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mental health commission

Bloomfield Hospital

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

BLOOMFIELD HOSPITAL

Stocking Lane, Rathfarnham, Dublin 16, D16C6T4

Date of Publication:
16 September, 2025

ID Number: AC0131

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

Conditions Attached:
None

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
Bloomfield Care Centre CLG

Registered Proprietor Nominee:
Mr Joe Kelly, Chief Executive Officer

Inspection Team:
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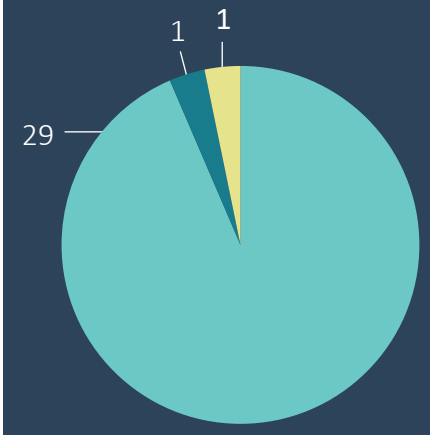
Professor James V Lucey MCRN000646

Inspection Date:
11 – 14 March 2025

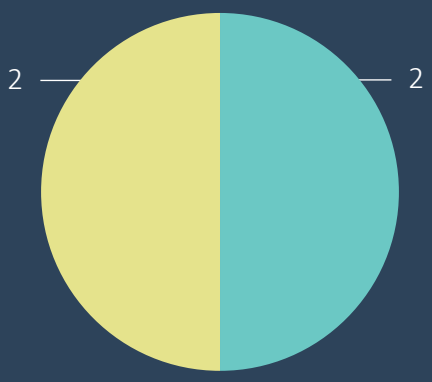
Previous Inspection date:
16 – 19 July 2024

Inspection Type:
Unannounced Annual Inspection

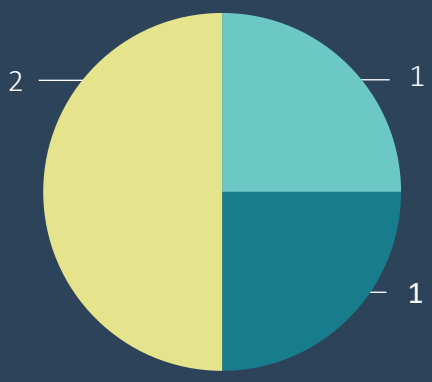
2025 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



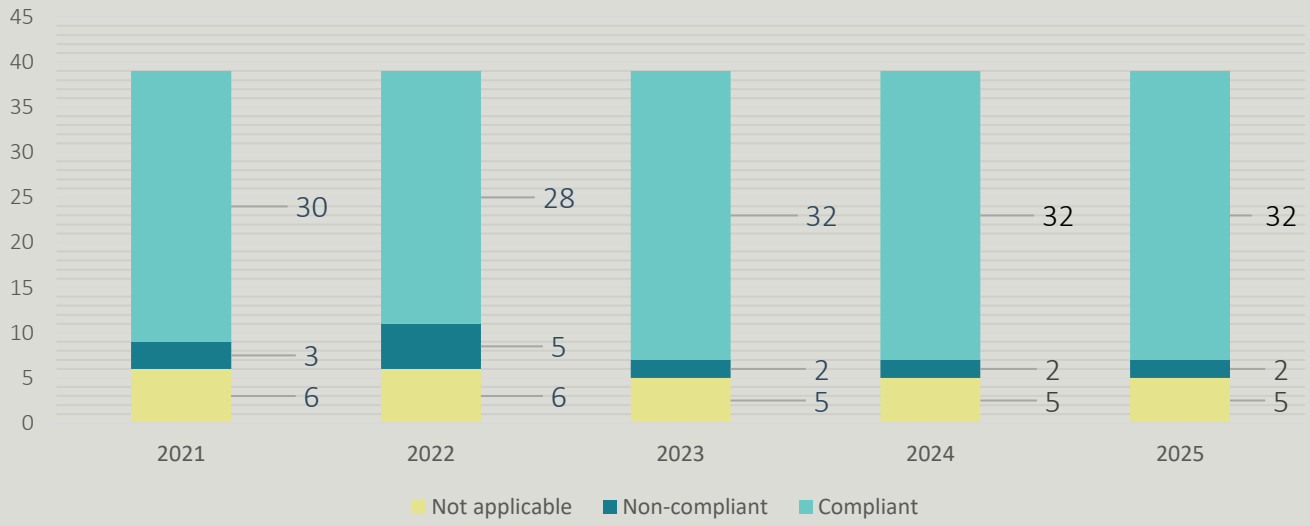
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2021 – 2025

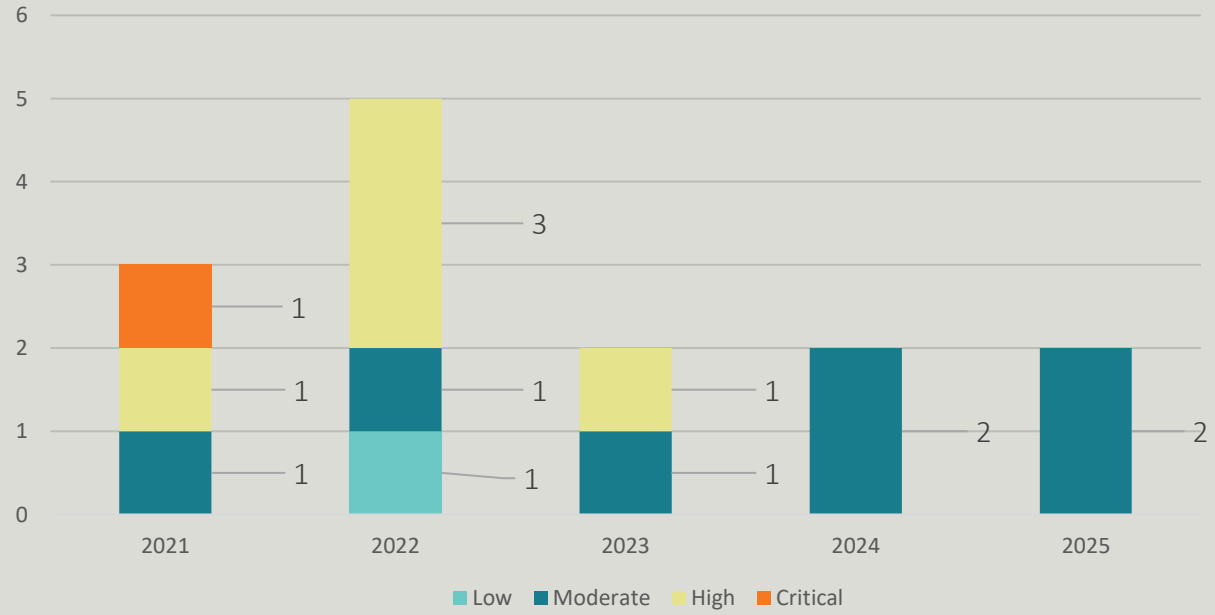
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Bloomfield Hospital was registered for 131 beds, it was a voluntary hospital located on Stocking Lane in Rathfarnham, south Dublin. The hospital was originally founded in 1812 by the Religious Society of Friends in Ireland (Quakers). It provided treatment for residents with a range of severe and enduring mental health issues and neuropsychiatric disorders. The approved centre provided residential and specialist mental health assessment, treatment, and support services to adults throughout Ireland. It also provided a national facility for the care of residents with Huntington's disease. Bloomfield Hospital was an independent non-profit organisation.

The approved centre was comprised of seven distinct units:

- Kilakee was a 21-bed unit that provided care for residents with Huntington's Disease.
- Kylemore was a 15-bed unit that was the Specialist Rehabilitation Unit (SRU).
- Owendoher was a 26-bed unit that provided care for residents with enduring mental illness and challenging behaviour.
- Donnybrook was a 31-bed unit that provided care for psychiatry of later life.
- Laurel Hill was a 12-bed unit that provided care for residents with high dependency needs.
- Pearson was an 8-bed unit that provided care for residents with severe and enduring mental illness with higher levels of independence.
- Swanbrook an 18-bed unit was not in use at the time of inspection.

The hospital had a modern dining facility for both staff and residents. The shared dining facility and attached kitchen was fully refurbished in late 2024 into a new purpose-built area for both residents and staff to enjoy. The new dining facility named J.B.'s was designed to enable all residents including those in large comfort chairs and wheelchairs to attend the dining facility and sit at the tables for meals. The area included a quiet staff relaxation area and a staff lunch preparation area with microwaves and fridges. Outdoor seating was also installed for residents and staff to enjoy their meals outside in the summer months.

There was a well-equipped occupational therapy room, library, hairdressing salon/beauty room, a resident run shop, and a visiting room. These were all situated off a link corridor known as 'Wicklow way'. The approved centre had extensive grounds, which were accessible to residents and visitors. Residents also had access to a sensory garden, courtyards, and landscaped gardens.

The approved centre had four consultant psychiatrist led multi-disciplinary teams (MDT), a general practitioner (GP), social workers, occupational therapists, pharmacists, physiotherapists, psychologists, nursing staff, a speech and language therapist, and a dietician. Admissions to the approved centre were pre-planned and by referral.

Fire remedial works in Donnybrook and Swanbrook units and all other residential accommodation had been completed. Beds remained decommissioned in Swanbrook unit. Fire remedial works had been completed in the dining area and kitchen and along the Wicklow-Way corridor. Remaining fire remedial works included the day activity centre ground and first floor, reception and the two-storey administration block.

Inspector of Mental Health Services Summary

The inspection of Bloomfield Hospital was unannounced and occurred over four days from 11th to 14th March 2025. This report reflects the findings over this period only. The inspection was well coordinated by staff and management in the approved centre. Overall, the approved centre is clean, well-presented and maintained throughout. It is evident that great care and consideration is given in providing a therapeutic, and welcoming environment to residents and their families.

In 2025, the inspection team found two areas of non-compliance, Regulation 15: Individual Care Plans and the Code of Practice on the Use of Physical Restraint. Both areas were also found non-compliant in last year's inspection. However, measures implemented by the service since the last inspection demonstrated progress in these areas. The senior management team was aware of the issues concerning care plans and physical restraint and were proactively seeking solutions.

Significant progress has been made in the past few years in addressing the previously high rates of non-compliance specifically relating to Regulation 26: Staffing and Regulation 22: Premises. The service has successfully reduced rates of non-compliance, and this had resulted in the previous condition assigned to the centre's registration being revoked.

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 a dedicated Head of Quality, Risk, and Compliance position. During the inspection resident feedback was overall very positive regarding the care and treatment they received in the approved centre, and they spoke warmly of staff.

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

Resident Profile	
Number of registered beds	***131***
Total number of residents	**108**
Number of detained patients	6

Number of wards of court	12
Number of residents under the Assisted Decision Making Act	3
Number of children	0
Number of residents in the approved centre for more than 6 months	100
Number of patients on Section 26 leave for more than 2 weeks	0

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 a music therapist, activities co-ordinators, physiotherapists and an art therapist.

A range of therapeutic group programmes were available to residents which included Zumba, Tai Chi, music therapy, family therapy, art therapy, pet therapy, compassion-focused therapy for psychosis, walking groups, cooking and baking groups, newspaper groups, decider skills groups, budgeting groups, gardening groups, reality orientation groups, cognitive stimulation groups, physiotherapy groups, emotional regulation groups, and social skills groups.

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	91%	85%	94%	94%	94%

Conditions of registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

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

1. Speech and Language Therapy co-ordinated training with Nursing and Health Care Attendant staff to improve knowledge and practical skills around nutrition.

2. The Killakee Unit was shortlisted for the Specialist Care Centre in Mental Health of the year in the 2025 Irish Healthcare Centre Awards.

3. Twenty-five nurses completed training in Nursing and Midwifery Board of Ireland (NMBI) approved category 1 training in Holistic care in Huntington's disease.

4. A family psychoeducation group commenced in the Killakee unit. The objective of this group was to promote a place for exchanging experiences and ideas focused on families where they feel free to talk about their own experiences, and to promote mutual support.

5. Fitness initiatives were enhanced in the approved centre by introducing new equipment, such as a recumbent bicycle, which provided a low-impact option for improving cardiovascular health.

6. Friday fitness sessions were held in the Special Rehabilitation Unit (SRU), focusing on strength building, flexibility, and cardiovascular health. These programs encouraged residents to remain physically active and contributed to both their physical and emotional well-being.

7. The approved centre purchased a new vehicle with disabled access giving residents greater opportunities for access to activities in the community.

8. The introduction of an Emergency Grab Bag for use outdoors if a resident, staff member or visitor had a fall/accident on the grounds of the hospital.

9. The psychology and activities team in collaboration celebrated World Mental Health Day. There were activities for staff and the residents such as movie screening in the activity centre, sound bath and relaxation sessions on the units for residents and staff, and a gratitude wall for staff and residents.

10. Lunch and learn sessions entitled "Mind over matter: Beat Stress, Improve Clarity and Find your balance" were organised for staff.

Although this document outlines some of the criteria that may contribute to demonstrating the excellent quality of the service provided, the service provider may wish to highlight and communicate any additional quality initiatives that are aimed at delivering excellence in their service. The information gathered may then be used by the Inspector to inform the inspection report.

The suggested criteria, as outlined in each of the above regulations, are evidence based and informed by The National Quality Framework: Driving Excellence in Mental Health Services 2023.

- **Regulation 05: Food and Nutrition**
  - New intensive training for health care assistants (HCA's) and nursing staff on food consistency by speech and language therapists and dietitians
  - Implementation of St Andrew's Healthcare Nutrition Screening Instrument (SANSI) and associated training
  - Increased hours for dietitians
  - Increased menu choices and options for residents
  - Clear menus now displayed on large TV screens for residents
  - Food presentation was audited to ensure it was well presented

- **Regulation 09: Recreational Activities**
  - Residents attended swimming classes in community pools
  - The Occupational Therapist (OT) Department conducted Pool Activity Level (PAL) assessments to showcase resident's interests for activities provision
  - The approved centre takes into consideration residents' interests while creating a schedule of recreational activities. Bloomfield introduced the following based on resident's needs, interests and requests: Cooking classes, knitting club, book club group, gardening club
  - Behavioural support plans were co-developed with residents to capture their needs and interests for activities provision
  - The approved centre recognises and responds to the needs of specific cultures and minority groups and ensures that the range of recreational activities are culturally specific
  - Celebration of international Women's and Men's Day
  - Reminiscence Therapy was based upon cultural memories for individual residents
  - Wheelchair Travel was an in-house activity where residents "travel" through the various cultures and countries in their wheelchairs

- **Regulation 11: Visits**
  - The approved centre maintains physical environments and facilities that are fit for purpose, welcoming, well-decorated and well designed
  - The approved centre provides information about visiting in a manner which is accessible and understandable to all

- **Regulation 13: Searches:**
  - The approved centre has multilingual resources in place to ensure that all residents had a clear understanding of the search procedures

- **Regulation 14: Care of the Dying:**
  - The approved centre incorporated holistic approaches; spiritual, religious and holistic needs of residents were documented in the Advance Healthcare Directives.
  - There were care of the dying booklets available to the residents and families
  - The Interfaith Room was available to residents and their family members at any time
  - The approved centre accommodated families of residents who wished to use the Interfaith Room for removal services
  - The approved centre had facilities to accommodate families to stay overnight with their relative when end of life care was being provided to a resident

- **Regulation 16: Therapeutic Services and Programmes**
  - Social work developed a psychoeducation programme for family members and supporters of residents in Kilakee. It involved advanced care planning.

- **Regulation 19: General Health**
  - The service demonstrated a high standard of quality practice in integrating physical health care within a mental health setting. General health is managed by an onsite General Practitioner and general health nurse, with a strong focus on chronic disease management and early risk identification. This included QRISK assessments for cardiovascular risk, 24-hour ambulatory blood pressure monitoring for hypertension, and establishment of a diabetic register with targeted screening and referrals. Chronic Obstructive Pulmonary Disease, heart failure, and arrhythmias were identified and referred appropriately
  - Smoking cessation support, vitamin D supplementation, high dose antipsychotic therapy monitoring, and onsite Tissue Viability Nurse expertise further enhance patient care.

- **Regulation 20: Provision of Information to Residents**
  - The approved centre promoted resident advocacy groups
  - The approved centre provided information in a manner which was accessible and understandable to all
  - All booklets were provided in different font sizes and languages
  - Residents own language was displayed in their bedrooms on all applicable signage (e.g. “bathroom” or “wardrobe”)
  - Picture booklets were available for information such as Speech and Language Therapy (SLT) for patients who could not read/understand text
  - The approved centre communicated in a variety of media: Information was available in hard copy/online, video calls can be arranged as required, interpreters were available as needed

- **Regulation 21: Privacy**
  - The approved centre provided culturally appropriate services to ethnic communities; religious services were available for the different faith groups, celebrations of international food days, celebration of Pride month for residents and staff (Pride parade held by residents)
  - The approved centre empowered residents to manage their own lives through developing life and social skills; teaching residents to cook to assist life management, support residents to

attend education and external organisations; e.g. DSPCA and the Men's Shed in the community
  - Residents were supported to manage their own monies with the assistance of staff via Credit Unions and Banks
  - There were Peer Support Workers in the approved centre

- **Regulation 22: Premises**
  - The approved centre ensured that the physical environment was designed to achieve best outcomes for residents, as there was quiet rooms and sensory rooms available on the units.
  - The approved centre redeveloped the canteen for shared dining space to accommodate all residents including those that use mobility aids. There was a hair dressing salon available to residents for patients.

- **Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines**
  - High-dose antipsychotic therapy (HDAT) was closely monitored as part of the deprescribing programme, ensuring ongoing assessment tailored to each resident response. The introduction of the eNOVA medication system strengthened medication safety, incorporating built in documentation for PRN effectiveness, individual and hospital-wide PRN usage tracking, reporting to drugs and therapeutics group. Monthly antimicrobial resistance monitoring tracks prescriptions, indications, and durations, alongside culture and sensitivity reports to identify bacterial resistance patterns. eGFR results are reviewed monthly to detect impaired kidney function, with results integrated into individual resident profiles on a medication management system called Digicare. Ongoing collaboration with the pharmacist aims to further develop this data management with eNova, ensuring continuous improvements in medication safety and resident care.

- **Regulation 26: Staffing**
  - The approved centre acknowledges that staff may suffer trauma through their work and takes steps to ameliorate the risk and manage the effect. The approved centre provides and ensures that staff have undertaken training in a variety of areas. For example, but not limited to:
  - Unconscious bias, discrimination, and stigma
  - Human rights
  - Advocacy and the recovery ethos
  - Assisted decision making and positive risk-taking, where required
  - Child protection, where applicable
  - Specific mental health therapies where applicable
  - Specific mental health conditions.
  - The approved centre provided annual personal and professional development planning and facilitates opportunities for non-technical skills training (e.g. policy development, leadership skills, and change management).
  - The approved centre provides skilled staff to facilitate the generation of a holistic, multidisciplinary, co-produced, individualised, and recovery-oriented care plan.

- **Regulation 29: Operating Policies and Procedures**
  - Policies, procedures, protocols, and guidelines were in place that relate to the standards and criteria of the National Quality Framework
  - The approved centre incorporated feedback from residents, families and carers into its policies, procedures, protocols, guidelines, and education programmes
  - The approved centre had policies and procedures in place for human resource management including retention of staff

- **Regulation 31: Complaints Procedures**
  - The approved centre has a complaints process which is visible and easily accessible to families and carers in addition to residents.
  - The approved centre provided training to staff on making and managing complaints: All staff completed online Complaint Management training and in-person Complaint Management training with the Head of Quality, Risk & Compliance
  - The approved centre has a process in place to gather feedback from families and residents
  - Residents have the opportunity to speak about issues at Resident Community Meetings

- **Regulation 32: Risk Management Procedures**
  - The approved centre had an audit and integrated quality and safety committee promoting a culture of governance with benchmarking across services. The risk management processes were developed in order to facilitate organisational learning within the approved centre and shares the learning with other relevant services.

3.0 Governance

The approved centre was under the overall governance of a Board of Directors who meet monthly. The Chief Executive Officer (CEO), Chief Financial Officer (CFO) and Clinical Director attended the Board of Directors meeting each month, the remaining Senior Management Team (SMT) members rotated attendance once per quarter. The SMT at the time of inspection met weekly and comprised of the CEO, CFO, Clinical Director, Director of Nursing, Head of Human Resources, Head of Facilities and Technical Services, and Head of Quality, Risk & Compliance. Issues such as service development and strategy, recruitment, serious incidents, occupational health, and safety, safeguarding, quality improvement, facilities, finance, risk management, and data protection, were discussed at these meetings.

Governance was strengthened by a Clinical Governance committee which was held monthly. The Clinical Governance committee meetings minutes evidenced agenda items such as quality improvement plans, sub-committee reports, quality and risk, compliance, adverse events, complaints and compliments, safeguarding, and items for escalation to SMT or the Board were discussed. The Clinical Governance committee comprised of the SMT, and had representation from physiotherapy, dietetics, speech & language therapy, social work, psychology, occupational therapy, human resources, infection control, nursing, and neuropsychiatry. The members completed an overview of the serious incidents reported within the approved centre and reviewed any issues identified as part of their risk management processes.

Subordinate committees included an infection, prevention and control committee, a medical emergencies committee, an audit committee, a health and safety committee, a reduction of restrictive practices committee, a food and nutrition committee, a prevention and management of aggression committee, a falls committee, and a drugs and therapeutics committee. All subordinate committees provided reported to the Clinical Governance committee.

The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded using an electronic standardised template and risk rated and uploaded to the National Incident Management System (NIMS) system. The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had departmental risk registers that were maintained and overseen by Clinical Managers and the Head of Quality, Risk and Compliance, applicable risks had been escalated to the corporate risk register. Senior management formally reviewed the risk register every quarter and updated the register's content and control measures as necessary. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Training in risk management was provided to staff.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. The numbers and skill mix of staff were sufficient to meet the residents' needs. Health and Social care professionals, including occupational therapy, psychology, social work, physiotherapy, dietetics and speech and language therapy were accessible to all residents.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, and psychology. The inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. All disciplines had formal and informal clinical supervision arrangements in place where appropriate. Annual staff training plans were completed to identify and address training needs. Operational risks highlighted within these questionnaires included: recruitment and retention of staff. The identified risks were effectively mitigated by escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, weekly resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Peer Advocacy in Mental Health organisation contacted the approved centre regularly and spoke with residents; advocacy contact details were displayed within the approved centre. There were clear processes in place to follow up on any issues identified by service users.

The approved centre had an established culture of quality improvement. This was evident in the ongoing refurbishment of the approved centre. The progression and development of various quality initiatives in the approved centre was also a standing agenda item at the Clinical Governance committee meeting. A programme of audit was implemented by the multi-disciplinary team throughout the service. The Clinical Governance committee also provided a multi-disciplinary approach to policy development, review, approval and dissemination and all policies were up to date at the time of inspection.

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (79)	79	100%	75	95%	76	96%	79	100%	79	100%	77	98%
Medical (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Occupational Therapist (4)	4	100%	4	100%	4	100%	4	100%	4	100%	4	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (5)	5	100%	5	100%	5	100%	5	100%	5	100%	5	100%
Physiotherapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
HCA (95)	95	100%	92	96%	92	96%	95	100%	95	100%	89	93%
Other (21)	n/a	n/a	21	100%	88	92%	21	100%	21	100%	21	100%

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 22: Premises	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed Circuit Television	✓	Compliant
Regulation 26: Staffing	✓	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
Part 4 Rule Governing the Use of Mechanical Restraint	✓	Compliant
Part 4 Consent to Treatment	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

4.2 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2021 and 2025 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2021		2022		2023		2024		2025	
Regulation 15: Individual Care Plans	✓		✓		✓		✗	Moderate	✗	Moderate
Code of Practice for the use Physical Restraint	✓		✓		✓		✗	Moderate	✗	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 did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engage with residents in a number of different ways:

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

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

Ten residents spoke with the inspection team directly during the inspection. Residents expressed that they believed that they were well taken care of, that the hospital was 'brilliant', and that their rooms were 'lovely'. Residents commented that staff were obliging, responsive, encouraging, respectful and positive. Residents expressed feeling that the approved centre was very clean and complimented the new canteen. Residents commented that the food was very good and catered to their nutritional needs and that they had a good choice of meals. Residents stated that they met with their team to discuss their care plan regularly. Residents commented that the activities provided were good and there were lots to do during the day. Residents expressed feeling happy in the approved centre and that they wouldn't change anything.

Ten completed feedback questionnaires were received from residents. Seven residents indicated they were orientated to the unit on admission and provided with information about their diagnosis and care and treatment in a way they could understand, three residents indicated they could not remember if this had occurred. All ten residents indicated they knew who their multi-disciplinary team members were, nine out of ten residents understood what their care plan was, seven out of ten residents were "always" involved in goal setting as part of the care planning process, and three out of ten residents were "sometimes" involved. Six respondents said they could "always" talk to staff, give feedback to the team, and discuss worries or concerns with staff, four respondents said they could "sometimes" talk to staff.

All ten residents indicated there were enough leisure activities, group activities and talking therapies provided and were complimentary of the recreational and therapeutic programmes. Nine residents out of ten indicated that they "always" felt safe in the approved centre, while one resident indicated that they "sometimes" felt safe. All ten residents indicated they were happy with the manner in which staff spoke with

them, that their dignity and privacy were respected, and they could communicate freely with family/friends/advocates.

There was a sense of overall satisfaction with the approved centre. On a scale of 1-10, with 1 being poor and 10 being excellent, all residents scored eight out of ten for overall care and treatment.

5.2 Advocacy

The approved centre had an advocacy service. The advocate visited the approved centre on a regular basis and offered face-to-face individual and group consultations to residents. The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

6.0 Feedback Meeting

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

- Clinical Director
- Chief Executive Officer (CEO)
- Director of nursing
- Head of Quality Risk & Compliance
- Head of Facilities & Technical Services
- Assistant Director of Nursing
- Senior HR Generalist
- Senior Physiotherapist
- Senior Occupational Therapist
- Executive Assistant to CEO
- Senior Social Worker
- Clinical Nurse Manager 3 x 2
- Senior Clinical Psychologist

Apologies:

- Deputy CEO and Chief Financial Officer

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

7.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, as appropriate. All ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission.

The ICP of two out of ten residents were not recorded in the one composite set of documentation: these two ICPs were each amalgamated and interrupted with progress notes; reviews were documented in clinical notes. This meant these two ICPs were also not identifiable.

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

The ICPs inspected were reviewed by the multi-disciplinary team (MDT) in consultation with the resident weekly. Following this review, three ICPs were not updated to reflect any changes to the goals, treatment, care, best practice, or required resources.

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

a) **Three individual care plans were not updated by the multi-disciplinary team to reflect any changes to the goals, treatment, care, best practice, and required resources.**
b) **The individual care plans of two residents were not recorded in the one composite set of documentation.**

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was compliant on inspection. Please see ***Section 4.1: Compliant areas on this inspection****.*

10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

*Please see **Section 4.2: 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 February 2025. 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 addressed all stipulated requirements.

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:
    - Breakaway and de-escalation techniques as a component of the prevention and therapeutic management of violence and aggression.
    - 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 to indicate that staff involved in the use of physical restraint had read and understood the policy. All staff who participated in the use of physical restraint had received the appropriate training and in the related policies and procedures; and the training was in accordance with the approved centre's physical restraint training policy. A record of training was maintained.

Monitoring: An annual report on the approved centre's use of physical restraint was published on the approved centre's website. There was a multi-disciplinary review and oversight committee in place which met at least quarterly. The committee determined if there was compliance with the approved centre's own policies and procedures. The committee identified and documented areas for improvement and the

associated actions, the persons responsible and the timeframes for completion of any actions. The registered proprietor nominee was assured that each use of physical restraint was in accordance with the Mental Health Commission's code of practice. The committee produced a report following each meeting, and this report was available to the MHC upon request.

Evidence of Implementation: Three episodes of physical restraint were inspected.

Order of Physical Restraint in each episode of physical restraint: Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The order for physical restraint confirmed there were no other less restrictive methods available to manage the residents' presentation. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than two hours after the start of the episode of restraint. The order for physical restraint did not exceed a duration of 10 minutes.

In one episode of physical restraint it was not documented that the person was informed of the reasons for the physical restraint and the circumstances that would lead to the discontinuation of the physical restraint.

The clinical practice form had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the consultant psychiatrist within 24 hours. The Mental Health Commission was notified via Comprehensive Information System (CIS) of the start time and date, and the end time and date, of each episode of physical restraint in the correct format and within three days of each episode.

Dignity and safety: Staff involved in the episode of physical restraint had taken into account any relevant entries in the residents' individual care plan pertaining to specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint.

In one episode of physical restraint, there was no documented evidence that the person was continuously assessed following the use of restraint to ensure the person's safety. Specifically the following information was not documented: that the person's head and neck were supported where necessary, that the person's airway and breathing were not compromised, that observations were conducted including clinical indicators such as the monitoring of pulse, respiration and complexion, and that the person's physical and psychological health was monitored for as long as clinically necessary after using physical restraint.

Ending of physical restraint: The physical restraint was ended by the person who had led it in each episode. The time, date, and reason for ending the physical restraint was recorded in the clinical file on the date that the physical restraint ended, in each episode.

Recording of the Use of Physical Restraint: The episode of restraint was recorded in the clinical file, and it was clearly recorded in the clinical practice form. There was a copy of the clinical practice form in the clinical file, and it was available to the Mental Health Commission on request.

Clinical Governance: Each episode of physical restraint was reviewed by the members of the multi-disciplinary team (MDT) involved in the resident's care and treatment and documented in the clinical file within five working days of the date of restraint. The MDT review, including recorded actions decided upon and follow-up plans to eliminate or reduce interventions for the resident, was documented. The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of physical restraint.

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

a) **Orders for physical restraint: In one episode of physical restraint it was not documented that the person was informed of the reasons for the physical restraint and the circumstances that would lead to the discontinuation of the physical restraint, 3.8.**
b) **In one episode of physical restraint it was not documented that the person was continuously assessed throughout the use of the restraint to ensure their safety, 4.5. physical restraint 4.5(i) to (iv).**

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 : 10006400		**Three individual care plans were not updated by the multi-disciplinary team to reflect any changes to the goals, treatment, care, best practice, and required resources. The individual care plans of two residents were not recorded in the one composite set of documentation.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of the inspection, the reviewed care plans were corrected to ensure compliance with this regulation.	Quarterly care plan audits are conducted to measure compliance with this regulation.	No barriers, completed at the time of the inspection.	14/03/2025	Clinical Director & Director of Nursing
Preventative Action	A new individual care plan documentation booklet has been developed by Senior Nurse Management & the Clinical Director (who has responsibility for Allied Health Professionals). This booklet will guide the MDTs through the care planning process ensuring compliance with the regulation and best practice.	Quarterly care plan audits are conducted to ensure compliance with the regulation on care planning.	No barriers identified.	31/07/2025	Director of Nursing and Clinical Director

	Education and training on this regulation and the use of the new booklet has been developed and is currently being rolled out to the MDTs within the hospital. This training has been made mandatory for all MDT meeting members. The training is lead by Senior Nurse Management and the Clinical Director to ensure a MDT approach. The training is due to be completed by 31 July 2025.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10006402		**Orders for physical restraint: In one episode of physical restraint it was not documented that the person was informed of the reasons for the physical restraint and the circumstances that would lead to the discontinuation of the physical restraint, 3.8. In one episode of physical restraint it was not documented that the person was continuously assessed throughout the use of the restraint to ensure their safety, 4.5. physical restraint 4.5(i) to (iv).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A new updated version of our physical restraint documentation booklet has been developed in line with the fine detail of the physical restraint code of practice. Each requirement of the code has been listed as a mandatory field in the new booklet which will guide and assist staff to maintain compliance with the code.	Every episode of physical restraint is audited to ensure full compliance with the code of practice.	No barriers have been identified, implemented 23 June 2025.	23/06/2025	Director of Nursing
Preventative Action	A new updated version of our physical restraint documentation booklet has been developed in line with the fine detail of the physical restraint code of practice. Each	Every episode of physical restraint is audited to ensure full compliance with the code of practice.	No barriers have been identified, implemented 23 June 2025.	23/06/2025	Director of Nursing

	requirement of the code has been listed as a mandatory field in the new booklet which will guide and assist staff to maintain compliance with the code.				

Appendix 2: REGULATIONS, RULES and CODES of PRACTICE

REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

Regulation 4: Identification of Residents

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

Regulation 5: Food and Nutrition

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

Regulation 6: Food Safety

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

Regulation 7: Clothing

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

Regulation 8: Residents' Personal Property and Possessions

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

Regulation 9: Recreational Activities

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

Regulation 10: Religion

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

Regulation 11: Visits

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

Regulation 12: Communication

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

Regulation 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.
(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.
(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.
(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.
(6) The registered proprietor shall ensure that there is a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.
(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.
(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.
(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.
(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

Regulation 14: Care of the Dying

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

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

Regulation 15: Individual Care Plan

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

Regulation 16: Therapeutic Services and Programmes

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

Regulation 17: Children's Education

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

Regulation 18: Transfer of Residents

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

Regulation 19: General Health

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

Regulation 20: Provision of Information to Residents

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

Regulation 21: Privacy

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

Regulation 22: Premises

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

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

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

Regulation 24: Health and Safety

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

Regulation 25: Use of Closed Circuit Television

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

Regulation 26: Staffing

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

Regulation 27: Maintenance of Records

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

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

Regulation 28: Register of Residents

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

Regulation 29: Operating Policies and Procedures

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

Regulation 30: Mental Health Tribunals

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

Regulation 31: Complaints Procedures

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

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

Regulation 32: Risk Management Procedures

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

Regulation 33: Insurance

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

Regulation 34: Certificate of Registration

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

RULES UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

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

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

Rule: Section 69: The Use of Seclusion

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

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

Rule: Section 69: The Use of Mechanical Restraint

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

PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 Consent to Treatment

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

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

Code of Practice: Use of Physical Restraint

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

Code of Practice: Admission of Children

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

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

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

Code of Practice: Admission, Transfer and Discharge

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

Appendix 3: Background to the inspection process

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

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

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

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

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

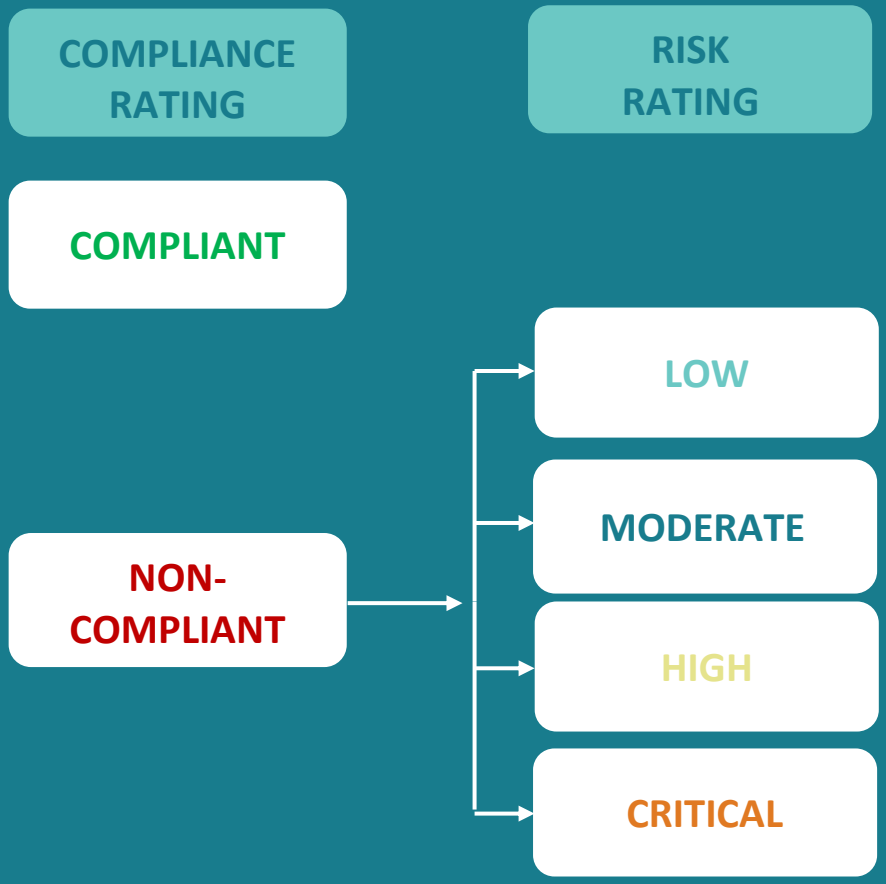
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

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



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

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

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

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