completed with	Yes	01/01/2026	Maintenance Manager, Business Manager, Area Director of Nursing.

	uneven paving blocks can be replaced in order to eliminate the trip hazard.	key stakeholders, Maintenance			
Preventative Action	A temporary barrier has been put in place to prevent residents and staff from entering the hazard area. Risk assessment completed on An Coillin Risk Register	Quarterly review and updated premises audit completed with Maintenance, Business Manager and Nurse Managers. Risk register is reviewed on a monthly basis at the Operational group meeting in An Coillin.	yes	01/01/2026	Maintenance Manager, Business Manager, Area Director of Nursing.

Appendix 2: REGULATIONS, RULES and CODES of PRACTICE

REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

Regulation 4: Identification of Residents

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

Regulation 5: Food and Nutrition

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

Regulation 6: Food Safety

(1) The registered proprietor shall ensure:
(a) the provision of suitable and sufficient catering equipment, crockery and cutlery
(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and
(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.
(2) This regulation is without prejudice to:
(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
(c) the Food Safety Authority of Ireland Act 1998.

Regulation 7: Clothing

The registered proprietor shall ensure that:
(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

Regulation 8: Residents' Personal Property and Possessions

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.
(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.
(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.
(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.
(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.
(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

Regulation 9: Recreational Activities

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

Regulation 10: Religion

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

Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.
(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.
(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.
(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.
(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.
(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

Regulation 12: Communication

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.
(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.
(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.
(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

Regulation 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.
(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.
(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.
(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.
(6) The registered proprietor shall ensure that there is 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.

Regulation 14: Care of the Dying

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.
(2) The registered proprietor shall ensure that when a resident is dying:
(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
(b) in so far as practicable, his or her religious and cultural practices are respected;
(c) the resident's death is handled with dignity and propriety, and;
(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.
(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
(a) in so far as practicable, his or her religious and cultural practices are respected;
(b) the resident's death is handled with dignity and propriety, and;
(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.
(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

Regulation 15: Individual Care Plan

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

Regulation 16: Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.
(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

Regulation 17: Children's Education

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

Regulation 18: Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.
(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

Regulation 19: General Health

(1) The registered proprietor shall ensure that:
(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
(c) each resident has access to national screening programmes where available and applicable to the resident.
(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

Regulation 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:
(a) details of the resident's multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.
(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

Regulation 21: Privacy

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

Regulation 22: Premises

(1) The registered proprietor shall ensure that:
(a) premises are clean and maintained in good structural and decorative condition;
(b) premises are adequately lit, heated and ventilated;
(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.
(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.
(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.
(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.
(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.
(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

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

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.
(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

Regulation 24: Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.
(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

Regulation 25: Use of Closed Circuit Television

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:
(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
(b) it shall be clearly labelled and be evident;
(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.
(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.
(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

Regulation 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.
(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.
(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.
(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

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

Regulation 28: Register of Residents

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

Regulation 29: Operating Policies and Procedures

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

Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.
(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.
(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.
(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.
(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.
(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.
(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.
(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.
(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

Regulation 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.
(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
(a) The identification and assessment of risks throughout the approved centre;
(b) The precautions in place to control the risks identified;
(c) The precautions in place to control the following specified risks:
(i) resident absent without leave,
(ii) suicide and self harm,
(iii) assault,
(iv) accidental injury to residents or staff;
(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
(e) Arrangements for responding to emergencies;
(f) Arrangements for the protection of children and vulnerable adults from abuse.
(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

Regulation 33: Insurance

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

Regulation 34: Certificate of Registration

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

RULES UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

Rule: Section 59: The Use of Electro-Convulsive Therapy

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

Rule: Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of

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

Rule: Section 69: The Use of Mechanical Restraint

(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.

PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 Consent to Treatment

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –
a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.
57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
(2) This section shall not apply to the treatment specified in section 58, 59 or 60.
60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-
a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,
And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.
61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –
a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,
And the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51(1)(b)(iii)

Code of Practice: Use of Physical Restraint

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

Code of Practice: Admission of Children

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

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

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

Code of Practice: Admission, Transfer and Discharge

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

Appendix 3: 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.

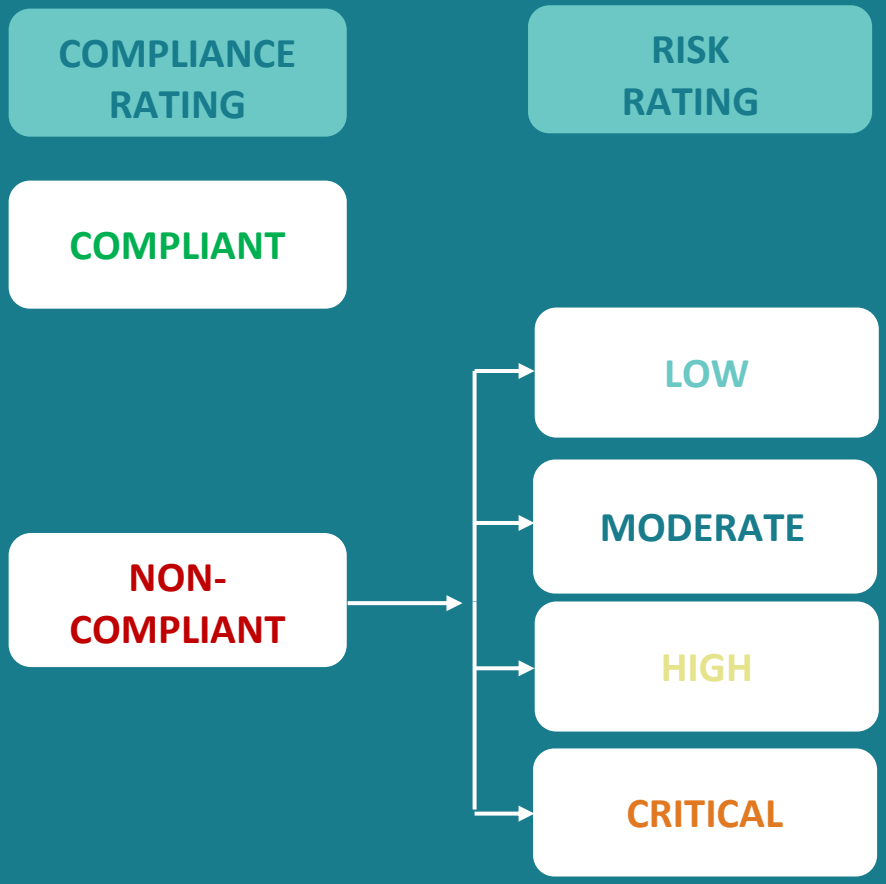
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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