St. Anne's Unit, Sacred Heart Hospital

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

ST. ANNE'S UNIT, SACRED HEART HOSPITAL

Pontoon Road, Castlebar, Co. Mayo, F23XV38.

Date of Publication:
20 October 2025

ID Number: AC0170

2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Psychiatry of later life

Conditions Attached:
None

Most Recent Registration Date:
1 October 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr. Steve Jackson

Inspection Team:
Damien Lanigan, Lead Inspector
Martin McMenamin
Sarah Jones

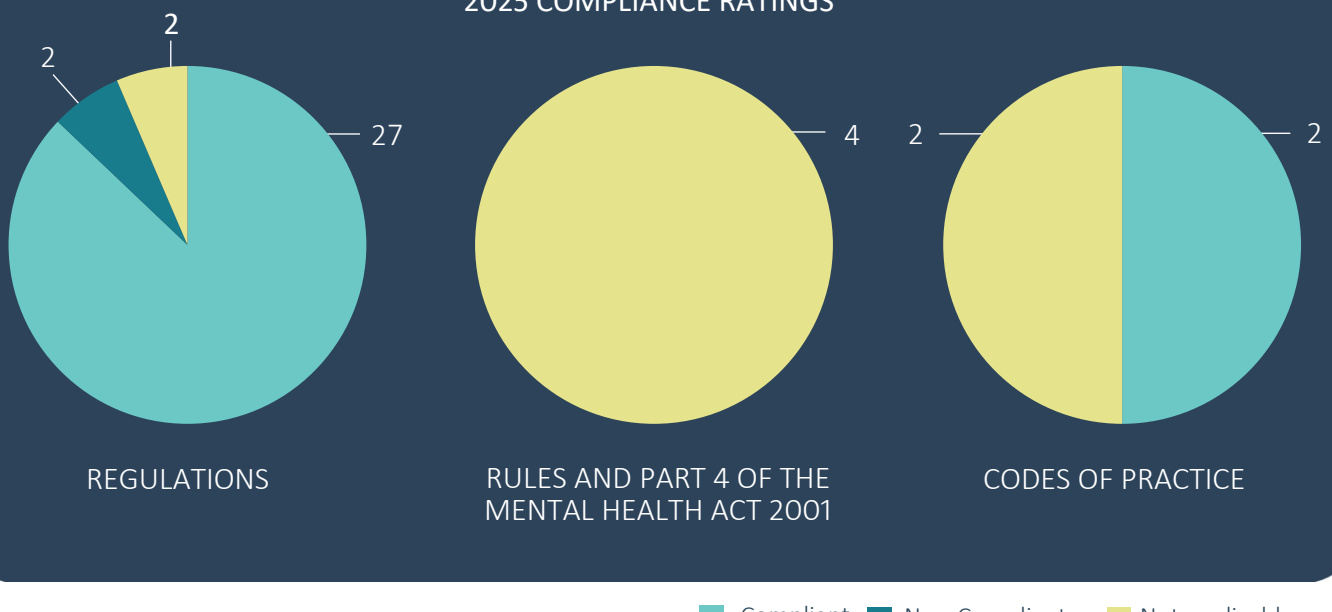
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
13 – 16 May 2025

Previous Inspection date:
5 – 8 March 2024

Inspection Type:
Unannounced Annual Inspection

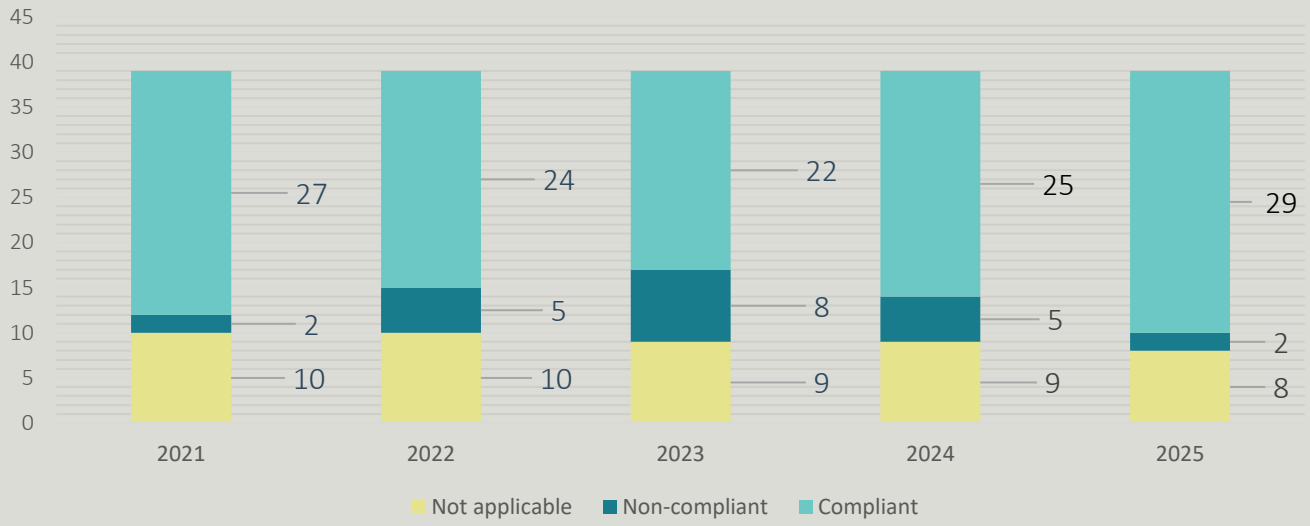
2025 COMPLIANCE RATINGS



RATINGS SUMMARY 2021 – 2025

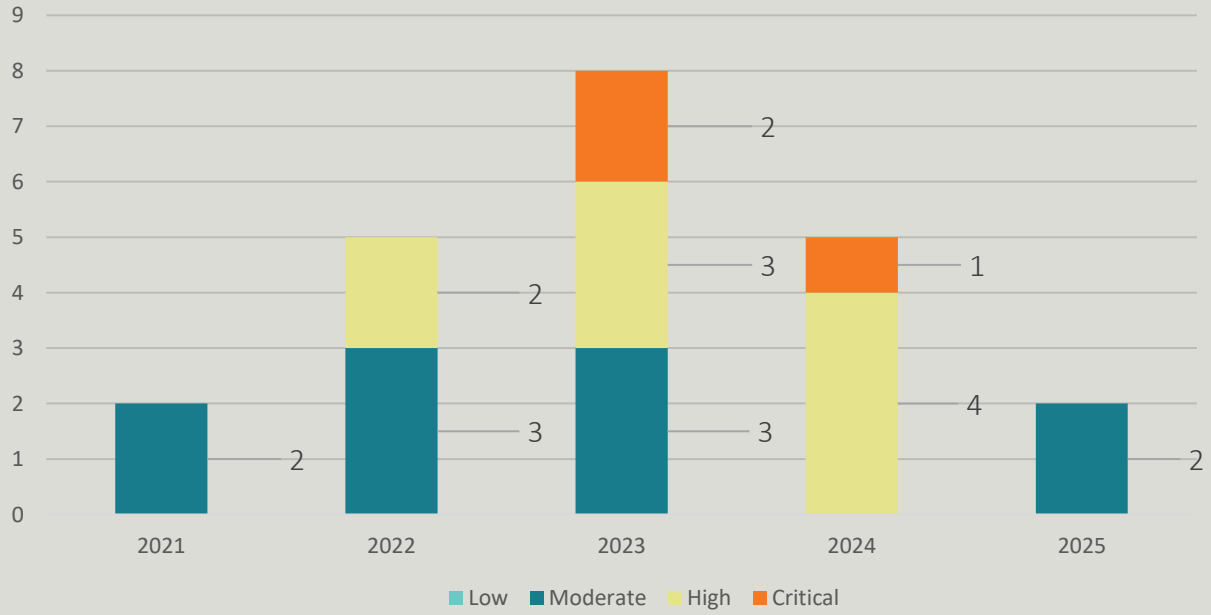
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

St. Anne's Unit was a single storey building located on the campus of the Sacred Heart Hospital in Castlebar Co. Mayo. Residents received care and treatment from two psychiatry of later life (POLL) multi-disciplinary teams who admitted residents over the age of 65 years to St Anne's Unit. These were the South Mayo POLL team and the North Mayo POLL team. There were also inpatient residents from the Sector 4 adult team at the time of inspection. At the time of inspection there were three residents in total in the unit.

The approved centre comprised of a main corridor with rooms on either side. There were two large dormitory style bedrooms which could accommodate 2 residents in each room. A shower room was accessible through one of the larger rooms and an en suite toilet was in the other. One communal assisted bathroom was accessible from the main corridor and there were male and female toilets, also on the main corridor. There were four single bedrooms which were not en suite. There was a well-equipped activities room, a large dining room, two large sitting rooms and large amounts of space for residents to move about in. There was a very large outdoor space which was largely tarmacadamed with a flower bed and raised planter beds, with outdoor furniture enclosed by new stone fencing installed since the last inspection.

Inspector of Mental Health Services Summary

St Anne's Unit is located on the campus of the Sacred Heart Hospital in Castlebar, Co. Mayo. The approved centre is registered to accommodate 8 residents. The approved centre has no conditions attached to its registration.

The inspection was unannounced and occurred over four days. The inspection report reflects findings of the inspection over this period only. The inspection process was very well co-ordinated and prepared for by the staff and management in the approved centre. Compliance with regulatory standards had improved since the 2024 inspection in a meaningful way. Work done by the approved centre in actively implementing a corrective and preventative action plan to correct areas of regulatory non-compliance was very evident on inspection.

This year the inspection team found two areas of non-compliance with minimum standards. While both of these areas were reoccurring since last year's inspection, they were reduced in their respective risk ratings since last year. A number of non-compliances identified during last year's inspection have been largely addressed. This included the provision of access to physiotherapy service for residents in St Anne's Unit,

reinstating access to the centres outdoor space for residents, reduction of ligature risks in the approved centre and the continued upgrading of fire safety at the centre. Changes in risk management processes at the centre allowed for identified risks to be controlled, monitored and audited in a comprehensive way. The inspection team observed that the approved centre had a cohesive team, that are invested in the delivery of safe and effective resident care and treatment in collaboration with the residents.

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

Resident Profile	
Number of registered beds	***8***
Total number of residents	**3**
Number of detained patients	0
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	0
Number of patients on Section 26 leave for more than 2 weeks	0

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	93%	83%	73%	83%	94%

Conditions of registration

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

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice 10000318	*21/03/2024*	*An Immediate Action Notice was issued as a result of the critical risk identified with Regulation 32: Risk Management Procedures.*	*The approved centre submitted assurances to the MHC in response to the immediate action notice, which included immediate corrective actions.*

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

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

- **Regulation 05: Food and Nutrition**
  - The two dining room menu boards were designed using a simplified layout with contrasting colours, which enhanced the ability of older adults to process and retain information about their food more effectively. The aim was to ensure that visual information was both accessible and informative for all residents.

- **Regulation 9: Recreational Activities**
  - St Anne's unit had a seven-seater car to facilitate outings and community engagement. Pet therapy was recently introduced in the approved centre with regular visits of a therapy dog to St Annes.

- **Regulation 12: Communication**
  - A ward electronic tablet was available for residents to maintain contact with family away or overseas during the admission period, via skype when required.

- **Regulation 16: Therapeutic Services and Programmes**
  - In March 2025 a Sensory Brief Screening tool was developed and introduced to St Anne's. The purpose of this tool was to get a snapshot of resident's sensory preferences. This information will help when identifying individual centred therapeutic inputs, and will be used by the Occupational Therapy (OT) to tailor the Self Soothe using your Senses group towards individual patient's preferences.

- **Regulation 19: General Health**
  - A new leaflet titled "Eating for a Healthy Heart" had been developed and introduced in January 2025, to help residents improve cardiovascular health through diet. This resource included practical advice and a visual guide to cardioprotective food portions, enhancing residents' understanding and ability to make informed dietary choices.

- **Regulation 20: Provision of Information to Residents**
  - A falls prevention leaflet for residents of the approved centre was developed and introduced in November 2024. This leaflet was designed to help residents consider what factors may increase their likelihood of having a fall, and had some simple tips and advice to help them reduce the risk of falling during their admission to St Anne's Unit.

- In November 2024, a heart-healthy information card, used during physical health assessment was introduced. This card helps residents interpret health examination results and provides clear guidance on preventive cardiology.

- **Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines**
  - A specialist mental health pharmacist attended the weekly multi-disciplinary team (MDT) meeting and completed audits to improve the safety of medication prescribing and administration. Such audits included a High Dose Anti-psychotic (HDAT) audit. All patients receiving HDAT were assessed and discussed at the Multi-Disciplinary Team meeting. Reductions had been made to reduce HDAT in cases where this was indicated. Alert Stickers to highlight residents receiving HDAT were added to Medication Prescription Administration Records (MPARs).
  - The mental health pharmacists and Non-Consultant Hospital Doctors had completed an audit which reviewed the prescribing of Sodium Valproate across Mayo mental health services; - this prompted an update within the Sodium Valproate policy and a new monitoring form and alert sticker have been created. The monitoring form was placed in clinical files to prompt annual review for those prescribed Sodium Valproate and the sticker on the clinical file to prompt the review date where required.
  - A Mayo mental health service Lithium Audit had been completed, and learning was shared within the service. The BNF Lithium Monograph had been updated with new dosing recommended and incorporated into the policy. The latest prescribing guidelines in psychiatry has been purchased and will be left in the nursing station in St Annes to support evidence-based prescribing.
  - Anti-cholinergic Burden scoring is completed for patients at risk of falls. This may be a useful guide for assessing the potential risk of anticholinergic adverse events on patients and this was highlighted on the MPARs and discussed at MDT meetings.

- **Regulation 27: Maintenance of Records**
  - St Annes unit had established processes to identify areas for improvement in record management with weekly clinical record checks and annual audits.

- **Regulation 29: Operating Policies and Procedures**
  - Mayo Mental Health Services (MMHS), as part of its commitment to the development, implementation and timely review of Policies, Procedures, Protocols and Guidance's (PPPG's), had a policy steering group which was chaired by the Nurse Practice Development Co-ordinator. It valued the contribution and feedback of the service user and their representatives and had Peer Support Workers as members of the policy steering group. Other members included the Social Worker, Psychologist, Occupational Therapist, Assistant Director of Nursing, Quality & Patients Safety Advisor, Consultant Psychiatrist, Clinical Nurse Specialist in Infection and Prevention Control (IPC) and Clinical Nurse Specialist in Self Harm. This group met bi-monthly, working collaboratively to endeavour that the PPPGs in MMHS were reviewed regularly by the appropriate stakeholders, never go out of date and the group also devised policies in response to service need and developments.

- **Regulation 31: Complaints Procedures**
    - There were monthly residents' meetings where feedback from residents was encouraged and valued. Minutes were recorded with actions and these were followed up with residents, either at the next meeting or in person.

- **Regulation 32: Risk Management Procedures**
    - Learning and Education Notifications issued by the MMHS Quality and Safety Committee were disseminated to all staff to enhance awareness and practice.
    - The Mayo Mental Health Service maintained a dedicated Audit and QPS Committee that fostered a strong culture of governance, ensuring benchmarking and standardisation across services. As part of this annual audits of risk management were conducted to assess compliance and drive service improvements.
    - Quarterly reviews of incidents within the Approved Centres were compiled by the QPS Advisor and shared with the Approved Centres' management teams to support informed decision-making and enhance service quality.

3.0 Governance

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

In the meantime, governance and oversight of MMHS remained with two core forums: the MMHS Area Management Team (AMT) meeting and the MMHS Quality and Patient Safety Committee (QPSC) meeting. Both meetings were scheduled monthly. The head of service chaired the MMHS QPSC meetings, which were attended by HSE managers, registered proprietor, clinical leads, managers of health and social care disciplines, risk advisors, health and safety representatives, and senior administrators. The Executive Clinical Director (ECD) chaired the MMHS AMT, which were attended by the head of service, HSE managers, clinical leads, managers of health and social care disciplines and senior administrators. The Quality and Patient Safety Committee monitored and maintained the Area Mayo Mental Health Services risk register. Minutes of these meetings documented discussions and review of any serious incidents that had taken place within the service. Escalated complaints were also reviewed at this meeting.

Sub-committees such as the Health and Safety Committee, the Policies, Procedures, Protocols and Guidelines (PPPG) Steering Group, the Drugs and Therapeutics Committee, the Infection Prevention Control Committee, and the Multi-disciplinary Team Operational Group reported to the AMT and QPSC meetings. The Therapeutic Services and Programmes and Recreational Activity Group met bi-monthly and provided updates to the Operational Group. A multi-disciplinary approach was fostered within governance structures and clinical care, and an ethos of continuous quality improvement was evident. Locally, the St Anne's Unit Business meeting met monthly and monitored and updated the approved centre's risk register. This meeting also discussed matters relating to infection control, maintenance, clinical auditing of practice, resident feedback, restrictive practice uses within the approved centre and issues relating to health and safety.

Responsibilities for risk management were allocated at management level and throughout the approved centre to ensure effective implementation. There was a quality and patient safety advisor available to the approved centre and the person with overall responsibility for risk was identified and known by all staff. The approved centre had a local risk register and defined pathways for escalation and de-escalation of risks to and from QPSC and the AMT as appropriate. The risk register contained health and safety risks, clinical risks, corporate and operational risks. Any individual resident related risks were discussed by their treating team as required. Incidents were recorded and risk-rated on the National Incident Management System (NIMS) and were reviewed as appropriate to identify any trends or patterns occurring in the service. Serious Reportable Incidents (SRE's) were discussed and investigated by the Serious Incident Management Team (SIMT). There were clearly defined processes and procedures for learning from any near misses or incidents occurring in the approved centre.

An organisational chart clearly identified the structures of leadership and the lines of authority and accountability within the approved centre. Governance questionnaires from each discipline provided the

inspection team with information about the governance structures. Each head of discipline outlined clear strategic goals for the service and the systems that were in place to monitor goal attainment. Clinical supervision was provided for medical staff and the health and social care professional groups. There was evidence of appropriate line management supervision structures in place within each department.

The numbers and skill mix of the staffing were sufficient to meet the residents' assessed needs, however, heads of discipline reported staffing shortages. This included in nursing and psychology services where the risk to the provision of care and the therapeutic services and programmes received at the approved centre was managed by the heads of disciplines. Processes by local and area management to try to address these vacancies including applying through the national derogation scheme in order to approve recruitment, had proved to be unsuccessful with posts being delimited by the HSE. Risks to the provision of therapeutic services to residents were documented on the local risk register. Nursing vacancies were managed using redeployment of staff from other areas of MMHS and use of overtime. A vacant psychology post in the North POLL team was managed by a process of referral to the principal psychologist. All other managers of health and social care disciplines said they were prioritising the approved centre in so far as practicable.

Resident input in governance and quality improvement processes was facilitated throughout the service. Resident community meetings and suggestion boxes provided residents with the forum to voice requests, suggestions and concerns. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service (formerly the Irish Advocacy Network). Advocacy was provided weekly at the approved centre. The advocacy contact details were displayed within the approved centre. The process of making complaints and the Complaints Officer contact details were displayed within the approved centre and in the resident information booklet. Complaints were dealt with by the staff in the approved centre and were documented with clear actions and outcomes detailed in a timely manner or in accordance with the approved center's policy. The residents also benefited from input of a peer support worker and an Area Lead for Mental Health Engagement who attended management meetings relevant to the approved centre

Restrictive practice use in St Anne's was closely monitored. There were policies in place for the use of restrictive practices and a policy for the reduction of the use of restrictive practices. There was an oversight and review committee which met every three months to review any episodes of restrictive practice should they occur. A report was provided to the registered proprietor following each meeting.

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing	14	100%	14	100%	12	86%	14	100%	14	100%	14	100%
Medical	9	100%	9	100%	8	88%	9	100%	9	100%	9	100%
Occupational Therapist	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker	3	75%	4	100%	4	100%	4	100%	4	100%	4	100%
Psychologist	1	50%	2	100%	1	50%	2	100%	2	100%	2	100%
Dietitian	0	0%	1	100%	1	100%	1	100%	N/A	N/A	1	100%
Pharmacist	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%

Health Care Assistant	3	100%	3	100%	3	100%	N/A	N/A	3	100%	3	100%

Therapeutic Services and Programmes

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning.

The Psychiatry of Later Life (POLL) south and north teams provided in reach for residents, as did any Adult Sector team residents accommodated in St. Anne's for one-to-one interventions. The service used a mobile sensory table. Therapeutic groups at the time of the inspection included the following: self sooth with your senses, recover through music, pet therapy and relaxation. This was reviewed and adapted as necessary with the needs of residents.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

4.0 Compliance

4.1 Compliant areas on this inspection

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

Regulation/Rule/Act/Code		2025
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 16: Therapeutic Services and Programmes	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 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	
Regulation 15: Individual Care Plan	✗	Moderate	✓		✓		✗	High	✗	Moderate
Regulation 22: Premises	✗	Moderate	✗	High	✗	Critical	✗	High	✗	Moderate

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

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre 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.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment 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 availed of the opportunity to meet with the inspection team during the inspection and two completed questionnaires were also received from residents during the inspection. General comments made by residents included that they liked being in the centre, felt the environment was peaceful, safe, they felt cared for and listened too. Some residents reported that they enjoyed the food and enjoyed the activities and the time that staff gave to them and residents knew who was looking after them and who to talk to if they had a difficulty.

Of the two completed questionnaires, both respondents indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood. Both respondents indicated sometimes when asked how often they got information on their diagnosis, care and treatment in a way that they understood. Both respondents indicated that they found the information useful.

Both respondents indicated that they understood what their care plan was. One indicated that they were always involved in setting goals for their individual care plans while one indicated sometimes to this question. Both of the respondents indicated that they knew their multi-disciplinary team members, and both indicated that they knew their keyworkers.

Both respondents indicated that they were always able to discuss worries or concerns with a member of staff. All respondents felt there was enough leisure activities and enough group activities in the approved centre. One respondent reported that there was enough talking therapies available while the other respondent didn't want talking therapy. All the respondents indicated that they were happy with how staff spoke with them and felt their privacy and dignity was respected.

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

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

5.2 Advocacy

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

The advocacy report reflected feedback from residents relating to positive aspects and some areas for improvement to the care received in St Anne's Unit.

- Residents reported being happy in and appreciating the care in St Anne's Unit.
- Residents liked having visitors at the centre and being able to go out with their families from the centre. They also enjoyed leave periods as part of preparing to go home.
- Residents appreciated being brought out and the one-to-one time with staff to support them with activities like shopping and personal care and social outings.
- Residents reported receiving information from staff on external supports in the community.
- Residents reported enjoying recreational and therapy groups such as the music group.
- Residents reported that staff gave them instructions on self-help techniques to help manage their symptoms and illness.
- Resident reported wanting more support to manage their external affairs whilst in hospital such as bills and property management.
- Residents wanted more discussion about their medications with their doctors and wanted more information on whether medications would impact on their ability to drive after discharge.
- Residents wanted more opportunity to view long term accommodation options when considering post discharge care.
- Residents would like access to bereavement and loss counselling.

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:

- Acting Registered Proprietor
- Acting Executive Clinical Director
- General Manager/Business Manager
- Area Director of Nursing
- Occupational Therapy Manager
- Occupational Therapist
- Principal Psychology Manager
- Principal Social Worker
- Nurse Practice Development Coordinator
- Regulatory Compliance Advisor
- Clinical Nurse Manager 3
- Consultant
- Dietetics Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Three ICPs were inspected. The ICPs were a composite set of documents that were identifiable and uninterrupted and were not amalgamated with progress notes. The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment of the resident within seven days of admission. The ICPs was discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

One out of three individual care plans did not identify appropriate goals for the resident. Two out of three individual care plans were not reviewed by the multi-disciplinary team (MDT) in consultation with the resident every week. In the case of one individual care plan that was reviewed, it was not updated to reflect changes to the goals, treatment, care, and required resources as per the assessed needs of the resident.

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

a) **One individual care plan did not identify appropriate goals for the resident.**
b) **Two individual care plans were not reviewed by the multi-disciplinary team (MDT) in consultation with the resident every week.**
c) **Following review, one individual care plan was not updated contemporaneously to reflect changes to the goals, treatment, care, and required resources as per the assessed needs of the resident.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Residents in the approved centre had access to personal space: all resident rooms were adequately sized and all bathroom, shower, toilet and single bedroom locks should have an override function. Residents had enough space to move about freely inside and outside of the approved centre.

Large communal rooms were provided. There was suitable heating in day areas and in bedrooms. Rooms were ventilated. The new LED lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs.

There was a plan to address identified ligature points in the approved centre that was costed, funded and time bound. Work that had been completed since the last inspection as part of this upgrading plan in the centre included: Installation of radiator covers, an anti-ligature retrofit of all toilet and shower areas in the ward, the installation of an anti-ligature handrail on main ward corridor, the encasing of exposed pipework and cables, anti-ligature/anti-climb garden fence was erected, the installation of 8 reduced ligature profile beds and bed tables and the fitting of anti-ligature handles on windows.

While these works were on-going at the time of the inspection to address ligature point risks, not all identified ligature points had been minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair on the inside and outside. A programme of routine maintenance for cleaning, decontamination and repair of assistive equipment was in place and there was a routine programme for general or decorative maintenance.

The approved centre was very clean, hygienic and free from offensive odours. There were sufficient toilets and showers for residents in the approved centre. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address the residents' needs and furnished to support resident independence and comfort. Assisted devices and equipment were available to address resident needs.

The approved centre was non-compliant with this regulation because not all ligature points were minimised to the lowest practicable level, based on risk assessment, 22(3).

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 refer to ***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 not applicable on inspection. Please refer to ***Section 4.3: Areas that were not applicable 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 refer to **Section 4.1: Compliant areas on this inspection** for the list of compliant codes of practice on this inspection.*

*Please refer to **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 : 10006465		One individual care plan did not identify appropriate goals for the resident.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The relevant Multi-disciplinary Team (MDT) was contacted during the inspection and the Individual Care Plan (ICP) was reviewed and updated to include additional appropriate goals for the resident.	Monthly ICP audits	Yes	16/05/2025	Executive Clinical Director, Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker & Principal Psychologist.
Preventative Action	Individual Care Plans (ICPs) are reviewed monthly through Regulation 15 audits. Multi-Disciplinary Team (MDT) members and managers partake in the audits. Audit report and analysis are presented at	Monthly ICP audits	Yes	31/05/2025	Executive Clinical Director, Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker & Principal Psychologist.

	monthly Multi-disciplinary Team Business Meeting and individual reports circulated to each Multi-disciplinary Team. Training provided to all healthcare professionals on an ongoing basis. MMHS YouTube ICP tutorial available to all healthcare professionals on induction.				
Reason ID : 10006466		**Two individual care plans were not reviewed by the multi-disciplinary team (MDT) in consultation with the resident every week.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The relevant Multi-disciplinary Team (MDT) was contacted during the inspection and the Individual Care Plans (ICP) were review and updated. The team were reminded of the requirement to review and update all ICP's every week.	Monthly ICP audits	Yes	16/05/2025	Executive Clinical Director, Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker & Principal Psychologist
Preventative Action	Individual Care Plans (ICPs) are	Monthly ICP audits	yes	31/05/2025	Executive Clinical Director, Area Director of Nursing, Occupational

	reviewed monthly through Regulation 15 audits. Multi-Disciplinary Team (MDT) members and managers partake in the audits. Audit report and analysis are presented at monthly Multi-disciplinary Team Business Meeting and individual reports circulated to each Multi-disciplinary Team.				Therapy Manager, Principal Social Worker & Principal Psychologist
Reason ID : 10006467		**Following review, one individual care plan was not updated contemporaneously to reflect changes to the goals, treatment, care, and required resources as per the assessed needs of the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The relevant Multi-disciplinary Team (MDT) was contacted during the inspection and the ICP was reviewed and updated to reflect any changes to the goals, treatment, care, best practice and required resources.	Monthly ICP audits	yes	16/05/2025	Executive Clinical Director, Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker & Principal Psychologist.

Preventative Action	Individual Care Plans (ICPs) are reviewed monthly through Regulation 15 audits. Multi-Disciplinary Team (MDT) members and managers partake in the audits. Audit report and analysis are presented at monthly Multi-disciplinary Team Business Meeting and individual reports circulated to each Multi-disciplinary Team.	yes	Monthly ICP audits	31/05/2025	Executive Clinical Director, Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker & Principal Psychologist.

Regulation 22: Premises					
Reason ID : 10006468		**Not all ligature points were minimised to the lowest practicable level, based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature audit completed as per the HSE Mental Health Services: Ligature Risk-Reduction Policy and Audit Tool. All identified ligature anchor points are risk rated and action plan developed. The Ligature Reduction group meets three monthly to review and update progress. Work is ongoing in area of ligature reduction and contractors will be on site again carrying out the remaining works.	Annual Ligature Audits with three monthly reviews and updates.	yes	28/02/2026	Area Director of Nursing, Business Manager, Maintenance Manager
Preventative Action	Three monthly meeting of the Ligature Reduction group with input from MDT members, Maintenance and Business managers.	Annual Ligature Audits with three monthly reviews and updates.	yes	23/06/2025	Area Director of Nursing, Business Manager, Maintenance Manager

	The existing ligature risks are mitigated through the use of the Observation policy with increased observation based on risk assessment.				

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.

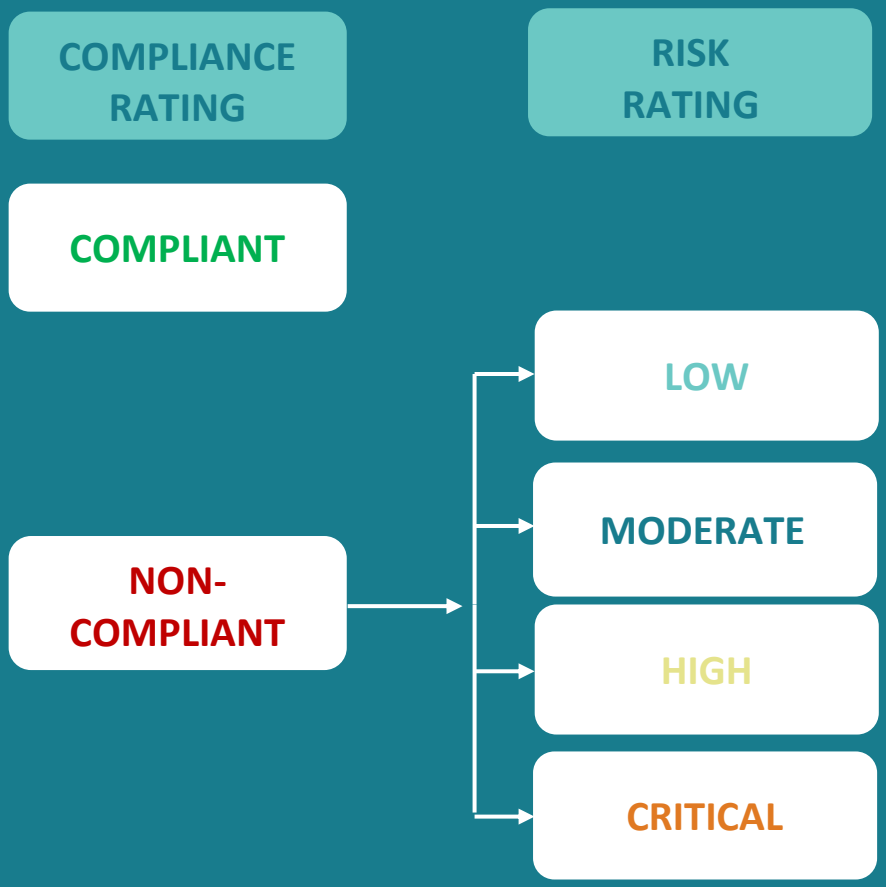
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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