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St John of God Hospital

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

ST JOHN OF GOD HOSPITAL

Stillorgan, Co Dublin

Date of Publication:
16 September, 2025

ID Number: AC0126

2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Care for People with Intellectual Disability

Conditions Attached:
None

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
St John of God Hospital CLG

Registered Proprietor Nominee:
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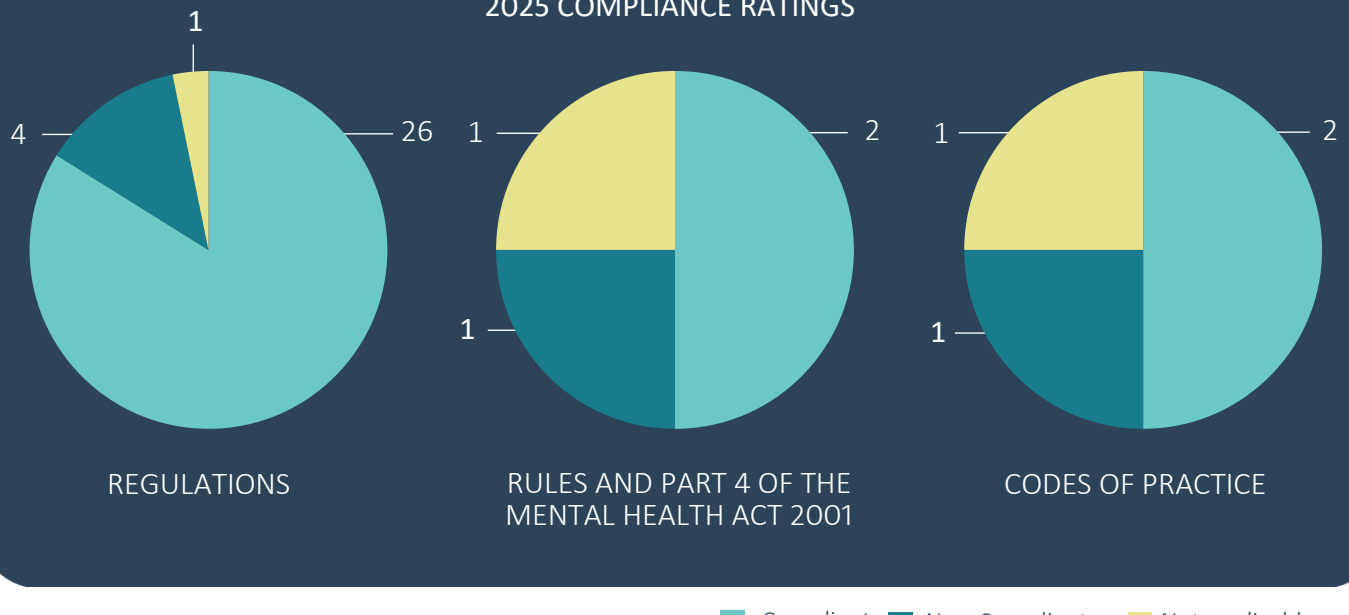
Inspection Date:
11 – 14 February 2025

Previous Inspection date:
11 – 14 June 2024

Inspection Type:
Unannounced Annual Inspection

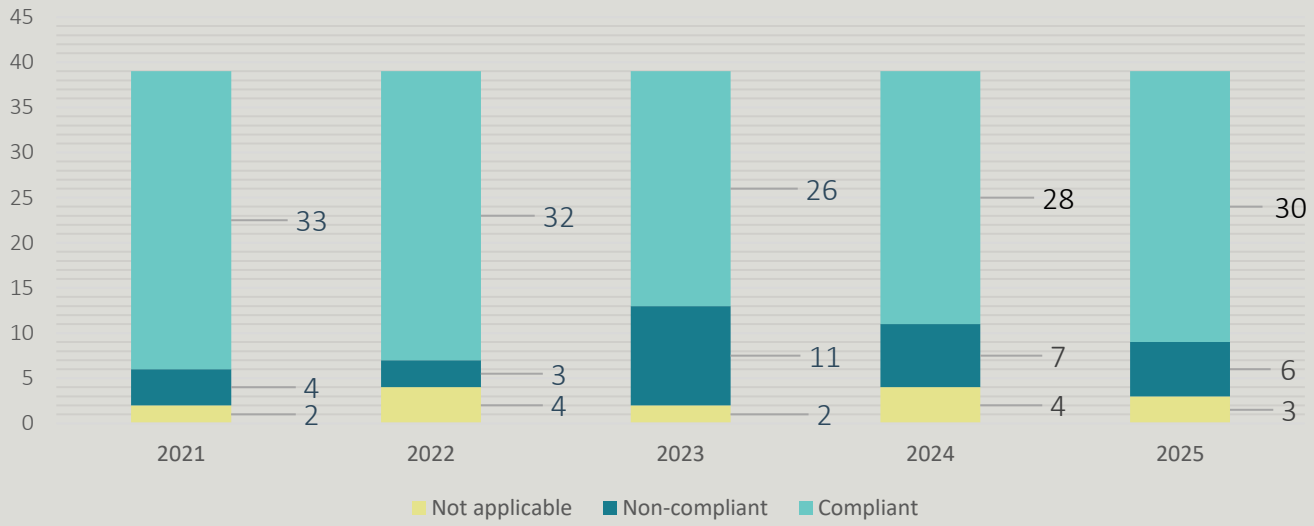
2025 COMPLIANCE RATINGS



RATINGS SUMMARY 2021 – 2025

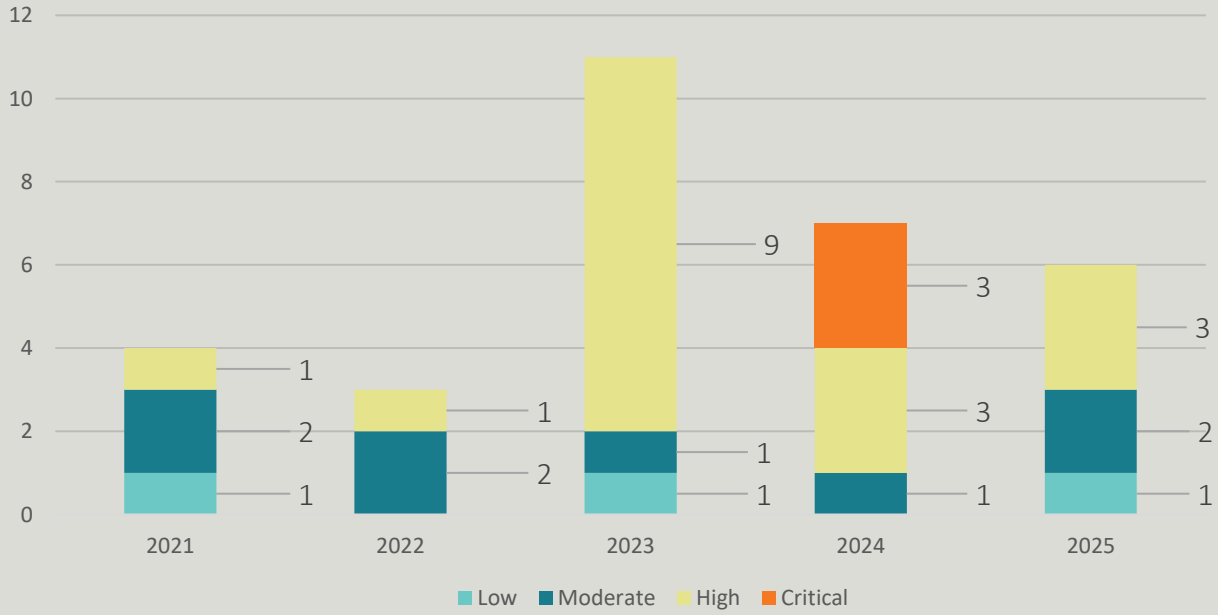
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

St John of God Hospital is located in Stillorgan, South County Dublin. Eight admitting teams provide assessment and treatment of general adult mental health care, addiction disorders, eating disorders and psychiatry of later life. St John of God Hospital takes referrals from the country as a whole and also provides inpatient care facilities for the Dublin Southeast community mental health teams based at Cluain Mhuire.

The approved centre is set amongst expansive grounds which incorporate various leisure facilities such as walking paths, pitch and putt, tennis, soccer and basketball. Accommodation comprises seven separate suites and residents are accommodated in a combination of single, double and four-bed rooms, with a blend of en suite bathrooms and shared bathrooms with shower facilities.

St. Camillus suite is designated for the assessment, care, and treatment of residents with an addiction disorder. St Brigid's unit provides the assessment and treatment of eating disorders and general adult mental health care. St. Peter's suite is allocated for residents who present in an acute phase of their illness and who require intensive nursing and medical care. St. Peter's suite has a seclusion facility. St. Paul's and St. Joseph's suites also serve acute admissions but have lower levels of acuity than St. Peter's suite. The Carrig Fergus suite is a specialist suite for psychiatry of later life residents and Riversdale provided general adult mental health care.

Various amenities are available to residents on site such as a pharmacy, multi-faith room, church, gymnasium and coffee shop. Therapeutic activities are provided in dedicated group rooms, activity rooms, and in the occupational therapy kitchen. Each suite has a dining room and lounge area for resident use.

Inspector of Mental Health Services Summary

The inspection of St John of God Hospital was unannounced and occurred over four days from 11th February to 14th February, 2025. This report reflects the findings at the time of inspection.

The experience of the inspection suggests that compliance is improving within St John of God Hospital. Overall compliance rates had improved since the last inspection with a reduction in the number of non-compliant findings from seven in 2024 to six in 2025. Re-occurring areas of non-compliance included Regulation 15: Individual Care Plan, Regulation 22: Premises, Regulation 26: Staffing and the Rules Governing

the Use of Seclusion. There was a decrease in the risk ratings in relation to Regulation 22: Premises, the Rules Governing the Use of Seclusion in 2025, and measures implemented by the service since the last inspection demonstrated progress in these areas. The inspection team were concerned that Regulation 15: Individual Care Plan and Regulation 26: Staffing remained non-compliant in 2025 with a high risk rating. Other areas of non-compliance on this inspection included Regulation 25: CCTV and the Code of Practice on the Use of Physical Restraint.

Areas of good practice identified on this inspection included a varied programme of therapeutic services and programmes, and a dedicated pharmacy service available to all residents. The management and staff of the approved centre demonstrated a commitment to providing a quality service through the implementation of quality initiatives, investment in the physical environment, and a focus on improving compliance with the recent recruitment of a dedicated quality and compliance manager.

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

Resident Profile	
Number of registered beds	**168**
Total number of residents	**164**
Number of detained patients	12
Number of wards of court	1
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	8
Number of patients on Section 26 leave for more than 2 weeks	0

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	89%	91%	70%	80%	83%

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

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice: IAN10000336	*10 October 2024*	*3 critical risks identified at 2024 inspection: Reg 19 General Health, Reg 22 Premises, Rules Governing the Use of Seclusion*	*At 2025 inspection* • *General Health was compliant.* • *Premises non-compliant rated as high.* • *Restrictive non-compliant practices rated as moderate.* *IAN closed and will continue to monitor through CAPAs and QSNs.*
Regulatory Compliance Meeting	*20 November 2024*	*Discuss plan to ensure general health needs are met. Discussed plan to reduce use of restrictive practice and ensure compliance with COP on Physical Restraint and Rules Governing the Use of Seclusion.*	*At 2025 inspection:* • *General Health was compliant.* • *Premises non-compliant rated as high.* • *Restrictive non-compliant practices rated as moderate.* *Closed and will continue to monitor through CAPAs and QSNs.*

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- **Regulation 16: Therapeutic Services and Programmes**
  - A principal specialist psychologist role was established to oversee the delivery of DBT therapy in the approved centre, and to facilitate the extension of DBT informed group therapy programme from eight to 12 sessions.
  - Psychology staff members engaged in training in specific trauma therapies and developed a group therapy programme focused on building resilience and resourcefulness in the management of trauma.
  - The social work department devised and implemented a new healthy relationships group and also piloted a systemic couple and family therapy service.
  - A dedicated OT resource was allocated to St Peter's ward to facilitate a therapeutic group programme based on the ward. This programme addressed the needs of residents in the acute phase of their illness.
  - OT staff members engaged in training in motivational interviewing which led to the facilitation of a Motivation and Change group for residents; and Compassion Focused Therapy for Eating Disorders (CFT-E) for one-to-one therapy with residents.

- **Regulation 19: General Health**
  - Breast Cancer Ireland attended the approved centre and held breast screening talks to raise awareness of breast cancer and promote national screening services.

- **Regulation 20: Provision of Information to Residents**
  - New patient and family support materials were developed, including information booklets for the addiction services and the couple and family therapy service, ensuring accessible and informative resources were available for residents.
  - The patient handbook for the hospital was revised to ensure clarity for residents, and provide up-to-date information on rights, services, and support available for a better healthcare experience. A full refresh and update to the hospital website was completed to enhance accessibility, provide accurate and up-to-date information of the services provided, and improve the user experience for residents, visitors, and healthcare providers. This included detailed information on the consultants' leading teams, introduced clearer calls to action for feedback and complaints processes, and access to informative articles.
  - As part of the approved centre's commitment to digital transformation and sustainability, new digital communication totems were introduced in the approved centre which served as a central hub for sharing information about events, activities and updates.
  - The patient charter was updated with a focus on improving clarity, accessibility, and alignment with best practices in patient care, emphasising patient rights and responsibilities in a more transparent and inclusive manner.

- **Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines**
    - The approved centre High-Dose Antipsychotic Therapy (HDAT) Guideline was updated and a bespoke HDAT calculator was produced by the pharmacy department and the Drug and Therapeutics Committee.
    - Members of the pharmacy department collaborated on the recently published clinical practice guideline, "Metformin for the Prevention of Antipsychotic-Induced Weight Gain: Guideline Development and Consensus Validation." This work was part of the HRB-funded PROGRESS research study. This research provides a clear treatment algorithm that will support individuals with mental illness in prevention of antipsychotic-induced weight gain. The guideline brings together expertise from collaborators worldwide, underscoring the power of research and collaboration in improving patient care.
    - The approved centre Drug and Therapeutics committee lithium guideline was updated by a member of the pharmacy department.

- **Regulation 31: Complaints Procedures**
    - The approved centre reviewed the existing patient satisfaction survey form for St John of God Hospital to ensure wider participation and accessibility of feedback mechanisms. A new QR code was developed to facilitate feedback via a hybrid approach with utilisation of an online survey platform and print versions across the hospital. QR codes were displayed across key locations in the hospital encouraging residents and families to share feedback. In addition, a separate survey was developed for visitors to understand the needs of visitors, including the needs of families.

- **Regulation 32: Risk Management Procedures**
    - A newly established sexual safety committee in the approved centre produced a sexual safety policy for the hospital. The committee continues to complete work in raising awareness of sexual safety and understanding of the safety culture that is required. The committee held a public launch of the policy in the staff canteen and have also developed information that was integrated into the patient handbook. In addition, the committee have produced a new poster which has been displayed in all patient bedrooms in relation to privacy in hospital.
    - The Local Incident Management Team (LIMT) at St. John of God Hospital revised the incident management report template to reflect a more comprehensive approach to conduct incident reviews. In addition, members of staff attended a training course ‘Best Practice in Incident Review’ from an external training provider. The training provided a clear insight into the framework within which the review team member operates and provided understanding of requirements to carry out an investigation or review.

3.0 Governance

St John of God Hospital was founded by the Hospitaller Order of Saint John of God and was a subsidiary of Saint John of God Hospitaller Ministries. The approved centre was managed by the St John of God Hospital CLG (company limited by guarantee) with an independent board of directors who met eight times a year and a chief executive who reported to the board. Core governance meetings at board level included the Business and Audit Committee; Clinical Governance, Quality and Safety Committee; and the Governance, Performance and Nominations Committee.

Senior management team meetings took place weekly and had a rotating agenda which focused on four key areas: strategic direction; clinical and corporate governance, regulatory compliance and financial performance; operational performance; and departmental operations. Meetings were chaired by the chief executive and attended weekly by the deputy chief executive, clinical director, director of nursing, head of finance, head of human resources, head of information and communications technology and the head of operations. The clinical leads for social work, psychology, occupational therapy, and pharmacy attended these meetings on a monthly basis. Minutes of these meetings indicated that regular discussions took place regarding strategic planning, clinical governance, service developments, finance, risk, data protection, complaints and compliments, safeguarding, compliance, workforce planning and health and safety.

The approved centre had a Clinical Governance, Quality and Safety Executive Committee (CGQSEC) that convened monthly. Agenda items included key performance indicator (KPI) reports, committee updates, incident reports, infection control, and policy updates. Several sub-committees reported into the CGQSEC including risk management, quality and compliance, seclusion and restraint, clinical audit, drugs and therapeutics, sexual safety, safeguarding, health and safety, hospital finance, the committee for clinical effectiveness and quality improvement, and patient satisfaction, complaints and compliments committee. Since the last inspection a working group had been established to develop a strategy for the reduction and elimination of seclusion and restrictive practices. A separate working group had convened to review the process currently being utilised to undertake individual care plans in St John of God Hospital, and to establish a standardise process for care planning.

A new quality and compliance manager for St John of God Hospital had been employed since the last inspection, with responsibility for fostering and encouraging a culture of compliance and quality within the organisation. A structured compliance monitoring system had been implemented which incorporated the development of weekly compliance reports, tracking key performance indicators identified by the compliance committee.

There were clear processes within the organisation for the management of risk. All health and social care professionals had received training in risk management procedures. Responsibilities for risk management were allocated at management level and throughout the approved centre to ensure their effective implementation. There was a risk officer who had overall responsibility for risk management in the approved centre. Each department within the approved centre, along with each suite, held a local risk register and there were defined processes for escalation and de-escalation of risks to and from the hospital risk registers

as required. There was also an enterprise risk register which included risks from all facets of the St. John of God CLG group.

There were clear processes for reporting and reviewing incidents and near misses. Each suite had its own dashboard on the hospital-wide electronic incident reporting system known as Datix. All incidents were recorded and risk rated. Clinical incidents were reviewed by the relevant multi-disciplinary team and incidents that were risk rated moderate or higher were reviewed by the local incident management team (LIMT) which convened monthly and reported into the CGQSEC. All incidents were reviewed by the risk officer for any trends or patterns occurring in the service.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. All heads of discipline had defined strategic aims in relation to the approved centre. All disciplines had a system in place for supervision or professional development planning with staff. Clinical staff at the approved centre included nursing, psychiatry, psychology, social work, occupational therapy and pharmacy. Other disciplines included family therapists, addiction counsellors, art psychotherapist, activities coordinator and pastoral care. Vacancies identified at the time of inspection were managed by cross cover from relevant disciplines and the use of overtime and agency staff, which mitigated the impact on residents. Active recruitment campaigns were on-going to address the vacancies. At the time of inspection, not all staff had completed up-to-date mandatory training.

The approved centre had secured funding to upgrade the facility, including ligature remediation works, due to be completed by December 2025. In addition, there were plans to upgrade the information and communications technology (ICT) infrastructure by May 2025.

Resident engagement processes were facilitated throughout the service. Within the approved centre, regular resident community meetings, suggestion boxes and engagement with the complaints process were used to support service improvement. The approved centre had a complaints policy and an appointed complaints officer. Details of how to make a complaint were displayed in the centre and contact information for the nominated complaints officer was provided. A designated advocate attended the approved centre weekly and spoke directly with residents, and advocacy contact details were displayed within the approved centre. The approved centre had a consumer and carer's advocacy group (CCAG). In line with core values of the hospital, this group sought to act in an advocacy role by representing the views, experiences and needs of residents and their families, and to work in partnership with hospital management to improve and develop patient-centred and recovery-orientated services. Membership of this group was open to former residents (six months post discharge), carers, outpatients, and members of the public. The group met at least six times a year.

Therapeutic Services and Programmes
Social work, occupational therapy (OT) and psychology departments offered both individual and group-based treatment programmes to residents of the approved centre. There was additional therapeutic input from addiction counsellors, an activities co-ordinator, and an art psychotherapist. Further sessional input was provided by external instructors including a music therapist and yoga/meditation instructor.

The social work department offered a complementary therapy programme for the addictions service incorporating a weekly group which focused on enhancing communication in interpersonal relationships to promote early recovery with addictions. There was also a psychoeducation group and weekend leave planning group as part of the Addictions Rehabilitation Programme. The Eating Disorder Recovery Centre Programme included an interpersonal relationships group, family support group, and healthy relationships group. The social work department had also commenced a pilot couple and family therapy service in February 2025, facilitated by trained family therapists.

Psychology groups included Cognitive Behavioural Therapy (CBT), Compassion focused therapy (CFT), Dialectical Behaviour therapy (DBT), managing grief and loss, making connections and enhanced cognitive behaviour therapy (CBT-E) for eating disorders.

OT groups include sound meditation, yoga, progressive muscular relaxation, Zentangle - mindful drawing, music therapy, lunch cookery, medication support, life skills, lifestyle redesign - productivity and wellbeing, vocational and rehabilitation training options, motivation and charge, art psychotherapy, recovery themes and routines, recovery talk, and arts and crafts.

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 16: Therapeutic Services and Programmes	✓	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 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	Compliant
Regulation 24: Health and Safety	✓	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 32: Risk Management Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Rule on the Use of Electro-Convulsive Therapy	✓	Compliant
Part 4 Consent to Treatment	✓	Compliant
Code of Practice: Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients	✓	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 Plans	✓		✓		✗	High	✗	High	✗	High
Regulation 22: Premises	✓				✗	High	✗	Critical	✗	High
Regulation 25: Closed Circuit Television	✓		✓		✓		✓		✗	Low
Regulation 26: Staffing	✓		✗	Moderate	✗	Moderate	✗	High	✗	High
Rules Governing the Use of Seclusion	✓		✓		✗	High	✗	Critical	✗	Moderate
Code of Practice on Physical Restraint	✓		✗	High	✗	High	✓		✗	Moderate

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

4.3 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 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 Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, 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.

15 residents availed of the opportunity to meet with the inspection team. Positive aspects of care identified by residents during interview included the quality of care received from staff members, the high standard of food on offer, satisfaction with the availability of leisure activities and the provision of relevant information. Overall, residents stated that they were engaged in one to one or group therapies and met their consultant and multi-disciplinary team (MDT) on a regular basis. Suggestions about how the service could be improved included more ward-based activities on St Brigid's ward and additional services such as a library service for residents. One resident stated that they felt unsafe being in a mixed-gender ward and expressed a preference for a single gender ward. Residents in Riversdale suite expressed dissatisfaction with having to relocate to another suite for weekend mealtimes, this concern was addressed and resolved at the time of inspection.

13 completed service user experience questionnaires were received from residents of the approved centre. All respondents stated that they knew the members of their multi-disciplinary team and were happy with how staff communicated with them. 12 residents stated that they understood their Individual Care Plan (ICP). Five residents were always involved in setting goals for their ICP, three were sometimes involved, three were never involved and one resident did not wish to be involved. 12 respondents stated that they were always able to discuss worries or concerns with a member of staff as soon as they needed to, and 11 residents felt their privacy and dignity were respected. 12 out of 13 residents felt there were enough group activities, and 10 residents felt there were enough talking therapies. In response to the most positive aspects of their experience of the approved centre, residents identified the warm environment, nice staff, good facilities, and good food, sharing the experience with others, being in a safe place, medical attention, mindfulness, and yoga. Suggestions made to improve the service included more artistic activities and more one-to-one

therapeutic therapies. When asked to rate their overall experience of care and treatment on a scale of 1-10, the average response was 8.7.

5.2 Advocacy

The approved centre had access to an advocacy service from the Peer Advocacy in Mental Health. The advocate attends the centre weekly and a report from the advocate on their activities at the approved centre was received by the inspector.

It included both positive feedback and feedback on how improvements could be made to the service. The report included the following.
Positives as reported by residents to the peer advocate:

- Service users reported that they have good support from their MDTs and feel their inpatient care is very helpful in their recovery.
- Service users report a particularly safe care experience in the approved centre. Service users describe nursing staff as respectful, reassuring and kind. They are reported as extremely helpful; taking time to orient newly admitted service users to the units and to clearly explain suite routines, protocols and practices, observation levels that apply etc.
- Service users with experience of inpatient care in other services speak highly of the person-centred care offered in SJOG. They complement nursing staff for prompt and supportive interactions with them. They say they were always treated with dignity.
- Housekeeping staff are praised for their friendliness and attention to keeping things clean.
- The Complaints and Feedback process is described as generally prompt and efficient. However, some service users say that staff can sometimes be too busy to photocopy complaints for service users to keep for their own records.
- The food is described as high quality with lots of choice although some vegetarian options are reported as unimaginative.
- Service users appreciated the amenities SJOG offers, spacious and attractive grounds for walks and The Pomegranate Café for meeting their visitors.
- The quality of the OT programme was described as excellent, interesting, and varied.

Areas for improvement as reported by residents to the peer advocate:

- Some service users reported that they would like the option of having their care transferred to another psychiatrist during their stay.
- Service users describe St. Peter's Suite as cramped, often noisy, and claustrophobic. Some stated they were concerned for their safety in situations where there were very unwell and distressed people who show disinhibited and aggressive behaviours on the unit.
- Residents on St. Peter's Suite would like to see more activities offered.
- Female residents reported that male residents used the female toilets.
- Residents stated that they would prefer to receive advance notice of the arrival of the independent psychiatrist to allow them time to gather their thoughts and prepare for their interviews.
- Service users reported that they would like laundry services to be more accessible.

- Service users who are public patients remarked they do not have access to the same range of therapies offered to insured patients.
- Involuntary service users report it can be difficult to contact their legal representatives and may only meet them on the day of their tribunals.
- Service users stated that they disliked shared bedrooms where they felt they had little privacy.
- Residents reported that care planning approaches appeared to vary widely across teams with some service users reporting they were meaningfully involved in their care plan and feel listened to. Conversely, others stated they had minimal involvement in their ICPs. These ICPs were described as generic and not reflective of the self-identified needs and goals of the individual service user.
- Some service users reported they were not always offered choice or sufficient information in a form they can easily understand when started on new medications. They would prefer if clinicians would take more time to fully explain how the medication would help them. They stated that their queries about side effects were not always managed or dealt with sensitively and reassuringly.
- Residents reported that wider availability of Mental Health Commission publications such as 'Know your Rights' would be appreciated. Service users who were not native speakers of English would be grateful if staff would download materials in their preferred language.

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:

- Chief Executive
- Clinical Director
- Head of Operations
- Director of Nursing
- Deputy Chief Executive
- Deputy Director of Nursing
- Occupational Therapy Manager (Acting)
- Principal Psychologist
- Healthcare Risk Officer
- Quality and Compliance Manager
- Accommodation Manager
- Catering Manager
- Head of Human Resources
- Head of Information and Communications Technology
- Chief 2 Pharmacist (on behalf of Head of Pharmacy)
- Technical Services Manager
- Administrative Coordinator

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 HIGH

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Ten ICPs were inspected. The ICPs were a composite set of documents which addressed the residents' goals, mental health care and treatment needs based on a multi-disciplinary team (MDT) assessment of the person and where practicable, in consultation with them. The documents within the ICPs were identifiable and uninterrupted and were not amalgamated with progress notes.

Eight of the ten ICPs were developed by the MDT following a comprehensive assessment of the resident within seven days of admission. However, two of the ten individual care plans inspected were not developed by the multi-disciplinary team, instead only medical and nursing staff disciplines developed those two individual care plans. The ICP was discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

All ICPs inspected identified appropriate goals for the resident, the care and treatment required to meet the goals, the responsibilities for implementing the care and treatment and the resources required to provide the care and treatment identified.

The ICPs were not all appropriately reviewed by the MDT in consultation with the resident. Two ICPs were not reviewed by the relevant members of the MDT.

Three ICP's inspected were not updated to include the debrief following restrictive practices.

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

a) **Two of the individual care plans inspected were not developed by the multi-disciplinary team, instead only medical and nursing staff disciplines developed those two individual care plans.**
b) **Two of the individual care plans inspected were not reviewed by the multi-disciplinary team.**
c) **Three of the individual care plans inspected were not updated to include the debrief following restrictive practices.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents in the approved centre had access to personal space and all resident rooms were adequately sized. Communal rooms were provided for residents and residents had space to move about, including outdoor spaces. There was suitable and sufficient heating in day areas and in bedrooms. Lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs. Hazards were minimised in the approved centre.

Not all ligature points were minimised to the lowest practicable level, based on risk assessment. At the time of the inspection the approved centre was in the process of ligature remediation works. The works were ongoing, with a completion date of December 2025.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination and repair of assistive equipment. Records were maintained. The approved centre was clean, hygienic, and free from offensive odours on the inside, though on the outside of the approved centre some external windows and glass panels were dirty.

There were enough toilets and showers for residents in the approved centre, with at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address the residents' needs and furnished to support resident independence and comfort.

Assisted devices and equipment were available to address resident needs.

The approved centre was non-compliant with this regulation because the overall environment was not developed and maintained with due regard to the safety and well-being of residents, staff and visitors, for the following reasons:

a) **Some external windows and glass panels were in need of cleaning, 22(3).**
b) **Ligature risks were not minimised to the lowest practical level based on risk assessment, 22(3).**

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating LOW

INSPECTION FINDINGS

The approved centre had clear written policy and protocols in relation to the use of CCTV for observing residents. The policy was last reviewed in March 2023.

There were signs in prominent positions which indicated where CCTV cameras were located throughout the approved centre. The existence and use of CCTV or other monitoring systems was disclosed to all residents and their representatives. Residents were monitored solely for the purposes of ensuring the health, safety and welfare of that resident.

The use of CCTV, or other monitoring systems, had been disclosed to the Mental Health Commission or the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe residents were incapable of recording or storing a resident's image on a tape, disc, hard drive or in any other form.

CCTV cameras transmitted images to a monitor that was not viewed solely by the health professional responsible for the resident. Specifically, the CCTV in Riversdale Ward was visible to residents and non-clinical staff through the window of the nurses station on Days 1 and 2 of the inspection. This was resolved on Day 3 of the inspection.

CCTV was not used to monitor a resident if they started to act in a way which compromised their dignity.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the monitoring station was viewed only by the health professional responsible for the health and welfare of the resident: CCTV was visible to non-clinical staff and other residents in one ward, 25(d).

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 June 2024 and included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing were sufficient to meet resident needs. There were eight multi-disciplinary teams in the approved centre. These included medical, nursing, psychology, social work, occupational therapy, and pharmacy staff. There were 11.49 Whole Time Equivalent (WTE) nursing vacancies at staff nurse grade. At the time of inspection these vacancies were being managed through the use of overtime and agency nursing staff, to mitigate the impact on residents. There was a part time senior social work post and a part time basic grade social work post vacant. At the time of inspection, cross cover was provided by other social workers within the approved centre. There was one vacancy in the Occupational Therapy department, however all teams had an allocated occupational therapist. Residents had access to other specialist services such as a dietitian and speech and language therapist via private referral. An appropriately qualified staff member was on duty and in charge at all times, and this was documented.

Staff had access to education and training through a coordinated and monitored annual training schedule. At the time of inspection, staff members were actively booking available training dates, however not all disciplines had booked upcoming training courses. Not all healthcare staff were trained in fire safety, basic life support, management of violence and aggression, and safeguarding. Not all mandated persons in the approved centre were trained in Children First.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre. The following table shows the percentage staff trained in the mandatory training subjects:

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (118)	105	89%	85	72%	88	75%	111	94%	63	54%	79	70%
Medical (19)	18	95%	15	79%	16	84%	19	100%	16	84%	15	79%
Occupational Therapist (10)	10	100%	7	70%	9	90%	10	100%	10	100%	8	80%

Social Worker (8)	8	100%	8	100%	8	100%	8	100%	8	100%	8	100%
Psychologist (12)	12	100%	12	100%	11	92%	12	100%	12	100%	11	92%
Pharmacist (9)	9	100%	7	78%	9	100%	9	100%	N/A	N/A	9	100%
Addiction Counsellor (6)	4	67%	4	67%	5	83%	6	100%	6	100%	5	83%

The approved centre was non-compliant with this regulation because not all staff had undertaken mandatory training in Basic Life Support, Children First, Safeguarding, Management of Violence and Aggression, and Fire Safety, 26(4).

8.0 Inspection Findings – Rules

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

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

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

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

Section 69: The Use of Seclusion

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated January 2025. The policy addressed the following:

- Who may initiate, and who may carry out, seclusion.
- The provision of information to the person being secluded, which included information about their rights, presented in accessible language and format.
- The safety, safeguarding and risk management arrangements that were to be followed during any episode of seclusion.

The approved centre had separate written policies in relation to the reduction of seclusion and the training of staff involved in the use of seclusion. The policy on the reduction of seclusion was last reviewed in March 2024 and addressed:

- How the approved centre aimed to reduce or, where possible eliminate, the use of seclusion.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce and the use of post-incident reviews to inform practice.
- How the approved centre would provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion.

The policy on staff training addressed:

- Who would receive training based on the identified needs of persons who are secluded and staff.
- The areas to be addressed within the training programme, including training in:
    - Alternatives to seclusion.
    - Trauma-informed care.
    - Cultural competence.
    - Human rights including the legal principles of restrictive intervention.
    - The prevention and therapeutic management of violence and aggression (including “breakaway” and de-escalation techniques).
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional, or somatic causes or triggers of the person’s behaviours.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in seclusion.

Training and Education: A written record indicated that staff involved in seclusion have read and understood the policy. All staff who participated, or may participate, in the use of seclusion received the appropriate training in its use and in the related policies and procedures.

A record of attendance at training was maintained.

Monitoring: An annual report on the use of seclusion in the approved centre was published on the registered proprietor's website. A multi-disciplinary review and oversight committee accountable to the registered proprietor nominee analysed in detail every episode of seclusion. The committee met at least quarterly and:

- Determined if each episode of seclusion reviewed complied with the rules governing the use of seclusion.
- Determined if each episode of seclusion reviewed complied with the approved centre's own policies and procedures relating to seclusion.
- Identified and documented any areas for improvement.
- Identified the actions, the persons responsible, and the timeframes for the completion of any actions.
- Assured the registered proprietor nominee that each use of seclusion was in accordance with the Mental Health Commission's rules.
- Produced a report following each meeting of the review and oversight committee. This report was made available to staff to promote on-going learning and awareness and to the Mental Health Commission upon request.

Evidence of Implementation: Seclusion facilities were furnished, maintained and cleaned in such a way that ensured the person's inherent right to personal dignity and privacy was respected. There were two seclusion rooms on St Peter's Unit and seclusion rooms were constructed to withstand high levels of violence. There were no ligature points or electrical fixtures. The seclusion room doors including the newly installed seclusion bathroom door were anti-barricade.

Seclusion facilities contained a newly installed intercom system. Heating and air conditioning were externally controlled for the room. There were limited furnishings, all of which met current health and safety requirements. The room was large enough to support the patient and a team of staff. The patient had sight of a clock displaying the time, day and date. As far as possible, the seclusion room was set away from communal sitting rooms and bedrooms, without being isolated. A window in the room gave a clear view of the outdoor environment, without being visible to unauthorised persons outside. The patient had ready access to sanitary facilities and sanitary items, as appropriate. Seclusion facilities were not used as bedrooms, and bedrooms were not used as seclusion facilities. Following documented, suitable risk assessments, the patient had periods of access to secure outside areas and a record of daily outdoor access was maintained.

The clinical files of three persons who had been secluded were examined. Orders for seclusion were appropriately initiated and renewed, where applicable. The dignity and safety of the persons being secluded were respected. Seclusion was initiated by the most senior registered nurse (RN) on duty, following a comprehensive an assessment of the patient as practicable. This included a risk assessment, the outcome of which was recorded in the clinical file. The seclusion order was recorded in the clinical file and on the seclusion register. A registered medical practitioner (RMP) was notified of the seclusion episode within 30 minutes and medically examined the patient within two hours of the commencement of the episode. No later than 30 minutes following the medical examination, the RMP contacted the

patient's consultant psychiatrist (CP) or the duty CP to inform them of the episode of seclusion. The RMP recorded the outcome of this discussion in the clinical file. Where the CP ordered the continued use of seclusion, they also ordered the duration. No seclusion order was made for a period of time longer than four hours from the commencement of the seclusion episode.

The CP's order confirmed that there were no less restrictive ways available to manage the patient's presentation. The CP undertook a medical examination of the patient and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The examination was recorded in the clinical file. The patient was informed of the reasons for, likely duration of, and circumstances which lead to the discontinuation of seclusion, except where such information was prejudicial to their mental health, well-being or emotional condition. A record of this communication, or an explanation of why it did not occur, was recorded in the clinical file. In accordance with the patient's wish, their representative was informed of the seclusion and a record of this communication, or an explanation of why it did not occur, was entered in the clinical file. The registered proprietor appropriately notified the Mental Health Commission of the start time and date and the end time and date of each episode of seclusion.

The registered nurse responsible for the care of a person in seclusion, conducted the monitoring of the person under direct or continuous observation using sight and sound.

Patients placed in seclusion were kept under direct observation by a RN for the first hour of seclusion, and under continuous observation within sight and sound of a RN after the first hour. A written record of the patient was made by a RN every 15 minutes. Following risk assessment, a nursing review of the patient took place every two hours to assess whether the episode of seclusion could be ended. The assessment and decision were recorded. A medical examination was carried out by a RMP every four hours. The decision to end or continue seclusion was recorded. Upon commencement of an episode of seclusion, an appropriate seclusion care plan for the patient was developed by a RN.

Seclusion orders were renewed by an order made by a RMP under the supervision of the CP or the duty CP following a medical examination, for a further period not exceeding four hours to a maximum of five renewals (24 hours) of continuous seclusion. Where the seclusion order was renewed beyond 72 hours of continuous seclusion, the CP or the duty CP undertook a medical examination; this was recorded in the clinical file and where a decision was made by the CP or the duty CP, to continue to seclude a person for a total period exceeding 72 hours, the MHC was provided with additional information.

Seclusion was ended appropriately, and emotional support was provided to the person in the direct aftermath of the episode. An in-person debrief followed each of the three episodes of seclusion. A multi-disciplinary team review followed these episodes of seclusion.

In the case of one individual out of the three individuals secluded, their individual care plan was not updated to reflect the outcome of the debrief and in particular, their preferences in relation to restrictive interventions going forward.

The registered proprietor appointed a named senior manager who was responsible for the approved centre's reduction of seclusion.

The approved centre was non-compliant with this rule because the individual care plan for one resident was not updated to reflect the outcome of the debrief, and in particular, their preferences in relation to restrictive interventions going forward, 7.8.

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

Use of Physical Restraint

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated December 2024. It addressed the following:

- The provision of information to the person which included information about the person's rights, presented in accessible language and format.
- Who could initiate and who may carry out physical restraint.
- The safety, safeguarding and risk management arrangements that should be followed during any episode of physical restraint.

The approved centre had a policy on the reduction of physical restraint, which was last reviewed in March 2023 and addressed the following:

- How the approved centre aimed to reduce, or where possible eliminate, the use of physical restraint within the approved centre.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.
- How the approved centre would provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint.

Policies and procedures regarding staff training included:

- Who would receive training based on the identified needs of persons who are restrained and staff.
- The areas to be addressed within the training programme, which included training in:
    - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
    - Alternatives to physical restraint.
    - Trauma-informed care.
    - Cultural competence.
    - Human rights, including the legal principles of restrictive interventions.
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.
    - The monitoring of the safety of the person during and after the physical restraint.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in physical restraint.

Training and Education: There was a written record that all staff involved in the physical restraint had read and understood the policy.

All staff who participated, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures and this training was in accordance with the policy outlined above.

A record of attendance at training was maintained.

Monitoring: A multi-disciplinary review and oversight committee met at least quarterly and:

- Determined if each episode of physical restraint reviewed complied with the code of practice on the use of physical restraint.
- Determined if each episode of physical restraint reviewed complied with the approved centre's own policies and procedures relating to physical restraint.
- Identified and documented any areas for improvement.
- Identified the actions, the persons responsible, and the timeframes for completion of any actions.
- Assured the registered proprietor nominee that each use of physical restraint was in accordance with the Mental Health Commission's code of practice.
- Produced a report following each meeting of the review and oversight committee which was available to the Mental Health Commission on request.

Evidence of Implementation: Three episodes of physical restraint were inspected. Orders for physical restraint were appropriately initiated, ended and recorded. The orders for physical restraint were not renewed in the episodes examined. The dignity and safety of the person being restrained was respected. The Mental Health Commission was notified of the start time and date and the end time and date of each episode of physical restraint in the format specified by the Mental Health Commission within three days of the restraint.

Appropriate emotional support was provided to the person following the episode of physical restraint and support was offered to other persons who witnessed the restraint of the person. An in-person debrief with the person who was restrained follow every episode of physical restraint and each episode was reviewed by members of the multi-disciplinary team (MDT) within five working days from the date of the restraint. The individual care plans of two residents was not updated to reflect the outcome of the debrief, and in particular, each of their preferences in relation to restrictive interventions going forward

The MDT recorded actions decided upon, and follow-up plans to eliminate or reduce restrictive interventions for the person. A named senior manager was responsible for the approved centre's reduction of physical restraint.

The approved centre was non-compliant with this code of practice because the individual care plans of two residents was not updated to reflect the outcome of the debrief, and in particular, each of their preferences in relation to restrictive interventions going forward, 5.5.

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 : 10006406		**Two of the individual care plans inspected were not developed by the multi-disciplinary team, instead only medical and nursing staff disciplines developed those two individual care plans.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All clinical teams have been made aware of the continued importance of compliant care plans. A weekly audit is in place to ensure compliance and this is monitored weekly by the Clinical Director and Registered Proprietor Nominee.	Weekly MDT Care Plans are completed by each clinical team unless more frequently indicated.	Achievable	25/06/2025	Clinical Director
Preventative Action	An MDT Working Group has been established, chaired by the Clinical Director, to review the current care planning process and identify any gaps or inconsistencies. Findings from this review will be shared across all clinical teams to promote a consistent, standardised approach. Based on the group's recommendations, targeted training will be delivered to all MDT	Progress of the MDT Care Plan Working Group will be monitored monthly through the Compliance Committee and by the Registered Proprietor Nominee.	Achievable	30/09/2025	Clinical Director.

	members to ensure care plans are developed in line with best practice and regulatory requirements.				
Reason ID : 10006407		**Two of the individual care plans inspected were not reviewed by the multi-disciplinary team.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All clinical teams have been made aware of the continued importance of compliant care plans. A weekly audit is in place to ensure compliance and this is monitored weekly by the Clinical Director and Registered Proprietor Nominee.	Weekly MDT Care Plans are completed by each clinical team	Achievable	25/06/2025	Clinical Director
Preventative Action	An MDT Working Group has been established, chaired by the Clinical Director, to review the current care planning process and identify any gaps or inconsistencies. Findings from this review will be shared across all clinical teams to promote a consistent, standardised approach. Based on the group's recommendations, targeted training will be delivered to all MDT members to ensure care plans are developed in line with best practice and regulatory	Progress of the MDT Care Plan Working Group will be monitored monthly through the Compliance Committee and by the Registered Proprietor Nominee.	Achievable	30/09/2025	Clinical Director.

	requirements. Based on the group's recommendations, targeted training will be delivered to all MDT members to ensure care plans are developed in line with best practice and regulatory requirements.				
Reason ID : 10006408		**Three of the individual care plans inspected were not updated to include the debrief following restrictive practices.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following each restrictive practice incident, the individual care plan will be reviewed within two working days to ensure the post-incident debrief is appropriately documented. Where the debrief is missing, the clinical team will be notified and required to update the care plan immediately to reflect the discussion and any changes to the treatment approach.	Clinical audit will be completed after each episode and action plans will be developed as required.	Achievable	06/06/2025	Clinical Director.
Preventative Action	All individual care plans will be audited monthly by the Seclusion and Restraint Reduction Group specifically for post-incident updates. Any patterns of non-compliance will be	Clinical audits will be completed after every episode. The results will be reviewed by the Seclusion and Restraint Reduction Group and the Compliance Committee and	Achievable	06/06/2025	Clinical Director.

	communicated to the relevant teams, and targeted training or support will be provided. This will be overseen by the Clinical Director.	monitored by the Registered Proprietor Nominee to ensure compliance.			

Regulation 22: Premises					
Reason ID : 10006409		**The overall environment was not developed and maintained with due regard to the safety and well-being of residents, staff and visitors because some external windows and glass panels were in need of cleaning, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Window Cleaning Schedule increased to bi-annual in 2025 for all accessible windows. Windows that are not accessible during the bi-annual scheduled cleaning will be audited to identify all such locations. A specialised cleaning programme will then be developed and costed, with the objective of establishing a sustainable funding mechanism and appropriate cleaning schedule	Quarterly Monitoring	Achievable	31/08/2025	Technical Services Manager & Accommodation Services Manager
Preventative Action	Quarterly monitoring of window cleaning schedule at Head of Dept. Meeting. Allocation of budget line in place.	Tracked bi-annually to ensure adherence to the schedule and included in annual service planning	Achievable	31/08/2025	Head of Operations
Reason ID : 10006410		**The overall environment was not developed and maintained with due regard to the safety and well-being of residents, staff and visitors because ligature risks were not minimised to the lowest practical level based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The building works associated with the ligature remediation project commenced in Q1	Monthly progress monitored through the Compliance Committee outlining key	Achievable	31/01/2026	Head of Operations

	2025 and are ongoing, with the objective of addressing all identified high-risk areas within the Adult Approved Centre	milestones and next phases within the project timelines.			
Preventative Action	Continuous ligature audit cycle and implementation of the ligature minimisation policy and establishing funded remediation plans	Tracked through policy review updates, risk assessments and audits.	Continuous ligature audit cycle and implementation of the ligature minimisation policy	31/12/2025	Head of Operations

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10006404		**The registered proprietor did not ensure that the monitoring station was viewed only by the health professional responsible for the health and welfare of the resident: CCTV was visible to non-clinical staff and other residents in one ward, 25(d).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CCTV monitor re-located to a position in Riversdale Nurse station, and is now not visible to non-clinical staff or residents	Completed	Achievable	11/06/2025	Head of IT
Preventative Action	CCTV monitors will now be included as a standard item in the environmental audit alongside whiteboards and other display boards. This will ensure that personal data, including visual monitoring, is only visible to authorised healthcare professionals. Any instances of inappropriate visibility will be flagged and addressed immediately to prevent recurrence.	Audits are completed regularly as per Clinical Audit schedule	Achievable	28/11/2025	Clinical Audit Team

Regulation 26: Staffing					
Reason ID : 10006411		Not all staff had undertaken mandatory training in Basic Life Support, Children First, Safeguarding, Management of Violence and Aggression, and Fire Safety, 26(4).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Targeted approach to completion mandatory training, with full review of data and urgent training requirements addressed by all departments.	Fortnightly progress Report monitored by the Compliance Committee and the Registered Proprietor Nominee outlining key milestones and next steps.	Achievable	31/12/2025	Head of HR
Preventative Action	Monthly sharing of training requirements with HODs and review of progress by Head of HR on a monthly basis	Monthly monitoring by Head of HR to address issues with Training Coordinator and responsible Heads of Function.	Achievable	31/12/2025	Head of HR

Rules Governing the Use of Seclusion					
Reason ID : 10006405		**The individual care plan for one resident was not updated to reflect the outcome of the debrief, and in particular, their preferences in relation to restrictive interventions going forward, 7.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Clinical audit of restrictive practices will be completed within two working days of the restrictive practice being implemented. Where this aspect is noted to be non-compliant the clinical team will be contacted and the non-compliance rectified to ensure compliance.	Viclatity clinical audit will be completed. Compliance rating will be provided and action plans will be developed as required. Audits will be completed within 2 working days of each corrective action.	Achievable.	06/06/2025	Chair and Vice Chair of the Seclusion and Restraint Reduction Group
Preventative Action	The seclusion and restraint reduction group will monitor the results of these audits on a monthly basis. Where trends with teams / patient cohorts are discovered this will be communicated to all the relevant teams involved. Corrective actions will be devised and put in place to address any trends noted. This group will also monitor and govern the implementation of the Seclusion and Restraint reduction strategy overseen by the Clinical Director and Registered Proprietor Nominee.	Trending of clinical audits will be completed. Data surround seclusion and physical restraint will be collated and reviewed monthly.	Achievable	06/06/2025	Chair and Vice Chair of the Seclusion and Restraint Reduction Group

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10006412		**The individual care plans of two residents was not updated to reflect the outcome of the debrief, and in particular, each of their preferences in relation to restrictive interventions going forward, 5.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following each restrictive practice incident, the individual care plan will be reviewed within two working days to ensure the post-incident debrief is appropriately documented. Where the debrief is missing, the clinical team will be notified and required to update the care plan immediately to reflect the discussion and any changes to the treatment approach.	Clinical audit will be completed after each episode and action plans will be developed as required.	Achievable	06/06/2025	Clinical Director.
Preventative Action	All individual care plans will be audited monthly by the Seclusion and Restraint Reduction Group specifically for post-incident updates. Any patterns of non-compliance will be communicated to the relevant teams, and targeted training or support will be provided. This will be overseen by the Clinical Director.	Clinical audits will be completed after every episode. The results will be reviewed by the Seclusion and Restraint Reduction Group and the Compliance Committee and monitored by the Registered Proprietor Nominee to ensure compliance.	Achievable	06/06/2025	Clinical Director.

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 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.

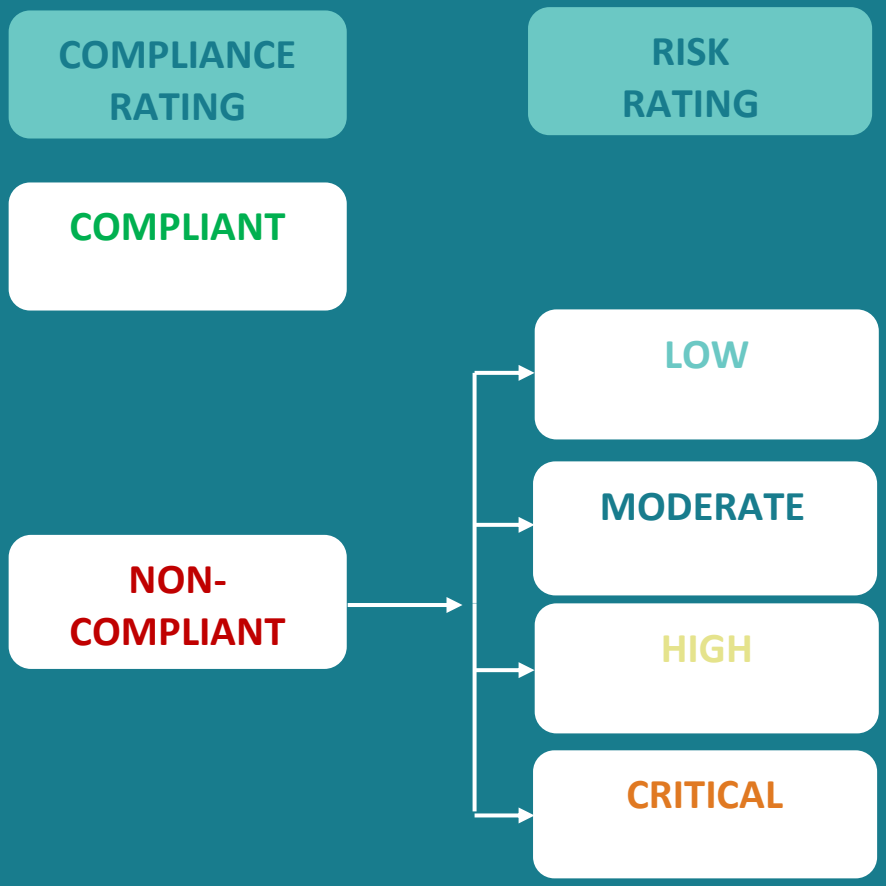
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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