

# Cois Dalua

Annual Inspection  
Report 2025

*Promoting Quality, Safety and  
Human Rights in Mental Health*



**mhc**

coimisiún meabhair - shláinte  
mental health commission

# COIS DALUA

Meelin, Knockduff Upper, Newmarket, Co.  
Cork P51 AP90

## Date of Publication:

20 October 2025

ID Number: AC0128

## 2025 Approved Centre Inspection Report (Mental Health Act 2001)

### Approved Centre Type:

Continuing mental health care / long stay  
Mental health rehabilitation

### Conditions Attached:

None

### Most Recent Registration Date:

01 June 2024

### Registered Proprietor:

Nua Healthcare Services

### Registered Proprietor Nominee:

Mr Noel Dunne

### Inspection Team:

Aoife Gallaher, Lead Inspector  
Carol Brennan-Forsyth  
Marianne Griffiths

### Inspection Date:

29 April– 02 May 2025

### Previous Inspection date:

27 – 01 March 2024

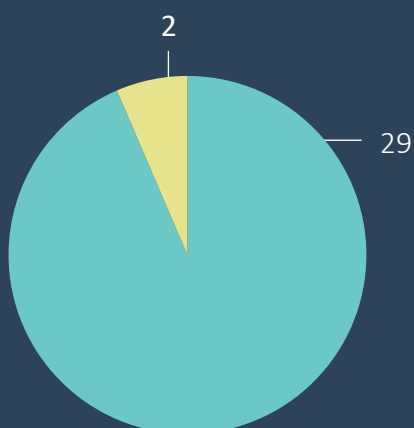
### The Inspector of Mental Health Services:

Professor James V Lucey MCRN000646

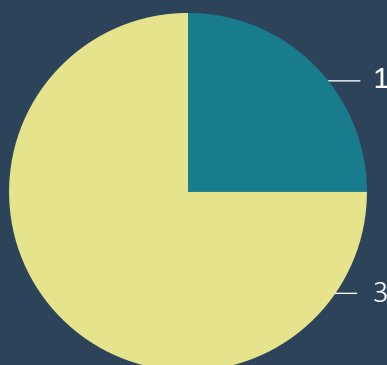
### Inspection Type:

Unannounced Annual Inspection

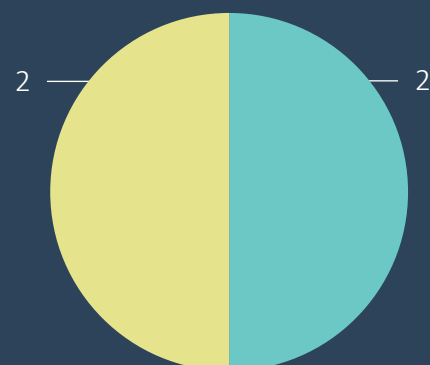
## 2025 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE  
MENTAL HEALTH ACT 2001



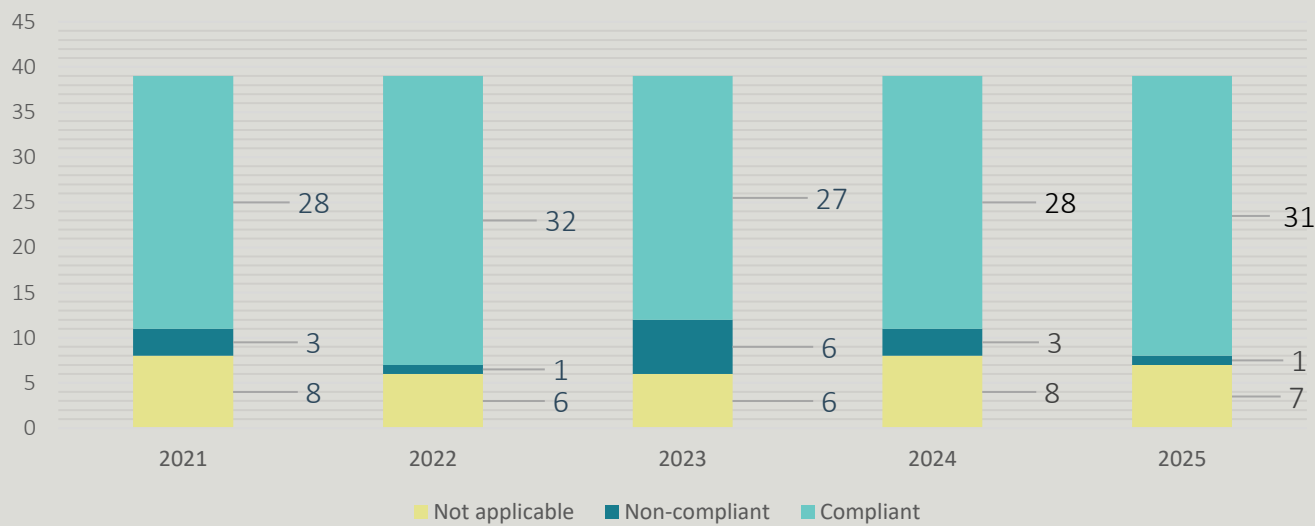
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

# RATINGS SUMMARY 2021 – 2025

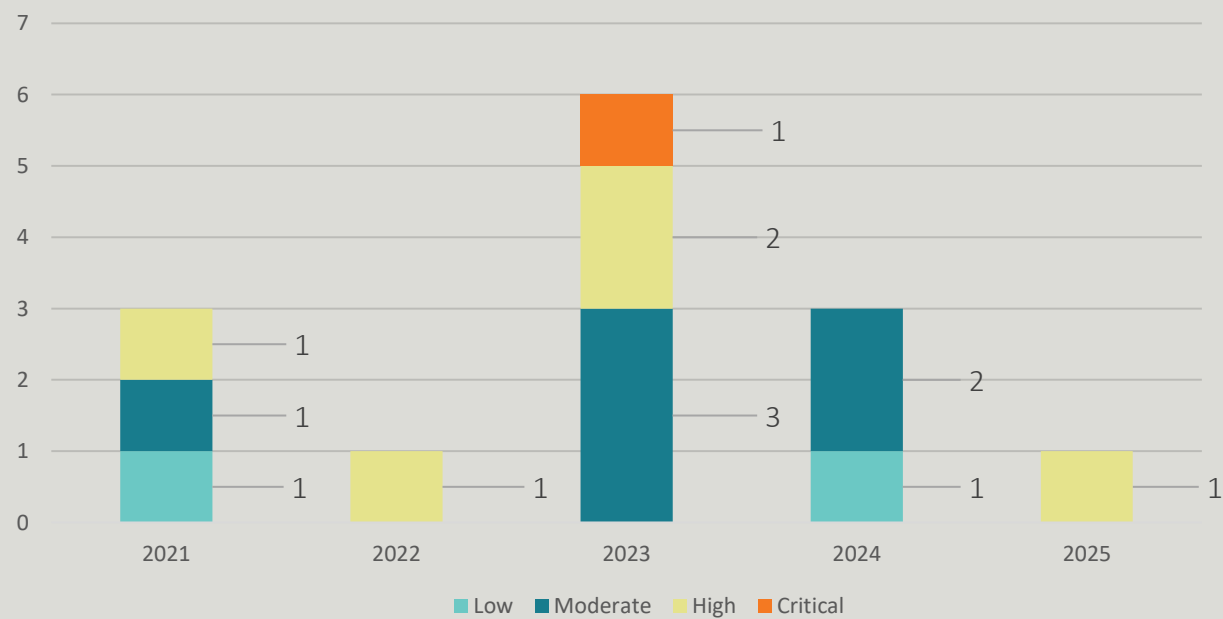
Compliance ratings across all 39 areas of inspection are summarised in the chart below

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2021 – 2025



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2021 – 2025



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# 1.0 Inspector of Mental Health Services – Review of Findings

**Inspector of Mental Health Services**

**Professor James V Lucey**

## Description of Approved Centre

Cois Dalua is a privately operated approved centre owned and managed by Nua Healthcare. It is located in a small rural village of Meelin in Co. Cork. The approved centre is registered for continuing mental health care/long stay and mental health rehabilitation and accepts nationwide referrals from Ireland and the United Kingdom.

At the time of inspection Cois Dalua consisted of a single storey building with a two-storey extension with accommodation for 19 residents. A new detached two storey building called “Kellehers Cottage” was located beside the main building, providing accommodation for four further residents increasing the registered number of beds to 23.

The main building consisted of the original single storey building and a newer lower ground floor extension. Accommodation consisted of 14 single en suite bedrooms on the ground floor, two en suite bedrooms and two one-bedroom self-contained apartments on the lower ground floor, which could be accessed by an elevator or stairs. The bedrooms and apartments were decorated with residents’ personal effects and furnished to each resident’s individual needs.

Communal areas on the ground floor included a family room, multi-purpose room used for group work or as a quiet room, a gym, equipped with exercise machines and equipment, a low stimulus room, laundry room, dining room, kitchenette, television room, and a multi-purpose room. A further laundry room, dining room and kitchen were located on the lower ground floor. Outdoor facilities included both an enclosed garden, and a sensory garden which could be accessed by all residents.

Kelleher’s cottage consisted of four single en suite bedrooms, two on the ground floor and two upstairs. Communal facilities included a laundry room, sitting room and kitchen area which led to a large, enclosed garden.

The approved centre is located on its own grounds and is surrounded by fencing. The entrance to the main building is secured by gates which were opened using a key code system. Residents were provided with the code to the gates, unless otherwise risk assessed. The area to the front of the main building provided parking for the approved centre’s vehicles.

## Inspector of Mental Health Services Summary

Cois Dalua is located on its own grounds in a small rural village of Meelin in Co. Cork. The approved centre was comprised of two separate buildings. A single storey building which offered accommodation to 19 residents, and newly constructed Kellehers Cottage which provides accommodation for a further four residents, increasing the registered bed number for the 2025 annual inspection to 23. The inspection of Cois Dalua was unannounced and occurred over a four-day period, from the 29<sup>th</sup> April to 2<sup>nd</sup> May 2025 inclusive. This summary reflects the findings at the time of the inspection only.

There was a focus on continuous improvement of the quality of service delivery. A Quality and Safety committee comprised of senior management, convened every two weeks to discuss quality and safety improvements. To further improve quality and compliance, the Quality Assurance department, led by the Head of Quality and Safety, conducted unannounced bi-annual inspections, with results reported to the Registered Proprietor Nominee for review and escalation if appropriate.

In 2024, the service was non-compliant with three areas of regulations. In 2025, there was a decrease in the rate of non-compliance, with one regulatory area found to be non-compliant. This related to Part 4 of the Mental Health Act 2001 Consent to Treatment. Full names of the medication were not listed on the Form 17: Administration of Medicine for More than Three Months Involuntary Patient (adult). This was remedied promptly when brought to the attention of the Clinical Director.

The inspection was very well co-ordinated by staff and management in the approved centre. Many aspects of service provision exceeded the minimum standards set out in mental health legislation. A multi-disciplinary approach was fostered within governance structures and clinical care. There was evidence of effective multi-disciplinary teamwork and comprehensive individualised care plans developed with residents and their representatives.

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

| Resident Profile                                                  |    |
|-------------------------------------------------------------------|----|
| Number of registered beds                                         | 23 |
| Total number of residents                                         | 16 |
| Number of detained patients                                       | 1  |
| Number of wards of court                                          | 1  |
| Number of residents under the Assisted Decision Making Act        | 3  |
| Number of children                                                | 0  |
| Number of residents in the approved centre for more than 6 months | 12 |
| Number of patients on Section 26 leave for more than 2 weeks      | 0  |

## Compliance summary

|              | 2021 | 2022 | 2023 | 2024 | 2025 |
|--------------|------|------|------|------|------|
| % Compliance | 90%  | 97%  | 82%  | 90%  | 97%  |

## Conditions of registration

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

## Ongoing escalation and enforcement actions at time of inspection

None.

## Escalation and enforcement actions commenced following this inspection

None.

## 2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- **Regulation 05: Food and Nutrition**

- A second chef and two kitchen assistants were recently employed. Kitchen assistants completed daily consultations with residents in relation to food choices and to involve residents in their nutritional care.
- The approved centre took into consideration residents' psychosocial needs by ensuring that the food offered was appetising, visually appealing, well-presented, and enjoyable.

- **Regulation 11: Visits**

- The approved centre maintained physical environments and facilities that were fit for purpose, welcoming, well-decorated and well designed.

- **Regulation 15: Individual Care Planning**

- The individual care planning (ICP) booklet used a SMART approach (specific, measurable, achievable, realistic, time-bound) which created a clear, actionable, and person centred and holistic care planning process.

- **Regulation 16: Therapeutic Services and Programmes**

- **A Life Skills Group:** This group was developed alongside the Discharge Planning Group as these had been identified by service users as a common goal shared. The Occupational Therapist (OT) devised this initiative to target specific life skill areas, such as domestic skill work, personal care, finance and medication management, and community integration involvement in the local community. The Discharge Planning Group mainly involved talking through the discharge process within the approved centre and wider company, and how the multi-disciplinary team (MDT) would achieve this from a recovery and skills perspective. This initiative was completed in a group setting ensuring that residents opinions were considered when commencing the group, and in the overall skill attainment phase.
- **Go Green Month:** This quality initiative coordinated by the occupational therapist (OT) was ongoing since January 2025 and continues to be implemented. Residents opinions were sought in the setting up of the group. The primary aim of the initiative was to educate and increase awareness among the residents on environmental issues and promote sustainable practices. With support from the OT and staff, residents constructed a plastic greenhouse. One resident took a leadership role and was empowered to continue to do this. Residents have been actively planting various herbs and vegetables, such as mint, parsley, and peas. They have also planted flowers, including daffodils and other varieties. Ongoing maintenance of the greenhouse and plants was carried out by the residents.
- **Community Involvement:** Residents participated in the National Spring Clean litter pick, where they cleaned outdoor areas around Cois Dalua.

- **Regulation 19: General Health**
  - Dedicated smoking cessation facilitators were in place and all residents who smoked had been offered support and guidance in smoking cessation.
- **Regulation 22: Premises:**
  - The approved centre ensures that the physical environment is designed to achieve best outcomes for residents and includes a designated quiet/ de-escalation room.
- **Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines:**
  - The approved centre has a digital medication record system.
- **Regulation 26: Staffing:**
  - There were monthly lectures and educational sessions for the multi-disciplinary team, such as bespoke training sessions on Clozapine training, psychosis management, attachment informed care. Instructor training in preventative of management of violence and aggression (PMVA) was facilitated for staff in the approved centre. There was a programme of placement for student nurses within the approved Centre. The training department in Nua Healthcare co-ordinated mandatory training.
- **Regulation 32: Risk Management Procedures:**
  - The quality assurance department attended the approved centre six monthly to conduct unannounced inspections. VI Clarity software was used as an auditing tool. The local management team provided updates based on six monthly audits to ensure continuous improvement. Weekly quality assurance reports were completed and returned to the registered proprietor nominee. There was a strong culture of clinical auditing, and continuous improvement of the quality of service delivery, evident within the approved centre.

## 3.0 Governance

Cois Dalua was under the governance of Nua Healthcare. At national level, a governance meeting convened weekly and was attended by members of Nua Healthcare senior management team and representatives of each department within Nua Healthcare. Agenda items included clinical and operational risks, incidents and regulation and compliance. A quality and safety meeting convened fortnightly, standing agenda items included incidents, corporate risk register, audits, staff retention, health and safety, fire safety, policy updates, restrictive practices, safeguarding and infection control management. Resident admissions, transfers and discharges were discussed at the weekly admission, transfer and discharge meeting. This meeting was attended by the admissions, transfers, and discharge team, the Clinical Director and the Director of Nursing of the approved centre.

At local level, there was a monthly clinical governance meeting chaired by the Clinical Director and attended by the Director of Nursing, Assistant Director of Nursing, Social Worker, Occupational Therapist, Psychologist and Deputy Chief Operating Officer as required. Agenda items included staffing, quality improvement, compliance, staff training, premises, feedback from residents, and clinical and operational risks. Minutes of both the national governance meeting and the quality and safety meeting were discussed at this meeting. The Therapeutic Programme and Recreational Activity Committee also met monthly to review upcoming therapeutic groups. Members of the multi-disciplinary team (MDT), frontline staff and residents attended and contributed to the review of therapeutic and recreational activities. A MDT review meeting in relation to resident's care and treatment, and a local management meeting also convened weekly. A comprehensive review of resident's care plans was undertaken bi-annually and attended by members of the MDT.

There were key personnel with responsibility for risk management in the approved centre. The person with overall responsibility for risk was the Director of Nursing who was identified and known by all staff. Responsibilities regarding risk were allocated at management level and the approved centre had support from the quality and safety department. Risks were identified and documented on risk management plans, with risk level calculated through a risk management metric. A local risk register identified health & safety risks, clinical risks and environmental risks. The register was monitored, reviewed quarterly and updated by the Director of Nursing. There was a separate corporate risk register, which was managed by the senior management team and the approved centre had a process of escalating risk to the corporate risk register through the national governance meeting if applicable. The approved centre had an Automated Incident Report System (AIRS) to record incidents, accidents, medication errors and near miss situations. Incidents were reviewed to identify any trends or patterns occurring in the service. Analysis of incidents took place at the weekly governance meeting and feedback given through the relevant line managers. Audits were conducted quarterly, bi-annually and annually by auditors within the Quality and Safety Department of Nua Healthcare. All clinical staff had received training on clinical risk management procedures appropriate to their role and function

An organisational chart identified the structures of leadership and the lines of responsibility and accountability within the approved centre. At the time of inspection, the approved centre was adequately

staffed, and numbers and skill mix of staffing were sufficient to meet resident needs. A new Registered Proprietor nominee commenced in post during the inspection. The approved centre had one multi-disciplinary team which included psychiatry, nursing, occupational therapy, psychology and social work, all of whom were based in the approved centre. The Clinical Director was based in the approved centre three days a week and provided on-call cover out of hours. A behavioural specialist post was vacant at the time of inspection and recruitment had commenced for this post. Recruitment for a full time consultant psychiatrist and a non-consultant hospital doctor (NCHD) had also commenced. A local pharmacist provided prescribed medication and reviewed prescriptions as part of an informal process, with plans to formalise this process.

All disciplines were up to date with mandatory training in Basic Life Support, Fire Training, Mental Health Act 2001, Management of Violence and Aggression, Safeguarding and Children's First Training. The approved centre had a comprehensive training schedule in place. There was a formal system of performance appraisals for staff in the approved centre conducted annually or as required. Annual staff training analysis was completed to identify and address training needs.

Resident's involvement in service delivery was facilitated by the availability of the compliment and complaints process to support service improvement. The process of making complaints and the complaints officer contact details were displayed within the approved centre and in the resident information booklet. Residents were involved in the development and review of their individual care plans. Resident forums and keyworker meetings were conducted weekly to facilitate resident contribution to review of the services and programs available to them. A weekly resident happiness form was completed with any concerns raised discussed within the keyworker sessions. Monthly resident community meetings took place in the approved centre, and this provided an opportunity for residents to raise concerns or make suggestions. Access to the National Advocacy Service was available if required by residents.

| Staff Training Record  |                    |      |             |      |                                       |      |                        |      |                                   |      |              |      |
|------------------------|--------------------|------|-------------|------|---------------------------------------|------|------------------------|------|-----------------------------------|------|--------------|------|
| Profession             | Basic Life Support |      | Fire Safety |      | Management of Violence and Aggression |      | Mental Health Act 2001 |      | Children First (mandated persons) |      | Safeguarding |      |
| Nursing                | 31                 | 100% | 31          | 100% | 31                                    | 100% | 31                     | 100% | 31                                | 100% | 31           | 100% |
| Medical                | 1                  | 100% | 1           | 100% | 1                                     | 100% | 1                      | 100% | 1                                 | 100% | 1            | 100% |
| Occupational Therapist | 1                  | 100% | 1           | 100% | 1                                     | 100% | 1                      | 100% | 1                                 | 100% | 1            | 100% |
| Social Worker          | 1                  | 100% | 1           | 100% | 1                                     | 100% | 1                      | 100% | 1                                 | 100% | 1            | 100% |
| Psychologist           | 1                  | 100% | 1           | 100% | 1                                     | 100% | 1                      | 100% | 1                                 | 100% | 1            | 100% |
| Other                  | 41                 | 100% | 41          | 100% | 41                                    | 100% | 41                     | 100% | 41                                | 100% | 41           | 100% |

| Therapeutic Services and Programmes                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| There is a Weekly Therapeutic/Recreational Activities Timetable focusing on rehabilitation, maintaining skills and integrating residents into the community. Residents have access to a variety of therapeutic activities in the approved centre and in the community e.g., gym, walking groups, multi-sensory sessions, new directions groups, activity taster groups, go green groups, work ability groups, cognitive behavioural |

therapy (CBT), social farming, gardening, outings, music therapy, sleep and food monitoring, external training courses and smoking cessation groups. Each discipline works together with the residents to provide a person-centred, needs based programme for each resident. Holistic integrated therapies are offered such as behaviour support.

# 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 15: Individual Care Plan                                           | ✓ | Compliant |
| Regulation 16: Therapeutic Services and Programmes                            | ✓ | Compliant |
| Regulation 18: Transfer of Residents                                          | ✓ | Compliant |
| Regulation 19: General Health                                                 | ✓ | Compliant |
| Regulation 20: Provision of Information to Residents                          | ✓ | Compliant |
| Regulation 21: Privacy                                                        | ✓ | Compliant |
| Regulation 22: Premises                                                       | ✓ | Compliant |
| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines | ✓ | Compliant |
| Regulation 24: Health and Safety                                              | ✓ | Compliant |
| Regulation 26: Staffing                                                       | ✓ | Compliant |
| Regulation 27: Maintenance of Records                                         | ✓ | Compliant |
| Regulation 28: Register of Residents                                          | ✓ | Compliant |
| Regulation 29: Operating Policies and Procedures                              | ✓ | Compliant |
| Regulation 30: Mental Health Tribunals                                        | ✓ | Compliant |
| Regulation 31: Complaints Procedures                                          | ✓ | Compliant |
| Regulation 32: Risk Management Procedures                                     | ✓ | Compliant |
| Regulation 33: Insurance                                                      | ✓ | Compliant |
| Regulation 34: Certificate of Registration                                    | ✓ | Compliant |
| Code of Practice on the Use of Physical Restraint                             | ✓ | 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 |      |  |  |  |  |
| Part 4 of The Mental Health Act 2001: Consent to Treatment | N/A                    | N/A  | N/A  | N/A  | ✗    | High |  |  |  |  |

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

## 4.3 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice                                                    | Details                                                                                                |
|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Regulation 17: Children's Education                                                 | As the approved centre did not admit children, this regulation was not applicable.                     |
| Regulation 25: Use of Closed Circuit Television                                     | As CCTV was not in use in the approved centre, this regulation was not applicable.                     |
| Rules Governing the Use of Electro-Convulsive Therapy                               | As the approved centre did not provide an ECT service, this rule was not applicable.                   |
| Rules Governing the Use of Seclusion                                                | As the approved centre did not use seclusion, this rule was not applicable                             |
| Rules Governing the Use of Mechanical Means of Bodily Restraint                     | As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As the approved centre did not admit children, this code of practice was not applicable.               |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients    | As the approved centre did not provide an ECT service, this code of practice was not applicable.       |

## 5.0 Service-user Experience

### 5.1 Service-user feedback

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

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

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

One resident met with the inspection team, who was very complimentary of the staff and the lovely food. Two completed questionnaires were received by the inspection team. Both answered that they felt privacy and dignity were not respected, one questionnaire documented that staff came into the room a lot. Both stated they knew who their keyworker was, both knew who their multi-disciplinary (MDT) members were, and both said they can communicate freely with their family and friends. On a scale of 1-10, with 1 being poor and 10 being excellent, the overall experience of care and treatment was rating 6 and 4

### 5.2 Advocacy

The Irish Advocacy Network was notified that the inspection team were in the approved centre. And responded that they have not provided service in Cois Dalua since the last inspection.

## 6.0 Feedback Meeting

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

- Registered Proprietor Nominee
- Deputy Chief Operating Officer
- Deputy Director of Services
- Operations Manager
- Assistant Director of Nursing x2
- Head of Quality and Safety
- Mental Health act Administrator
- Apologies received from Clinical Director

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 4.3: Areas that were not applicable on this inspection](#) for the list of regulations that were not applicable on this inspection.*

## 8.0 Inspection Findings – Rules

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

*None of the rules were applicable on this inspection. Please see [Section 4.3: Areas that were not applicable on this inspection](#).*

## 9.0 Inspection Findings – Mental Health Act 2001

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

*Part 4 of the Mental Health Act 2001 was non-compliant on inspection. Please see [Section 4.2: Non-compliant areas on this inspection](#).*

### Inspection findings

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment of the patient, and the patient was deemed unable to consent.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for each patient. It documented the following:

- A confirmation of the assessment of the patient's ability to understand the nature, purpose and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.
- Any views expressed by the patient.
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

The *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* did not document the full names of the medications prescribed to this patient. This was rectified on the first day of this inspection.

**The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment, due to the fact that the full names of the medication were not listed on the *Form 17: Administration of Medicine for More than Three Months Involuntary Patient (adult) - Unable to Consent*.**

# 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.

| Part 4 of the Mental Health Act 2001: Consent to Treatment |                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                     |                                                                                                                                                              |            |                                                                                                                       |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------------------------------------------------------------------------------------------------------------------|
| Reason ID : 10006469                                       |                                                                                                                                                                                                                                                                                                               | The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment, due to the fact that the full names of the medication were not listed on the Form 17: Administration of Medicine for More than Three Months Involuntary Patient (adult) - Unable to Consent. |                                                                                                                                                              |            |                                                                                                                       |
|                                                            | Specific                                                                                                                                                                                                                                                                                                      | Measurable                                                                                                                                                                                                                                                                                          | Achievable/Realistic                                                                                                                                         | Time-bound | Post-Holder(s)                                                                                                        |
| <b>Corrective Action</b>                                   | Further training has been arranged to be provided on the completion of regulatory forms, this training will be delivered to the following - Clinical Director (CD) Director of Nursing (DON), Assistant Director of Nursing (ADON), Mental Health Act Admin (MHA) Quality Assurance (QA) Psychiatrist on Call | Director of Nursing (DON) / Assistant Director of Nursing (ADON) Mental Health Act Admin (MHA) Quality Assurance (QA) Department will continue to monitor on a quarterly basis.                                                                                                                     | There are no barriers to implementation and all actions to address the immediate concerns raised by the Inspector will be closed in the agreed timeframe.    | 31/10/2025 | Clinical Director (CD) Director of Nursing (DON), Assistant Director of Nursing (ADON), Mental Health Act Admin (MHA) |
| <b>Preventative Action</b>                                 | Further training has been arranged to be provided on the completion of regulatory forms, this training will be delivered to the following - Clinical Director (CD) Director                                                                                                                                   | Clinical Director (CD) Director of Nursing (DON)/ Assistant Director of Nursing (ADON), Mental Health Act Admin (MHA) Quality Assurance (QA) Department will                                                                                                                                        | There are no barriers to implementation and all actions to address the immediate concerns raised by the Inspector will be closed in by the agreed timeframe. | 31/10/2025 | Clinical Director (CD) Director of Nursing (DON), Assistant Director of Nursing (ADON), Mental Health Act Admin (MHA) |

|  |                                                                                                                           |                                              |  |  |  |
|--|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|--|--|
|  | of Nursing (DON),<br>Assistant Director of<br>Nursing (ADON),<br>Mental Health Act<br>Admin (MHA)<br>Psychiatrist on call | continue to monitor on<br>a quarterly basis. |  |  |  |
|--|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|--|--|

## 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 is 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.

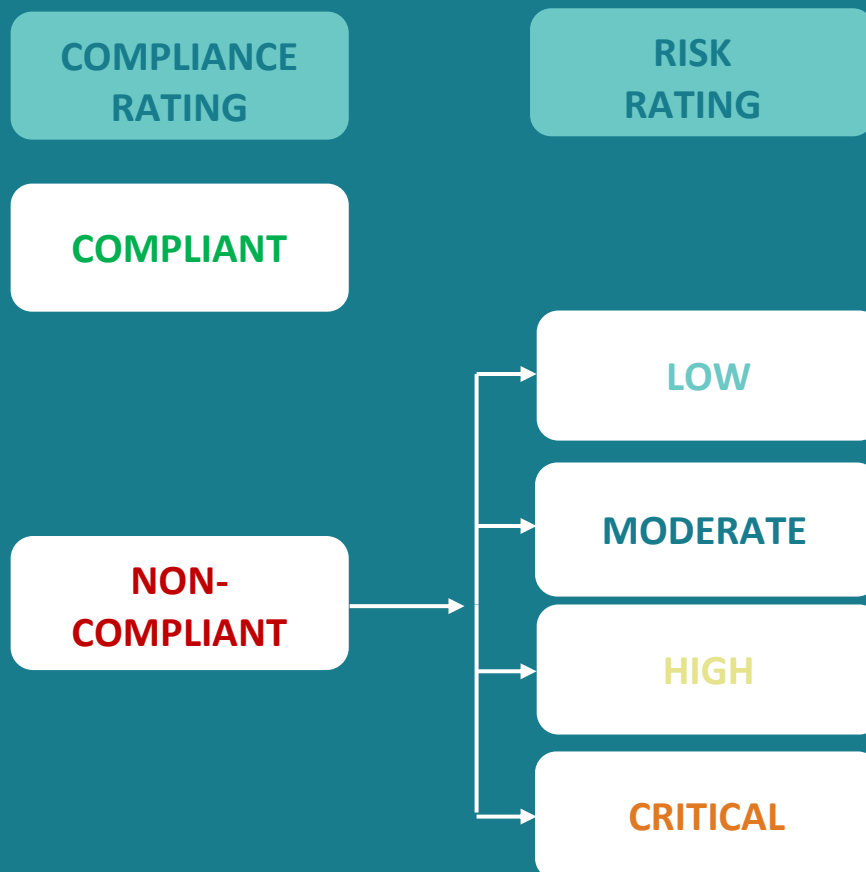
Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed 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.

