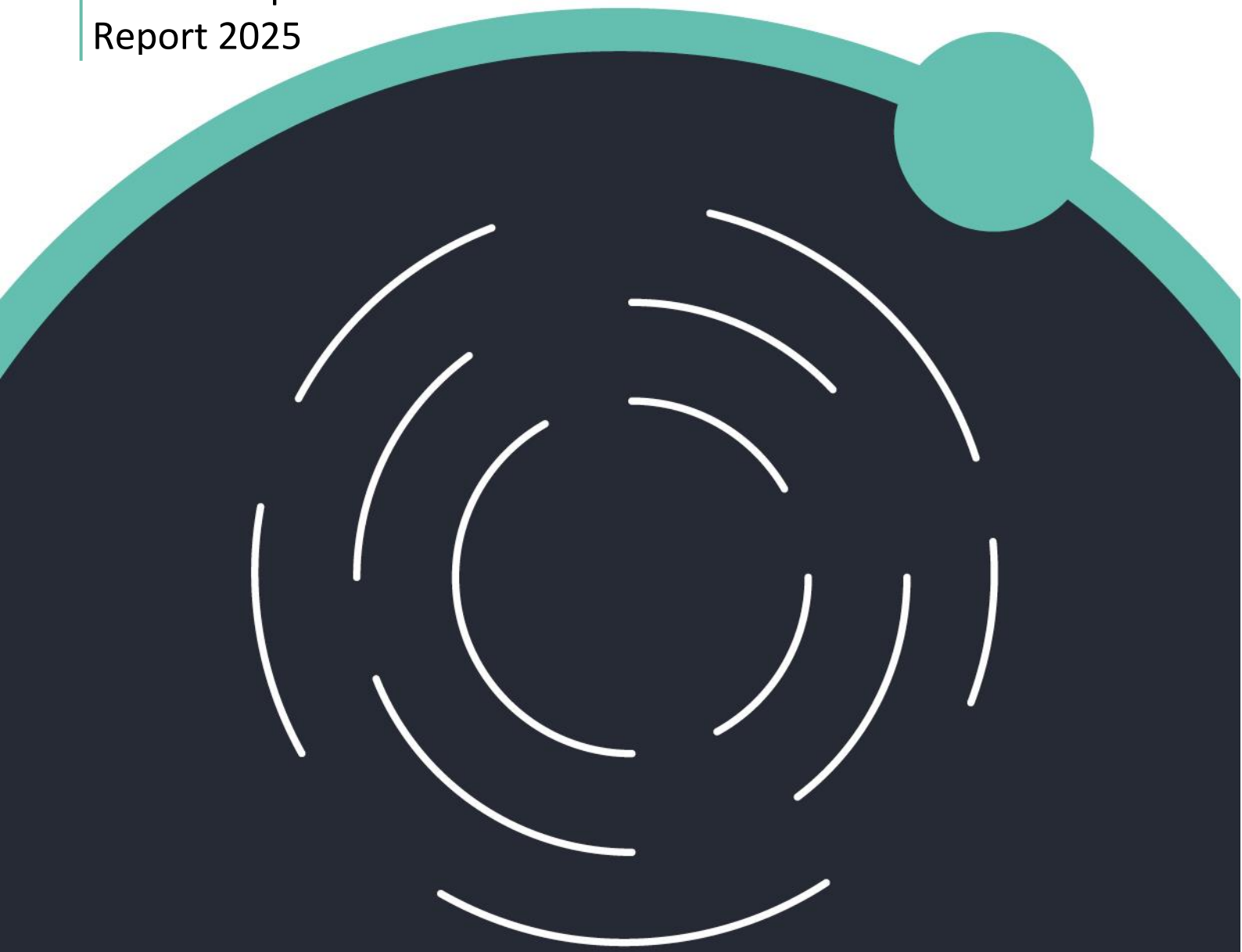
Adult Acute Mental Health Unit, University Hospital Galway

Annual Inspection Report 2025



Promoting Quality, Safety and Human Rights in Mental Health

ADULT ACUTE MENTAL HEALTH UNIT, UNIVERSITY HOSPITAL GALWAY

Newcastle Road, Galway

Date of Publication:
20 October 2025

ID Number: AC0076

2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life
Other: Homeless

Conditions Attached:
None

Most Recent Registration Date:
30 June 2024

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health Services

Inspection Team:
Susan O'Neill, Lead Inspector
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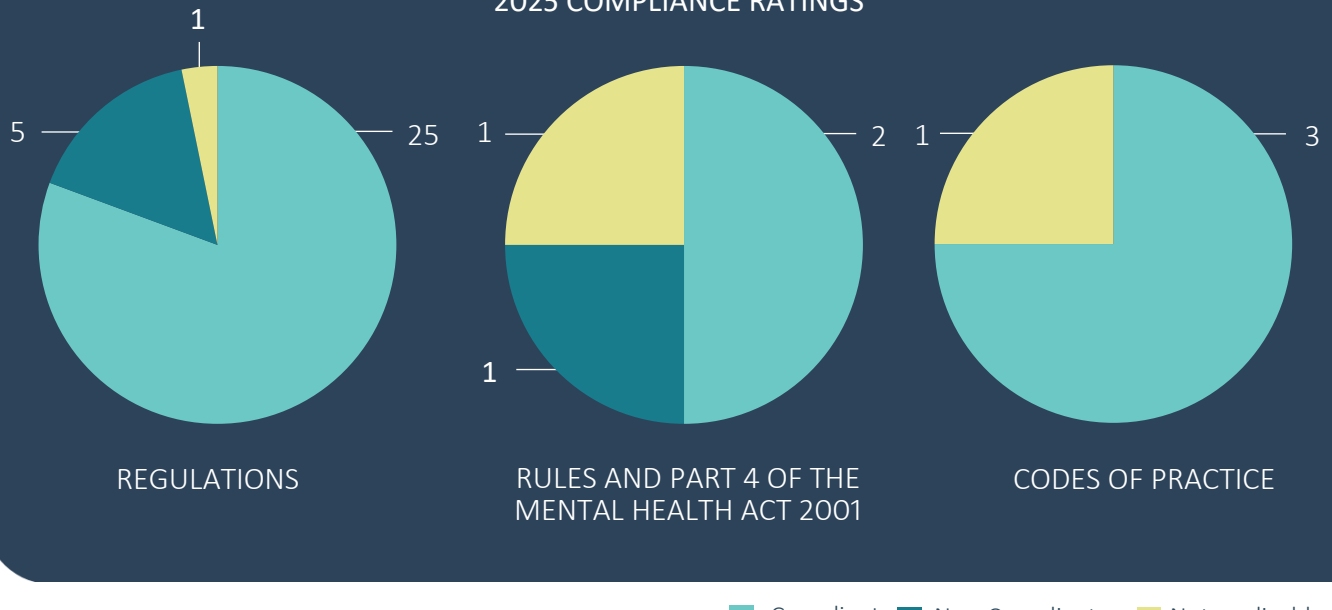
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
4 – 7 March 2025

Previous Inspection date:
19 – 22 March 2024

Inspection Type:
Unannounced Annual Inspection

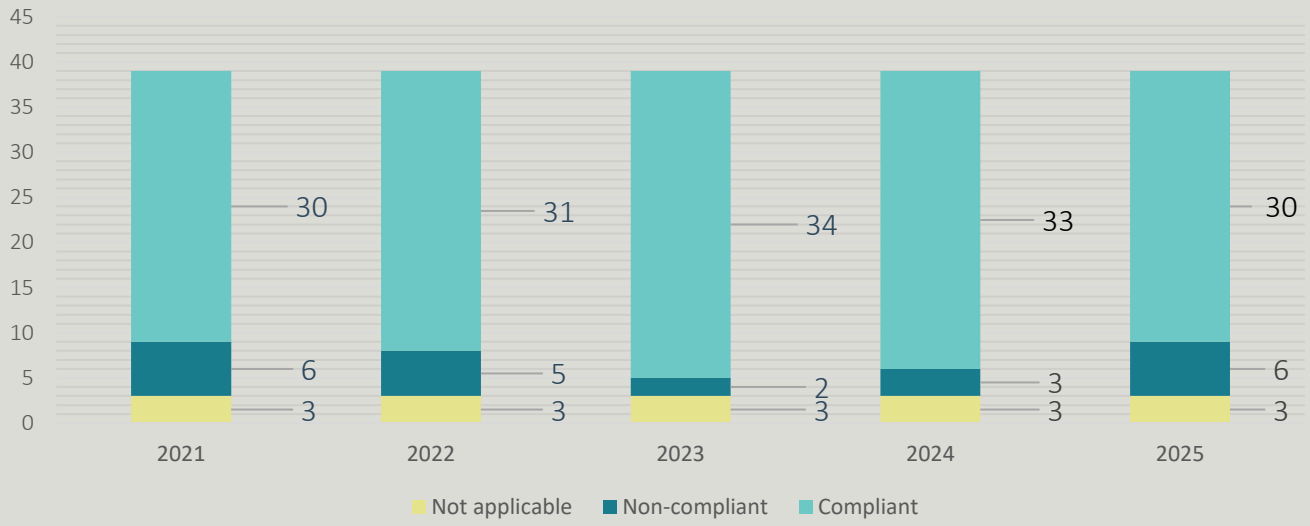
2025 COMPLIANCE RATINGS



RATINGS SUMMARY 2021 – 2025

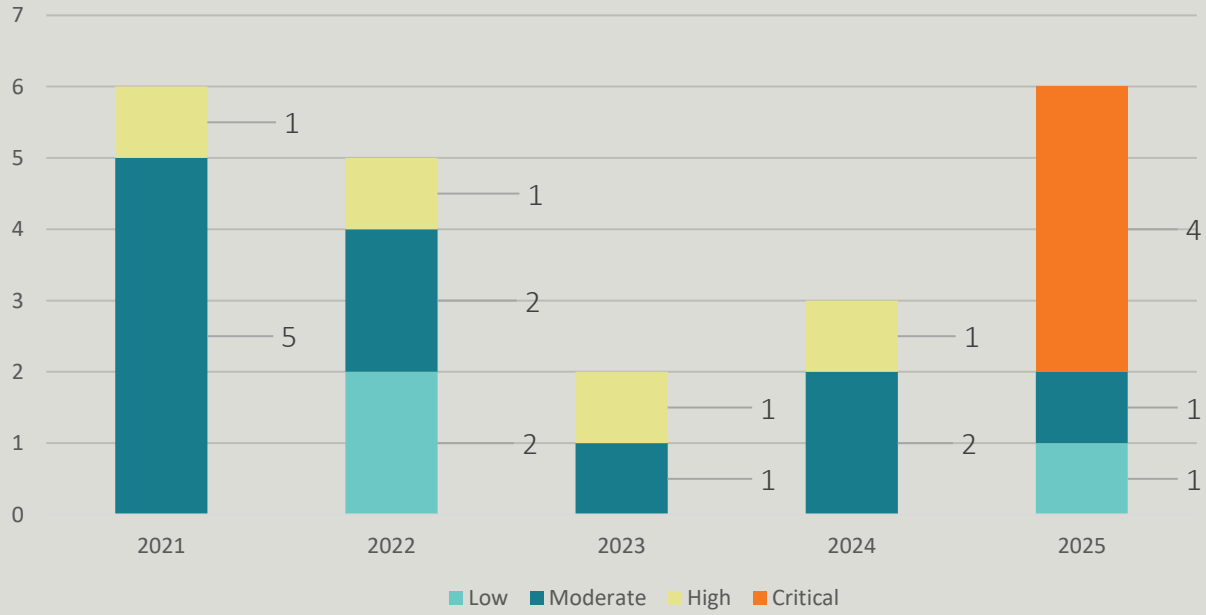
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

Description of Approved Centre

The Adult Acute Mental Health Unit, University Hospital Galway is located on the grounds of the University Hospital Galway. Thirteen consultant-led teams admit residents to the approved centre, which includes eight general adult teams, two teams specialising in the psychiatry of later life, one team specialising in mental health intellectual disability, one team specialising in rehabilitation and recovery and one team specialising in mental health for homeless people. Three more consultant-led teams, the liaison psychiatry team, the perinatal mental health team and the Crisis team can admit to the approved centre by referral to the on- call consultant or the consultant of the catchment area where the resident resides.

The approved centre is a purpose-built two-storey building with accommodation for 50 beds and consists of four separate suites: Hazel, Ash, Holly and Oak. Access to the building is facilitated by security staff located in the main reception area, along with a dedicated visitors room and an assessment room. Hazel, Oak and Ash suites are located on the ground floor. Both Hazel and Ash suites are general adult suites; Hazel suite consists of 19 beds and Ash suite contains 18 beds. Hazel suite contains one three-bed , two two-bed and twelve single en suite bedrooms. Ash suite contains two two-bed bedrooms and fourteen single en suite bedrooms. Both Hazel and Ash suites have access to a shared area, which contains a dayroom, a games room, a quiet room, a dining area and an outdoor garden area. Oak suite is the high observation unit and consists of five single en suite bedrooms. Oak suite also contains a dining room, a relaxation room, a seclusion facility and an outdoor garden area.

Holly suite, located on the first floor, consists of eight single en suite bedrooms, and is dedicated to psychiatry of later life. The bedrooms are decorated with the residents' personal effects and furnished appropriate to each resident's needs. Holly suite also contains a dining room, a visitors room, a lounge room and a quiet room. Residents have access to an outdoor enclosed space, which contains seating areas and raised garden beds. The first floor also houses administration and management offices, a room dedicated to hosting mental health tribunals, training rooms, an Electroconvulsive Therapy (ECT) suite and therapy facilities that includes a relaxation room, an art room and a therapy kitchen.

Inspector of Mental Health Services Summary

The Adult Acute Mental Health Unit (AAMHU) is located on the grounds of the University Hospital Galway. The inspection of the AAMHU was unannounced and occurred over a four-day period. The inspection report reflects findings of the inspection over this period only.

In 2025, the inspection team found six areas of non-compliance, reflecting an increase from three areas in 2024. Regulations relating to privacy, premises, risk management procedures and the Rule governing the Use of Seclusion were all risk rated as critical, the highest level of risk. Under Regulation 21: Privacy, there was a reoccurring non-compliance concerning the lack of locking mechanism on the single bedroom and en suite bathroom doors. During the inspection, one resident reported sometimes feeling unsafe specifically related to the lack of a locking mechanism on the door. Concerns about privacy when showering were also raised by another resident with the local advocate. Regarding the regulations governing premises and risk management procedures, there were numerous issues identified with the functioning of fire doors and adequacy of some of the fire safety measures. Service management were aware of the issue concerning the fire doors and were proactively seeking solutions.

The approved centre environment was observed to be calm and relaxed. There were many areas of good practice observed over the course of the inspection which included food safety, an emphasis on staff education and a high level of multi-disciplinary collaboration. The Safewards Model was implemented throughout the approved centre for the purpose of reducing conflict and enhancing shared care.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**48**
Number of detained patients	10
Number of wards of court	0
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	6
Number of patients on Section 26 leave for more than 2 weeks	1

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	83%	86%	94%	92%	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

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice 10000357	*31 March 2025*	*Following the annual regulatory inspection of 4 to 10 March 2025, the approved centre was found non-compliant with 6 regulations and 4 of these, Regulation 21, Regulation 22, Regulation 32 and the Rules Governing the Use of Seclusion Regulation were risk rated as critical.*	*Approved centre submitted plans to address these non-compliances in the approved centre. The MHC continues to engage with the HSE on these matters.*

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.

- **Regulation 05: Food and Nutrition:**
  - Monthly demonstrations were completed in the approved centre by a chef from the main kitchen; examples included smoothie making and build a burger.
  - The approved centre had processes in place for the involvement of residents in their nutritional care. Residents could feedback menu preferences at the community meetings.

- **Regulation 09: Recreational Activities:**
  - Residents were encouraged to make suggestions at the weekly mutual help meetings to inform the recreational activities timetable.
  - Residents were accompanied for walks off the AAMHU Hospital campus to local parks and amenities.

- **Regulation 11: Visits**:
  - There was a dedicated visitor room for children visiting family members in the AAMHU which had child friendly décor, toys and was strategically located externally to resident care areas.

- **Regulation 12: Communication**:
  - Mutual help meetings provided an opportunity for information sharing and updating residents on any developments in the AAMHU.

- **Regulation 14: Care of the Dying:**
  - The approved centre had single bedrooms to accommodate family staying overnight if end-of-life care is being provided.
  - The AAMHU worked in collaboration with colleagues in the general hospital to ensure the comfort of end-of-life residents to include pain management and control.

- **Regulation 16: Therapeutic Services and Programmes:**
  - Occupational Therapy and medical disciplines collaborated to deliver a Safety Planning Group Intervention. The initiative aimed to help those who had experienced recent suicidality to understand their warning signs and develop coping strategies. The intervention was open to both inpatients of AAMHU and outpatients.
  - The dietitian developed a diet and lifestyle resources information sheet which included QR codes. This enabled residents to access relevant information on healthy eating, weight management, diabetes and alcohol.
  - The dietitian developed an information leaflet for residents as a guide to staying healthy on

anti-psychotic medications.
    - The service implemented the Safewards model to support the management of conflict in the approved centre.

- **Regulation 20: Provision of Information to Residents**:
    - The patient information booklet was updated to include a sexual safety charter.
    - A resident advocacy representative visited the AAMHU to engage with residents. The advocate made representations on behalf of residents as required.
    - Safewards Mutual Help meetings occurred every Thursday where residents and staff came together to discuss a round of thanks, news, suggestions and requests. Notifications of these meetings were displayed throughout the AAMHU. Refreshments were provided at the meeting, creating a relaxed atmosphere.
    - Resident discharge packs were developed and included a wallet card of useful numbers and key contact details to assist service users on discharge.

- **Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines:**
    - There was a dedicated pharmacist assigned to the AAMHU who provided advice, guidance and support on all matters relating to medication.
    - Medication information leaflets were available for residents.
    - A risk management project aimed at improving and standardising the treatment of Acute Coronary syndrome (ACS) in the Adult Acute Mental Health Unit (AAMHU) was completed. The intervention involved placing the Galway University Hospital's ACS guidelines on every ward and an ECG machine in AAMHU. An ACS medications pack was developed to ensure relevant emergency medications were always available, and checking mechanisms designed. A guidance sheet for usage of the ACS guidelines in AAMHU was developed and placed alongside all copies of the guideline.

- **Regulation 26: Staffing:**
    - A new staff training plan was introduced which set out a detailed and streamlined plan for training across disciplines.
    - The medical team acquired a new web-based application called 'Psychiatry Induction Resource -Online' (PIRO). PIRO functioned to support the medical team to keep up to date with training needs by providing alerts when training is due and directing staff to appropriate training resources.

- **Regulation 27: Maintenance of Records**:
    - There was a full-time dedicated ward clerk on site to ensure that all records are maintained.
    - The maintenance of records was monitored through an auditing process.

- **Regulation 29: Operating Policies and Procedures:**
    - The operating policies and procedures were reviewed and updated in accordance with any changes in legislation and best practice guidelines.

- **Regulation 31: Complaints Procedures:**
    - There was a clinical complaints committee in place that met fortnightly.

3.0 Governance

In 2024, the HSE was restructured and was divided into six new HSE Health Regions which, in turn, consisted of Integrated Health Areas (IHAs); this replaced the hospital groups and Community Healthcare Organisations (CHO) which merged to form the new Health Regions. The approved centre, formerly part of Community Healthcare West, is located within the Integrated Health Area (IHA) of Galway Roscommon. The Galway Roscommon health area, combined with three other health areas (Sligo/Leitrim, Mayo, Donegal), forms the HSE West and Northwest Health Region. Due to the ongoing transition of governance from Community Healthcare West to the HSE Health Region, the governance of the approved centre, including lines of authority and the associated governance structures within the Galway Roscommon mental health services, had not changed at the time of inspection.

The approved centre was under the governance of the Galway and Roscommon Mental Health Service. The Galway and Roscommon Mental Health Services overarching governance process encompassed two core monthly meetings: the Area Management Team Meeting (AMT) and the Quality and Safety (QS) Committee meeting (QS). The AMT meeting convened monthly, chaired by the Head of Services and was attended by the general manager, Heads of disciplines, the Quality and Patient Safety advisor, and the Area Lead in Mental Health. Standing agenda items included human resources, finance, key performance indicators, risks management, health and safety and data protection. The QS meeting convened monthly, and was attended by the Head of Service, the business manager, heads of discipline and other senior management. Agenda included items such as incident and risk management, regulatory compliance, health and safety, and quality improvement.

Within the approved centre, the Acute Unit Business Meeting, which convened every six to eight weeks, was chaired by the clinical director and attended by representatives from various clinical disciplines, the business manager, the mental health act administrator and the quality and patient safety advisor. The Acute Unit Business Meeting functioned to support the management of clinical governance, operational, and quality and patient safety issues. Various specialist committees such as the audit committee, the Restrictive Practice Review Committee, the Drugs and Therapeutic Committee, and Delayed Discharge group reported to this forum.

The approved centre had a local risk register, and this was reviewed and updated at the local Business meeting. There were defined processes to escalate risks to the Galway Roscommon AMT risk register, which in turn, was reviewed at the QS meeting forum. If appropriate, risks could be further escalated to Community Healthcare West risk register, managed by the Senior Management Team. Overall, identified clinical risks, corporate risks and most of the health and safety risks were effectively managed in the approved centre. The inspection team, however, were concerned about the health and safety risks associated with the implementation of some of the fire safety measures on site. On inspection, it was observed, that eight different fire doors did not fully close upon release from an open position. This impaired the compartmentation of the facility. Compartmentation is the process of subdividing a facility into a number of smaller fire protected areas for the purpose of containing the spread of fire in parts of the facility and also to allow phased evacuation of people. There was an inadequate oversight process in place to promptly

identify problems with fire doors and consequently to repair them in a timely manner. Fire doors were not inspected by a specialist on a six-month basis; this was three months overdue at the time of inspection. During the inspection, the team also observed the practice of obstructing fire doors in an open position on four separate occasions. Apart from fire doors fitted with automatic door closer mechanisms, fire doors should remain in a closed position to ensure that, in the event of a fire occurring, the fire and toxic fumes are contained for as long as possible. Fire drills were conducted twice annually however a simulation of a nighttime drill was not conducted. This involves conducting the drill with minimum staff numbers to ensure that fire evacuation procedures will still be effective. Each resident on Holly suite, the unit for older adults, had a Personal Emergency and Evacuation Plan (PEEP) completed. However, three of the resident's plans did not specifically describe the evacuation equipment required for residents with impaired mobility; two other PEEPs were not signed or dated upon completion.

The approved centre had a standardised process for the management of incidents. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and were reviewed to identify any trends or patterns occurring in the service. Analysis of incidents took place at the Acute Business Meeting and feedback was given to staff through the relevant line managers.

Thirteen consultant-led teams admitted residents to the approved centre, which included eight general adult teams, two teams specialising in the psychiatry of later life, one team specialising in mental health intellectual disability, one team specialising in rehabilitation and recovery and one team specialising in mental health for homeless people. Staffing shortages were identified amongst some of the mental health disciplines. There were vacancies on the nursing team, however, a full staffing complement was achieved daily through the use of overtime working and agency nursing. Occupational therapy staff based in the approved centre consisted of two occupational therapists (OT) and one occupational therapy assistant. There was one vacant staff grade post however, at the time of inspection, there were no unmet needs for residents. Occupational therapists working in the community teams attended the relevant sector team individual care planning meetings in the approved centre on a weekly basis and communicated relevant outcomes to the ward-based OTs. There was one allocated post for a psychologist within the approved centre, but this had been vacant since September 2024. Attempts to recruit to the post were unsuccessful, however, a repeat recruitment drive was planned. Psychology services were provided via an in- reach model of care, whereby, psychologists based in the community sector teams and specialist teams visited the approved centre to assess and treat residents admitted by those same teams. At the time of inspection, there were no unmet resident needs or waiting lists for psychology services. There was one full time social worker based in the approved and social workers based in the community teams also visited the approved centre to attend the MDT meetings on a weekly basis. At the time of inspection, the medical team was fully staffed.

Most of the staff working in the approved centre had completed the required mandatory training (see training record table). Each head of discipline was responsible for the oversight of training completion within their team. Where there was any minor deficit, training dates had been scheduled for the relevant staff members.

Governance questionnaires were completed by each discipline and were returned to the inspection team. Each head of discipline provided an overview of the governance within their respective roles, issues of risk

or specific concerns and outlined strategic goals for the service and systems to monitor goal progression. A multi-disciplinary approach was fostered within governance structures and clinical care and the ethos of continuous quality improvement was visible. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development which included identifying training needs. The availability of supervision varied across departments ranging from formal and peer supervision within their own disciplines to being facilitated by external supervision.

Resident engagement in quality improvement processes was facilitated throughout the service by the use of suggestion boxes in the approved centre and the availability of the compliments and complaints process to support service improvement. The process of making complaints and the complaints officer contact details were displayed within the approved centre. Complaints had been investigated promptly and were documented with clear actions and outcomes detailed in the complaints log. Residents were involved in the development and review of their individual care plans. Weekly mutual feedback meetings took place which provided an opportunity for residents to raise concerns or make suggestions.

Mental Health Engagement and Recovery was a standing item on the agenda of the Galway and Roscommon Mental Health Services Area Management Team meeting. The area lead for Mental Health Engagement was a member of the Galway and Roscommon Area Management Team and the Quality and Safety Committee. There was a designated advocate from the Peer Advocacy in Mental Health Services who visited the approved centre weekly and spoke with residents. The advocate's contact details were displayed within the approved centre.

Therapeutic Services and Programmes

Therapeutic programmes and Services were provided by members of the multi-disciplinary team both on an individual basis and within group settings. Health and social care professionals based in the approved centre included two occupational therapists, an occupational therapy assistant, a social worker, and a dietitian. Psychology interventions were provided on an in-reach basis whereby, psychologists based in the community sector teams and specialist teams visited the approved centre to assess and treat residents admitted by those same teams.

The therapeutic timetable included the following groups facilitated by the occupational therapist:

1. A decider skills group was co-facilitated with a psychology assistant from the community
2. A safety planning group
3. A cooking group
4. Exercise/movement groups based on themes including gentle exercise, yoga, and walking.
5. A relaxation group
6. Psychosis art group – this is an initiative co-produced with residents to support creative expression in recovery.

The social worker facilitated a communications skills group. The dietitian facilitated a cookery and nutrition education group and a ward-based drop-in Dietitian Clinic. Weekly music therapy and art therapy groups were facilitated by a music and an art therapist respectively. Community services such as GROW, a nationwide peer support service, and the Galway Recovery College attended the approved centre each week to facilitate a peer support group and a Wellness Recovery Action Plan (WRAP) group.

Residents had access to community-based services such as FAI Kickstart to Recovery and, and the Galway Community Cafe.

Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (62)	59	95%	56	90%	57	92%	62	100%	62	100%	62	100%
Medical (59)	58	96%	53	90%	51	90%	59	100%	59	100%	5	100%
Occupational Therapist (3)	2	66%	3	100%	3	100%	3	100%	3	100%	3/3	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (14)	14	100%	14	100%	14	100%	14	100%	14	100%	14	100%
Dietitian (1)	1	100%	1	100%	1	100%	1	100%	N/A	N/A	1	100%
Pharmacist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	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 20: Provision of Information to Residents	✓	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 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 on the Use of Physical Restraint	✓	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	✓		✓		✓		✓		✗	Moderate
Regulation 19: General Health	✓		✓		✓		✓		✗	Low
Regulation 21: Privacy	✗	Moderate	✓		✓		✗	High	✗	Critical
Regulation 22: Premises	✓		✗	Low	✓		✓		✗	Critical
Regulation 32: Risk Management Procedures	✗	High	✓		✓		✗	Moderate	✗	Critical
Rules Governing the Use of Seclusion	✓		✓		✓		✓		✗	Critical

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

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre 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.

5.1 Service-user feedback

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

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

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

One resident spoke with the inspection team. Feedback was very positive; the resident was very complementary toward the staff, the variety of activities offered, and the quality of the food. The resident knew all their multi-disciplinary team, stating that all were very helpful. The person felt safe on the unit. The bedroom was described as very comfortable however, concerning privacy, the resident expressed that it would be nice to able to lock the en suite door.

Four service user experience questionnaires were completed and returned to the inspection team:

- Three residents reported that staff members explained what was happening in a way they could understand upon arrival to the approved centre, while resident reported that staff did not explain.
- Two residents reported that staff always provided information about their diagnosis, care and treatment in a way that was understandable, while the other two residents reported that this occurred sometimes.
- Two residents found the information provided about their diagnosis helpful while two other residents found it partially helpful only.
- All residents understood their individual care plan and three residents reported that they were always involved in setting goals; one resident indicated that they were never involved.
- All residents knew who the members of the multi-disciplinary team were but only two residents knew their keyworker was.
- Two residents indicated that they were always able to discuss worries or concerns with a member of staff, while two residents indicated that they could only do this sometimes.
- Two residents reported that there were enough leisure activities during the day, while two did not. One person indicated that more TV access and books would be of benefit. One person indicated that that more religious or spiritual activities might be facilitated.
- Three residents reported that there were enough group activities during the day.

- Two residents reported that there were enough talking therapies if needed. Two other residents indicated that there were not enough talking therapies.
- All respondents were happy with how staff talked to them. One person noted that while staff are busy, they always get back to them as soon as possible.
- Three residents felt that their privacy and dignity were respected.
- All residents were able to communicate freely with family, friends or advocates.
- Two residents felt safe all the time, while two residents only felt safe sometimes. One of the residents who reported feeling safe only sometimes, noted that people were coming into their room by accident and that they were never informed that their bedroom door is never locked.
- Three residents reported that they felt able to give feedback to staff and to make complaints when not satisfied with any part of their stay in the approved centre, and one resident reported feeling able to do this only sometimes.
- Respondents reported on the most positive aspects of service user experience. Comments included
    - the empathetic and patient nature of nursing staff
    - the consideration of the person's views by the consultant
    - compassion from staff
- Respondents also noted suggested improvement for the service. These included:
    - the provision of more talking therapies
    - the provision of more information when being given a diagnosis
    - more pillows and warm blankets
    - a prompter response upon patient request for specific items

5.2 Advocacy

The approved centre had an advocacy service. The inspection team received a report from the Peer Advocacy in Mental Health representative. Positive comments included the following:

- Residents appreciated the care and the food.
- Residents enjoyed the groups such as the occupational therapy group, the art group and the walking group. A desire for a least two walking groups per week was reported.
- Residents liked the outdoor space and enjoyed using the sitting room to watch TV etc.
- One resident was pleased to get colouring materials when she asked for them.
- Some residents enjoy the mutual support meeting.
- Some residents reported their appreciation regarding aspects of care such as receiving help with housing needs, having unaccompanied leave, support with medication changes, and therapy provision.
- One resident was pleased with the service provided by the Peer Support Worker.

Areas requiring improvement included the following:

- A desire for an indoor gym was reported while another resident suggested acquiring a punchbag. Another resident expressed a wish for unaccompanied leave to go to a gym.
- Residents suggested improvements to the premises such as installing an awning over the outside of the canteen door and installing more water fountains.

- One resident suggested a selection of music available to play on the unit.
- Residents suggested having more activities on the unit, particularly at weekends.
- Some residents reported needing help in finding accommodation or expressed concerns about current accommodation. Residents were either in contact with their social worker about these issues or seeking referral to a social worker.
- One resident expressed disappointment with the prescription of a particular type of medication as he had stated his wish not to take that same medication.
- Some residents reported needing help to organise Social Welfare payments.
- One resident expressed a desire to have more privacy. The resident expressed that it was not nice when a member of staff walks into the room when a person is in the shower, etc. (The advocate discussed this with the Clinical Nurse Manager at the time who confirmed that privacy would be respected.)
- One resident wanted to have a consultant psychiatrist that was of the same gender.

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:

- Administrative support
- Area Director of Nursing
- Assistant Director of Nursing
- Business Manager
- Clinical Director
- Clinical Nurse Manager 2
- Clinical Nurse Manager 3
- Maintenance Manager
- Pharmacist
- Principal Psychologist
- Principal Social Worker
- Quality and Patient Safety Advisor
- Registered Proprietor
- Senior Dietitian

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 a composite set of documents with allocated sections for needs, goals, treatment, care, resources required and space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes.

The ICP of three out of ten residents was not developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission.

The ICPs were discussed, agreed where practicable and drawn up with the participation of the resident and their representative, family and next of kin, as appropriate.

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

Two ICPs inspected were not reviewed by the necessary staff of the multi-disciplinary team (MDT) in consultation with the resident.

One ICP was not updated to reflect changes to the goals, treatment, care, best practice, and required resources.

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

a) **The individual care plans of three residents were not developed by the multi-disciplinary team.**
b) **The individual care plans of two residents were not reviewed by the multi-disciplinary team.**
c) **The individual care plan of one resident was not updated contemporaneously following review to reflect changes to treatment, care and required resources.**

Regulation 19: General Health

NON-COMPLIANT

Risk Rating LOW

INSPECTION FINDINGS

The approved centre had a policy and procedures for responding to medical emergencies, the policy was last reviewed in January 2024. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

Residents' general health needs were monitored and assessed as indicated by the residents' specific needs. Six monthly general health assessments were completed for residents where appropriate, however, upon inspection, two assessments were not completed comprehensively. The resident's weight was not recorded on the six-monthly assessment of one resident and the completion of a medication review was not recorded on the six-monthly assessment of another resident.

Residents on antipsychotic medication received a yearly assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram heart function assessment. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Access to the national screening programmes, such as breast check, cervical screening, and bowel screening were available where applicable to the needs of these residents.

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

a) **Each resident's general health needs were not comprehensively assessed as the six-monthly general health assessment completed for one resident did not record their weight, 19(1)(b).**
b) **Each resident's general health needs were not comprehensively assessed as the six-monthly general health assessment completed for one resident did not record a medication review, 19(1)(b).**

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

Staff displayed professional, engaging and compassionate attributes in their interactions with residents. Residents were called by their preferred name based on their self-identification. Staff appearance and dress was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

Residents' privacy and dignity was not appropriately respected at all times. The single bedrooms did not have a locking mechanism on the inside of the doors and the en suite bathrooms did not have locks on the doors. Resident feedback was obtained via service user questionnaire. One resident reported feeling safe only sometimes and noted that people were coming into their room by accident and that they were never informed that their bedroom door is never locked.

Where residents shared a room, the bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls. All residents wore clothes that respected their privacy and dignity.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times for the following reasons:

a) **Single bedrooms did not have a locking mechanism on the inside of doors.**
b) **En suite bathrooms did not have locks on the doors.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. The approved centre was adequately lit, heated and ventilated. Appropriate signage and sensory aids were provided to support residents in finding their way around the approved centre. Sufficient spaces were provided for residents to move about, including outdoor spaces. All resident bedrooms were appropriately sized to address the resident needs. Lighting in communal rooms was sufficiently bright to suit the needs of residents and staff. Hazards were minimised, and ligature points were minimised to the lowest practicable level, based on risk assessment. The approved centre provided suitable and appropriate furnishings, and enough toilets and showers for residents, with at least one assisted toilet. The centre provided assistive devices and equipment to address resident needs.

While the approved centre was clean on the inside it was not clean everywhere on the outside: there was graffiti on the walls of the Ash and Hazel garden. The approved centre was not kept in a good state of repair. There were eight sets of fire doors which did not close fully on release, which would impair proper door functioning in the event of a fire.

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

a) **The approved centre was not clean throughout as there was graffiti on the walls of the main garden area, 22(1)(a).**
b) **The condition of the physical structure and the overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff and visitors, as the fire doors were not inspected by a specialist every six months, 22(3).**
c) **The registered proprietor did not ensure that the overall environment was maintained with due regard to the safety and wellbeing of the residents, staff and visitors. There were eight sets of fire doors which did not close fully on release, which would impair proper door functioning in the event of a fire, 22(3).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

The approved centre had a comprehensive written operational policy and procedures in relation to risk management. The policy was last reviewed in February 2025. The risk management policy and associated safety statement addressed policy requirements, including:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. Clinical and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

In general, health and safety risks were identified, assessed, treated, reported, monitored however, not all fire safety risks were identified, assessed, treated or monitored. On inspection, it was observed, that eight different fire doors did not fully close upon release from an open position. This impaired the compartmentation of the facility. Compartmentation is the process of subdividing a facility into a number of smaller fire protected areas for the purpose of containing the spread of fire in parts of the facility and also to allow phased evacuation of people. There was an inadequate oversight process in place to promptly identify problems with fire doors and consequently to repair them in a timely manner. Fire doors were not inspected by a specialist on a six-month basis; this was three months overdue at the time of inspection. During the inspection, the team also observed the practice of obstructing fire doors in an open position on four separate occasions. Apart from fire doors fitted with automatic door closer mechanisms, fire doors should remain in a closed position to ensure that, in the event of a fire occurring, the fire and toxic fumes are contained for as long as possible. Fire drills were conducted twice annually however a simulation of a nighttime drill was not conducted. This involves conducting the drill with minimum staff numbers to ensure that fire evacuation procedures will still be effective. Each resident on Holly suite, the unit for older adults, had a Personal Emergency and Evacuation Plan (PEEP) completed. However, three of the residents' plans did not specifically describe the evacuation equipment required for residents with impaired mobility; two other PEEPs were not signed or dated upon completion.

The approved centre had provided a six-monthly summary report of all incidents to the Mental Health Commission (MHC) in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting within the required timeframe. An emergency plan specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures. The requirements for the protection of children and vulnerable adults within the approved centre are appropriate and implemented as required.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that an approved centre implemented the risk policy throughout the approved centre for the following reasons:

a) **Fire risks were not adequately assessed as not all Personal Emergency Evacuation Plans were completed adequately, 32(1).**
b) **Fire risks were not adequately identified or assessed as fire doors were not inspected by a fire specialist every six months, 32(1).**
c) **Fire risks were not adequately identified or assessed as the practice of obstructing designated fire doors in an open position was observed in the approved centre, 32(1).**
d) **Fire risks were not adequately assessed as completed fire drills did not include a night time simulation type drill, 32(1).**

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 CRITICAL

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It was reviewed on an annual basis. The policy was last reviewed in September 2024 and the policy addressed:

- Who may initiate, and who may carry out seclusion.
- The provision of information to the resident which included information about the resident's rights, presented in accessible language and format.
- The safety, safeguarding and risk management arrangements that were followed during an episode of seclusion including how seclusion was to be used only following a comprehensive risk assessment of the person.

The approved centre had a written approved policy on the reduction of restrictive practices which covered all stipulated requirements.

The approved centre also had a policy and procedures for training all staff involved in seclusion, which addressed who would receive training based on the identified needs of residents who were secluded and staff, and the identification of appropriately qualified persons to give the training. The policy and procedures for training all staff involved in seclusion did included the following:

- The areas to be addressed within the training programme, including alternatives to seclusion, trauma-informed care, cultural competence, human rights and the legal principles of restrictive intervention, the prevention and therapeutic management of violence and aggression and positive behaviour support that included the identification of causes or triggers of the resident's behaviours.
- The mandatory nature of training for those involved in seclusion.

Training and Education: All staff involved in seclusion had signed a document to indicate that they had read and understood the policy.

All staff who participated in the use of seclusion had received the appropriate training in its use and in the related policies and procedures. This training was in accordance with the approved centre's policy. A record of attendance at training was maintained.

Monitoring: The approved centre had a multi-disciplinary review and oversight committee for restrictive practices which met at least quarterly and determined if there was compliance with the rules on the use of seclusion and the approved centre's policies and procedures relating to seclusion. The committee reported to the registered proprietor nominee on the use of seclusion and whether it was in accordance with the Mental Health Commission's rules and produced a report following each meeting of the review

and oversight committee. There was a named senior manager responsible for the approved centre's reduction of restrictive practices.

Evidence of Implementation: Seclusion facilities were furnished and cleaned to ensure the patient's right to personal dignity and privacy. In all seclusion rooms in the approved centre, patients had sight of a clock which displayed the day, the time and the date. All seclusion rooms were constructed to withstand high levels of violence. There were no ligature points or electrical fixtures in the seclusion rooms. The rooms had externally controlled heating and air conditioning and limited furnishings. The rooms were large enough to support the patient and a team of staff.

Orders for seclusion: Three episodes of seclusion were reviewed during this inspection. Seclusion was initiated and orders for renewing seclusion (where applicable), were appropriately followed.

Dignity and Safety: The clothing worn in seclusion respected the right of the person to dignity, bodily integrity and privacy. Each patient was secluded in their own clothing.

The monitoring of the person in seclusion: The intercom equipment for communication by staff with individuals in seclusion was not in existence. There was no intercom system in place for observation by staff within sight and sound of an individual in seclusion.

This meant that it was not possible to hear communication into or out from the seclusion room at all times, and as such the fittings in the seclusion room were not of a quality as not to endanger the safety of a patient whilst in the seclusion room.

A seclusion care plan for the resident was developed by a registered nurse (RN) upon commencement of an episode of seclusion. The seclusion care plan included the following:

- Personal details, known clinical needs including mental and physical considerations, reasons for use of seclusion, a risk assessment and rating of risks identified, a risk management plan, a care plan, de-escalation strategies to be used, strategies to be used to end seclusion, and the person's preferences in relation to seclusion, where known, and considerations of outcomes of any previous debrief with the person, if applicable.
- Recognising signs where the person's behaviour was no longer deemed an unmanageable risk towards themselves or others, how potential risks may be managed, reference to specific support plans for the person and details of how the person's mental health needs would continue to be met while in seclusion, meeting of food or fluid needs, meeting of needs in relation to personal hygiene or dressing, meeting of elimination needs with specific reference to how privacy and dignity would be managed, and medication reviews in consultation with the RMP, monitoring of physical observations, and a strategy for ending seclusion indicating the criteria required for this to be reached.

It contained documentation of nursing reviews, medical reviews, a consultant review, records of observation of the patient during seclusion, monitoring of nutrition, hydration, physical observations and environmental aspects such as temperature and cleaning of the room.

The patient was directly observed by a RN for the first hour following the initiation of seclusion. After the first hour, the registered nurse commenced continuous observations. While the registered nurse remained in sight of the seclusion room, low volume sound could not be detected, as there was no intercom system installed in the seclusion room.

Every 15 minutes, the RN observed the patient and made a written record in the seclusion care plan – the record included levels of distress and type of observation being used, what the patient was doing and saying, the patient's level of awareness, the patient's physical health especially regarding breathing, pallor or cyanosis, whether elimination or hygiene needs were met, and whether hydration and nutrition needs were met.

Following risk assessment, a nursing review of the patient took place every two hours. During this review, a minimum of two staff members entered the seclusion room and assessed the resident. The reviews were recorded in the seclusion care plan, and they took place every two hours across the duration of the seclusion. The patient was assessed by nursing staff to determine whether the episode of seclusion could be ended. The assessment and decision were recorded.

Ending of seclusion: The episodes of seclusion were each ended by an RMP following discussion with the person in seclusion and relevant nursing staff, or by the most senior RN in the ward, in consultation with the patient in seclusion and an RMP.

An in-person debrief with the patient who was secluded occurred in the three episodes of seclusion. Each patient was given the opportunity to discuss the seclusion with members of the multi-disciplinary team regarding alternative de-escalation strategies, and the person's preferences in the event where a restrictive practice is needed.

All episodes of seclusion were reviewed by members of the multi-disciplinary team involved in the person's care and treatment no later than five working days after the episode.

The approved centre was non-compliant with this rule because adequate monitoring of the person in seclusion did not occur as there was no intercom system equipment in place to detect low volume sound during continuous observation by a registered nurse, 5.2.

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

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

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

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

Regulation 15 : Individual Care Plan					
Reason ID : 10006438		**The individual care plans of three residents were not developed by the multi-disciplinary team.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All heads of disciplines reminded of the necessity that all MDT members attend inpatient meetings on a consistent basis. Any staffing vacancies are escalated through the recruitment process for approval to fill.	Audit	Achievable	10/03/2025	Registered proprietor
Preventative Action	Quarterly audit of ICPS and findings reported back to the acute business meeting and emailed to all treating teams.	Audit	Achievable	17/06/2025	Registered proprietor
Reason ID : 10006439		**The individual care plans of two residents were not reviewed by the multi-disciplinary team.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All heads of disciplines reminded of the necessity that all MDT members attend inpatient meetings on a consistent basis. Any staffing vacancies are	Regular audit	Achievable	10/03/2025	Registered proprietor

	escalated through the recruitment process for approval to fill.				
Preventative Action	Regular updates provided to all disciplines at acute business meeting of completed quarterly audits in order to address any deficits or build upon existing good practice.	Regular audit	Achieavble	17/06/2025	Registered proprietor
Reason ID : 10006440		**The individual care plan of one resident was not updated contemporaneously following review to reflect changes to treatment, care and required resources.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	MDT identified for the above mentioned Individual. ICP was reviewed and updated. Reminder sent to all staff regarding the importance of up to date care planning and discussed at relevant meetings. Information and documentation available to all staff regarding the importance of up to date care planning.	Regular audit	Achievable	10/03/2025	Registered proprietor
Preventative Action	Reminder sent to all staff regarding the importance of up to date care planning and discussed at relevant meetings. Information and documentation available to all staff regarding the	Regular audit	Achievable	17/06/2025	Registered proprietor

	importance of up to date care planning.				

Regulation 19 : General Health					
Reason ID : 10006429		**Each resident's general health needs were not comprehensively assessed as the six-monthly general health assessment completed for one resident did not record their weight, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It is acknowledged that one resident did not have an update of their weight documented which was an administrative error and this was addressed immediately once identified.	Audit	Achievable	07/03/2025	Registered proprietor
Preventative Action	Regular review of physical health assessments to ensure no discrepancies from an administrative perspective	Audit	Achievable	07/03/2025	Registered proprietor
Reason ID : 10006430		**Each resident's general health needs were not comprehensively assessed as the six-monthly general health assessment completed for one resident did not record a medication review, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Each resident has their medication reviewed as part of their weekly MDT team meeting. It is acknowledged that there was not a specific dedicated medication review for one resident completed for the six-monthly general health assessment. This has been fully addressed and a reminder sent to all MDT's	Audit	Achievable	11/03/2025	Responsible consultant psychiatrists

	outlining that all elements of the document must be fully completed.				
Preventative Action	The AAMHU has a system in place where the MHA Administrator prompts MDT when a resident reaches the 6 months threshold which will result in the team completing the necessary reviews in accordance with this regulation.	Audit	Achievable	11/03/2025	Responsible consultant psychiatrists and MHA administrator

Regulation 21 : Privacy					
Reason ID : 10006431		**Single bedrooms did not have a locking mechanism on the inside of doors.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The AAMHU have been in ongoing communication with MHC regarding locks on doors in the AAMHU. The Mental Health Act (2001) does not actually mandate or state that there must be locks on doors in the approved centre. The registered proprietor has put appropriate arrangements in place to manage identified risks while promoting and respecting the privacy and dignity of residents. Residents being admitted to the AAMHU present with individual needs. Each risk is assessed and managed appropriately. Alternatives to locking doors are being used in an attempt to balancing risk to life and privacy. These include appropriate staffing levels, observation policy, ongoing clinical reviews and risk assessment and management. The AAMHU	The AAMHU will continue to review the use of locks on bedroom doors and ensuite bathrooms on an ongoing basis, taking into account service user profiles, structural changes etc.	Realistic	31/12/2025	Registered proprietor

	has carried out a comprehensive risk assessment pertaining to the fitting of locks on bedroom doors and ensuite doors which we believe, if installed presently, would contribute to the below: • Delayed Emergency Response – staff unable to enter quickly in a medical , psychiatric , or fire emergency (increasing the risk of harm ,self-harm – suicide or death) • Isolation of the resident- some residents may lock themselves away as a form of withdrawal, leading to increased social isolation and deteriorating mental state • Violence Harassment and aggression – locked doors may allow for unobserved aggressive behaviour, including assaults between residents or towards staff, especially in shared rooms. • Safeguarding concerns – the unit accommodates residents with a wide range of mental illnesses including complex diagnosis , MH				

	Intellectual disabilities and varying levels of vulnerabilities – the use of locked bedroom doors may raise safeguarding concerns as it would hinder timely staff intervention. • Increase resident safety incidents However, the HSE is mindful of the concerns highlighted by the MHC and in that regard, the below are a list of existing mitigation measures that safeguard residents whilst providing safe clinical care: • The nurse's station was relocated to the mid-way point of the corridor in both the Hazel and Ash Suite to enable a more centralised presence of clinical staff at all times. • All new admissions are facilitated with a bedroom closest to the nurses station and rotated accordingly based on risk management • Health Service Executive AAMHU UHG complete clinical risk assessments on all service users in the AAMHU as standard practice. The risk				

	assessment assess risk factors of suicide risk, violence, problems with alcohol/drugs, issues relating to activities of daily living such as self-neglect, medical health risks, risk of abuse (sexual/physical/emotional), vulnerability and general risks such as impulsivity and environmental issues. Risk management plans are then developed and implemented. • Clinicians undertake regular clinical reviews which would inform and update risk management plans and would include safeguarding assessments in relation to residents / patients admitted. This would obviously include for example where a person was exhibiting disinhibited behaviours or psychotic symptoms that they would require higher observation to ensure insofar as possible they do not pose a safeguarding risk to other patients and residents. • The AAMHU observation				

	policy forms part of a significant risk mitigation plan where service users may require higher levels of observation to include one to one special nursing observations in the absence of a high observation area. This requires clinicians to balance the need for privacy and dignity with that of safety. • Environmental risk assessments are also completed quarterly in the form of a ligature walkabout with a comprehensive ligature audit completed annually. This audit process considers room design, Service user factors, ligature identification and rating, compensatory factors and risk mitigation planning. • Weekly health and safety walkabouts are completed in the AAMHU. This ensures ongoing risk assessment, monitoring and mitigation in the context of the dynamic nature of risk. • The AAMHU consult with residents on an ongoing basis regarding privacy arrangements and how				

	their rights and wishes are respected. This has been facilitated through the following processes: • Ongoing clinical reviews with MDT team. There is adequate staffing levels in the AAMHU ensuring that there are staff available to residents at all times should they wish to speak with a staff member or raise any concerns. • The Irish Advocacy Network contact details are displayed throughout the AAMHU providing service users with an option to have peer advocates make representations to the service on their behalf. The designated Peer Advocate visits the AAMHU on Thursdays and meets with service users. This service is independent of the HSE. Any issues raised are reported back to nursing staff by the advocate. • As part of the Safewards initiative, Mutual help meetings take place every Thursday in the AAMHU. Notices are displayed				

	throughout the unit and all service users are invited to attend the meeting. This meeting aims to provide a forum for collaborative working between service users and staff where there is engagement in a round of thanks, round of news, round of suggestions and a round of requests and offers. • The HSE complaints policy your service your say is also displayed throughout the unit and is available for any person to make a comment, compliment or complaint (see attached). • In addition, the details of the local complaints committee is also displayed in the AAMHU with contact details. The AAMHU Information booklet also outlines how service users can raise issues of concern, make suggestions or complaints. • There are suggestion boxes located in the AAMHU for service users to put their comments, compliments or complaints. At no point				

	have locks or lack of privacy been raised in any of these forums which would suggest that the absence of locks on doors is not perceived as an issue by service users or their families. • Residents are also afforded the opportunity of 1:1 engagement with clinical staff should they wish to discuss concerns in a private manner and they are given an information booklet on admission, etc. The AAMHU will continue to review the use of locks on bedroom doors and ensuite bathrooms on an ongoing basis, taking into account service user profiles, structural changes etc.				
Preventative Action	Alternatives to locking doors are being used in an attempt to balancing risk to life and privacy. The HSE has involved a project manager to oversee the development of a high observation area within the AAMHU. This initiative has included consultation with relevant stakeholders including	The AAMHU will continue to review the use of locks on bedroom doors and ensuite bathrooms on an ongoing basis, taking into account service user profiles, structural changes etc.	Realistic	31/12/2025	Registered proprietor

	registered proprietor nominee, clinical staff, patients, etc. An area has been identified in the Hazel Suite and Ash suite and a proposal has been forwarded to the estates department for their consideration. The IHA Manager is engaging with HSE Estates to progress this matter. The below are some of the measures put in place regarding minimising risks in the interim of a high observation unit being pursued to be built: • The nurse's station was relocated to the mid-way point of the corridor in both the Hazel and Ash Suite to enable a more centralised presence of clinical staff at all times. • All new admissions are facilitated with a bedroom closest to the nurses station and rotated accordingly based on risk management • Health Service Executive AAMHU UHG complete clinical risk assessments on all service users in the				

	AAMHU as standard practice. The risk assessment assess risk factors of suicide risk, violence, problems with alcohol/drugs, issues relating to activities of daily living such as self-neglect, medical health risks, risk of abuse (sexual/physical/emotional), vulnerability and general risks such as impulsivity and environmental issues. Risk management plans are then developed and implemented. • Clinicians undertake regular clinical reviews which would inform and update risk management plans and would include safeguarding assessments in relation to residents / patients admitted. This would obviously include for example where a person was exhibiting disinhibited behaviours or psychotic symptoms that they would require higher observation to ensure insofar as possible they do not pose a safeguarding risk to other				

	patients and residents. • The AAMHU observation policy forms part of a significant risk mitigation plan where service users may require higher levels of observation to include one to one special nursing observations in the absence of a high observation area. This requires clinicians to balance the need for privacy and dignity with that of safety. • Environmental risk assessments are also completed quarterly in the form of a ligature walkabout with a comprehensive ligature audit completed annually. This audit process considers room design, Service user factors, ligature identification and rating, compensatory factors and risk mitigation planning. • Weekly health and safety walkabouts are completed in the AAMHU. This ensures ongoing risk assessment, monitoring and mitigation in the context of the dynamic nature of risk. • The AAMHU consult with residents on an ongoing				

	basis regarding privacy arrangements and how their rights and wishes are respected. This has been facilitated through the following processes: • Ongoing clinical reviews with MDT team. There is adequate staffing levels in the AAMHU ensuring that there are staff available to residents at all times should they wish to speak with a staff member or raise any concerns. • The Irish Advocacy Network contact details are displayed throughout the AAMHU providing service users with an option to have peer advocates make representations to the service on their behalf. The designated Peer Advocate visits the AAMHU on Thursdays and meets with service users. This service is independent of the HSE. Any issues raised are reported back to nursing staff by the advocate. • As part of the Safewards initiative, Mutual help meetings take place every				

	Thursday in the AAMHU. Notices are displayed throughout the unit and all service users are invited to attend the meeting. This meeting aims to provide a forum for collaborative working between service users and staff where there is engagement in a round of thanks, round of news, round of suggestions and a round of requests and offers. • The HSE complaints policy your service your say is also displayed throughout the unit and is available for any person to make a comment, compliment or complaint (see attached). • In addition, the details of the local complaints committee is also displayed in the AAMHU with contact details. The AAMHU Information booklet also outlines how service users can raise issues of concern, make suggestions or complaints. • There are suggestion boxes located in the AAMHU for service users to put their				

	comments, compliments or complaints. At no point have locks or lack of privacy been raised in any of these forums which would suggest that the absence of locks on doors is not perceived as an issue by service users or their families. • Residents are also afforded the opportunity of 1:1 engagement with clinical staff should they wish to discuss concerns in a private manner and they are given an information booklet on admission, etc.				
Reason ID : 10006432		**En suite bathrooms did not have locks on the doors.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The AAMHU have been in ongoing communication with MHC regarding locks on doors in the AAMHU. The Mental Health Act (2001) does not actually mandate or state that there must be locks on doors in the approved centre. The registered proprietor has put appropriate arrangements in place to manage identified risks while promoting and	The AAMHU will continue to review the use of locks on bedroom doors and ensuite bathrooms on an ongoing basis, taking into account service user profiles, structural changes etc.	Realistic	31/12/2025	Registered proprietor

	respecting the privacy and dignity of residents. Residents being admitted to the AAMHU present with individual needs. Each risk is assessed and managed appropriately. Alternatives to locking doors are being used in an attempt to balancing risk to life and privacy. These include appropriate staffing levels, observation policy, ongoing clinical reviews and risk assessment and management. The AAMHU has carried out a comprehensive risk assessment pertaining to the fitting of locks on bedroom doors and ensuite doors which we believe, if installed presently, would contribute to the below: • Delayed Emergency Response – staff unable to enter quickly in a medical , psychiatric , or fire emergency (increasing the risk of harm ,self-harm – suicide or death) • Isolation of the resident- some residents may lock themselves away as a form				

	of withdrawal, leading to increased social isolation and deteriorating mental state • Violence Harassment and aggression – locked doors may allow for unobserved aggressive behaviour, including assaults between residents or towards staff, especially in shared rooms. • Safeguarding concerns – the unit accommodates residents with a wide range of mental illnesses including complex diagnosis , MH Intellectual disabilities and varying levels of vulnerabilities – the use of locked bedroom doors may raise safeguarding concerns as it would hinder timely staff intervention. • Increase resident safety incidents However, the HSE is mindful of the concerns highlighted by the MHC and in that regard, the below are a list of existing mitigation measures that safeguard residents whilst providing safe clinical care: • The nurse's station was relocated to the mid-way				

	point of the corridor in both the Hazel and Ash Suite to enable a more centralised presence of clinical staff at all times. • All new admissions are facilitated with a bedroom closest to the nurses station and rotated accordingly based on risk management • Health Service Executive AAMHU UHG complete clinical risk assessments on all service users in the AAMHU as standard practice. The risk assessment assess risk factors of suicide risk, violence, problems with alcohol/drugs, issues relating to activities of daily living such as self-neglect, medical health risks, risk of abuse (sexual/physical/emotional), vulnerability and general risks such as impulsivity and environmental issues. Risk management plans are then developed and implemented. • Clinicians undertake regular clinical reviews which would inform and update risk				

	management plans and would include safeguarding assessments in relation to residents / patients admitted. This would obviously include for example where a person was exhibiting disinhibited behaviours or psychotic symptoms that they would require higher observation to ensure insofar as possible they do not pose a safeguarding risk to other patients and residents. • The AAMHU observation policy forms part of a significant risk mitigation plan where service users may require higher levels of observation to include one to one special nursing observations in the absence of a high observation area. This requires clinicians to balance the need for privacy and dignity with that of safety. • Environmental risk assessments are also completed quarterly in the form of a ligature walkabout with a comprehensive ligature audit completed annually. This audit process				

	considers room design, Service user factors, ligature identification and rating, compensatory factors and risk mitigation planning. • Weekly health and safety walkabouts are completed in the AAMHU. This ensures ongoing risk assessment, monitoring and mitigation in the context of the dynamic nature of risk. • The AAMHU consult with residents on an ongoing basis regarding privacy arrangements and how their rights and wishes are respected. This has been facilitated through the following processes: • Ongoing clinical reviews with MDT team. There is adequate staffing levels in the AAMHU ensuring that there are staff available to residents at all times should they wish to speak with a staff member or raise any concerns. • The Irish Advocacy Network contact details are displayed throughout the AAMHU providing service users with an option to have peer				

	advocates make representations to the service on their behalf. The designated Peer Advocate visits the AAMHU on Thursdays and meets with service users. This service is independent of the HSE. Any issues raised are reported back to nursing staff by the advocate. • As part of the Safewards initiative, Mutual help meetings take place every Thursday in the AAMHU. Notices are displayed throughout the unit and all service users are invited to attend the meeting. This meeting aims to provide a forum for collaborative working between service users and staff where there is engagement in a round of thanks, round of news, round of suggestions and a round of requests and offers. • The HSE complaints policy your service your say is also displayed throughout the unit and is available for any person to make a comment, compliment or complaint				

	(see attached). • In addition, the details of the local complaints committee is also displayed in the AAMHU with contact details. The AAMHU Information booklet also outlines how service users can raise issues of concern, make suggestions or complaints. • There are suggestion boxes located in the AAMHU for service users to put their comments, compliments or complaints. At no point have locks or lack of privacy been raised in any of these forums which would suggest that the absence of locks on doors is not perceived as an issue by service users or their families. • Residents are also afforded the opportunity of 1:1 engagement with clinical staff should they wish to discuss concerns in a private manner and they are given an information booklet on admission, etc. The AAMHU will continue to review the use of locks on bedroom				

	doors and ensuite bathrooms on an ongoing basis, taking into account service user profiles, structural changes etc.				
Preventative Action	Alternatives to locking doors are being used in an attempt to balancing risk to life and privacy. The HSE has involved a project manager to oversee the development of a high observation area within the AAMHU. This initiative has included consultation with relevant stakeholders including registered proprietor nominee, clinical staff, patients, etc. An area has been identified in the Hazel Suite and Ash suite and a proposal has been forwarded to the estates department for their consideration. The IHA Manager is engaging with HSE Estates to progress this matter. The below are some of the measures put in place regarding minimising risks in the interim of a high observation unit being pursued to be built: • The	The AAMHU will continue to review the use of locks on bedroom doors and ensuite bathrooms on an ongoing basis, taking into account service user profiles, structural changes etc.	Realistic	31/12/2025	Registered proprietor

	nurse's station was relocated to the mid-way point of the corridor in both the Hazel and Ash Suite to enable a more centralised presence of clinical staff at all times. • All new admissions are facilitated with a bedroom closest to the nurses station and rotated accordingly based on risk management • Health Service Executive AAMHU UHG complete clinical risk assessments on all service users in the AAMHU as standard practice. The risk assessment assess risk factors of suicide risk, violence, problems with alcohol/drugs, issues relating to activities of daily living such as self-neglect, medical health risks, risk of abuse (sexual/physical/emotional), vulnerability and general risks such as impulsivity and environmental issues. Risk management plans are then developed and implemented. • Clinicians undertake regular clinical				

	reviews which would inform and update risk management plans and would include safeguarding assessments in relation to residents / patients admitted. This would obviously include for example where a person was exhibiting disinhibited behaviours or psychotic symptoms that they would require higher observation to ensure insofar as possible they do not pose a safeguarding risk to other patients and residents. • The AAMHU observation policy forms part of a significant risk mitigation plan where service users may require higher levels of observation to include one to one special nursing observations in the absence of a high observation area. This requires clinicians to balance the need for privacy and dignity with that of safety. • Environmental risk assessments are also completed quarterly in the form of a ligature walkabout with a comprehensive				

	ligature audit completed annually. This audit process considers room design, Service user factors, ligature identification and rating, compensatory factors and risk mitigation planning. • Weekly health and safety walkabouts are completed in the AAMHU. This ensures ongoing risk assessment, monitoring and mitigation in the context of the dynamic nature of risk. • The AAMHU consult with residents on an ongoing basis regarding privacy arrangements and how their rights and wishes are respected. This has been facilitated through the following processes: • Ongoing clinical reviews with MDT team. There is adequate staffing levels in the AAMHU ensuring that there are staff available to residents at all times should they wish to speak with a staff member or raise any concerns. • The Irish Advocacy Network contact details are displayed throughout the AAMHU				

	providing service users with an option to have peer advocates make representations to the service on their behalf. The designated Peer Advocate visits the AAMHU on Thursdays and meets with service users. This service is independent of the HSE. Any issues raised are reported back to nursing staff by the advocate. • As part of the Safewards initiative, Mutual help meetings take place every Thursday in the AAMHU. Notices are displayed throughout the unit and all service users are invited to attend the meeting. This meeting aims to provide a forum for collaborative working between service users and staff where there is engagement in a round of thanks, round of news, round of suggestions and a round of requests and offers. • The HSE complaints policy your service your say is also displayed throughout the unit and is available for any				

	person to make a comment, compliment or complaint (see attached). • In addition, the details of the local complaints committee is also displayed in the AAMHU with contact details. The AAMHU Information booklet also outlines how service users can raise issues of concern, make suggestions or complaints. • There are suggestion boxes located in the AAMHU for service users to put their comments, compliments or complaints. At no point have locks or lack of privacy been raised in any of these forums which would suggest that the absence of locks on doors is not perceived as an issue by service users or their families. • Residents are also afforded the opportunity of 1:1 engagement with clinical staff should they wish to discuss concerns in a private manner and they are given an information booklet on admission, etc.				

Regulation 22 : Premises					
Reason ID : 10006441		**The approved centre was not clean throughout as there was graffiti on the walls of the main garden area, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The approved centre has a schedule of maintenance in place which includes painting. The graffiti art on the wall in the garden area has been painted over in view of the MHC non-compliance determination.	Regular maintenance walkabout and staff vigilance	Achievable	14/03/2025	Registered proprietor
Preventative Action	Regular maintenance walkabout and staff vigilance	Regular maintenance walkabout and staff vigilance	Achievable	14/03/2025	Registered proprietor
Reason ID : 10006442		**The condition of the physical structure and the overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff and visitors, as the fire doors were not inspected by a specialist every six months, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Upon completion of the most recent fire door inspection of the 15th of April, a tender process has been engaged for the repair and upkeep of all affected fire doors as per report and a maintenance programme is now being developed to carry out repair works in a safe manner	Fire door inspections are managed centrally through the maintenance department going forward to ensure they are carried out every six months.	Achievable	15/04/2025	Registered proprietor
Preventative Action	A system is now in place where repairs are dealt with	Fire door inspections are managed	Achievable	31/10/2025	Registered proprietor

	in a more case by case manner to ensure a more proactive approach to the upkeep of the doors based on a weekly check of doors by service and reporting back to maintenance issues arisen	centrally through the maintenance department going forward to ensure they are carried out every six months.			
Reason ID : 10006443		**The registered proprietor did not ensure that the overall environment was maintained with due regard to the safety and wellbeing of the residents, staff and visitors. There were eight sets of fire doors which did not close fully on release, which would impair proper door functioning in the event of a fire, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following on from the fire door inspection of the 15th of April, the replacement of effected fire doors has been identified. The works have been tendered, and a contractor has been appointed to carry out the replacement works in a safe manner. In the interim, carpenter from maintenance has carried out improvement works on the doors until the replacements are in place.	Fire door inspections are managed centrally through the maintenance department going forward to ensure they are carried out every six months.	Achievable	18/11/2025	Registered proprietor
Preventative Action	Fire door inspections are managed centrally through the maintenance department going forward to ensure they are carried out every six months.	Fire door inspections are managed centrally through the maintenance department going forward to ensure	Achieavble	18/11/2025	Registered proprietor

		they are carried out every six months.			

Regulation 32 : Risk Management Procedures					
Reason ID : 10006434		**Fire risks were not adequately assessed as not all Personal Emergency Evacuation Plans were completed adequately, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Personal Evacuation Plans were reviewed immediately and completed to the required standard.	Regular review	Achievable	07/03/2025	Registered proprietor
Preventative Action	Personal evacuation plans are reviewed on a regular basis to ensure all elements are completed to the required standard.	Regular review	Achievable	07/03/2025	Registered proprietor
Reason ID : 10006435		**Fire risks were not adequately identified or assessed as fire doors were not inspected by a fire specialist every six months, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Contract is updated with specialist company to ensure fire door inspection continuity. Fire door inspection took place on the 15th of April 2025. Previous fire door inspections took place on the 9th of January 2024 and the 5th of July 2024.	Regular review	Achievable	15/04/2025	Registered proprietor
Preventative Action	Fire door inspections are managed centrally through the maintenance department going forward to ensure they are carried out every six months.	Contract company provide written report to maintenance department following inspection processes	Achievable	31/10/2025	Registered proprietor

Reason ID : 10006436		Fire risks were not adequately identified or assessed as the practice of obstructing designated fire doors in an open position was observed in the approved centre, 32(1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A communication has been issued to all staff working in the AAMHU requesting them not to obstruct fire doors. This is monitored through health and safety walkabouts in the unit.	Ongoing review and staff vigilance	Achievable	23/03/2025	Registered proprietor
Preventative Action	Staff vigilance and for any issues to reported to line management at point of occurance. Fire training is ongoing for staff.	Regular review	Achievable	23/03/2025	Registered proprietor
Reason ID : 10006437		**Fire risks were not adequately assessed as completed fire drills did not include a night time simulation type drill, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The AAMHU can confirm that Ignite Fire & Safety Training Limited have been engaged to provide night time simulation fire drills at the AAMHU. Night time fire drills were completed on 19th May and 3rd June 2025. Further fire training has taken place on 30th July 2025. Fire training is being provided on an ongoing basis in accordance with training requirements.	Audit	Achievable	03/06/2025	Registered proprietor
Preventative Action	The AAMHU has an annual training schedule which	Audit	Achievable	03/06/2025	Registered proprietor

	includes night time simulation drills as part of fire training.				

Rules Governing the Use of Seclusion					
Reason ID : 10006433		**Adequate monitoring of the person in seclusion did not occur as there was no intercom system equipment in place to detect low volume sound during continuous observation by a registered nurse, 5.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The AAMHU assign a dedicated Registered Psychiatric Nurse within sight and sound of the resident at all times to monitor a resident in seclusion. This nurse is required to remain in the annex of the seclusion room where they are able to observe and hear the resident that is in seclusion for the duration of the seclusion episode. This level of observation also includes the resident's presentation in terms of their behaviour, colour, breathing and levels of distress. In addition to this operational system, a new intercom system has been installed and is operational since 11th April 2025 to further support compliance with the rules governing the use of seclusion.	Regular audit	Achievable	11/04/2025	Registered proprietor

Preventative Action	Staff briefing on the operational function of the intercom system	Registered proprietor	Achievable	25/04/2025	Registered proprietor

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.

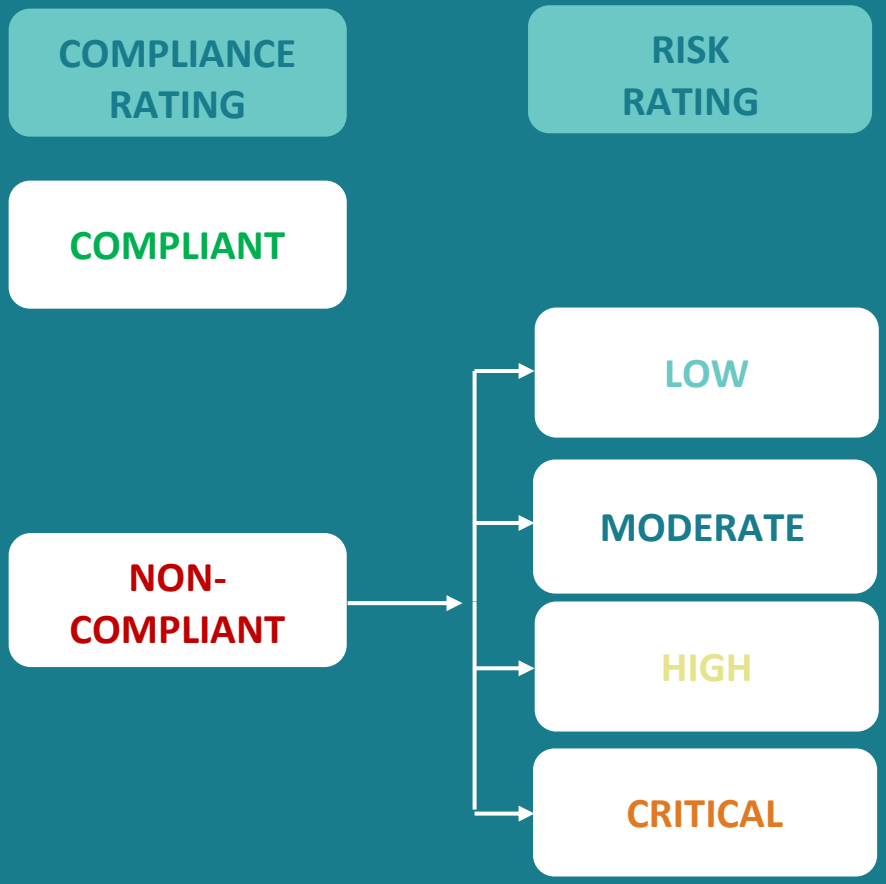
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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