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Nua Healthcare Services, Gormanston

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

NUA HEALTHCARE SERVICES, GORMANSTON

Flemington Road, Gormanston, Meath

Date of Publication:
10 April 2026

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2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay
Mental health rehabilitation

Conditions Attached:
Yes

Most Recent Registration Date:
19 February 2025

Registered Proprietor:
Nua Healthcare Services Limited

Registered Proprietor Nominee:
Ms Danika McCartney

Inspection Team:
Siobhán Dinan, Lead Inspector
Barbara McGeough
Damien Lanigan
Marianne Griffiths

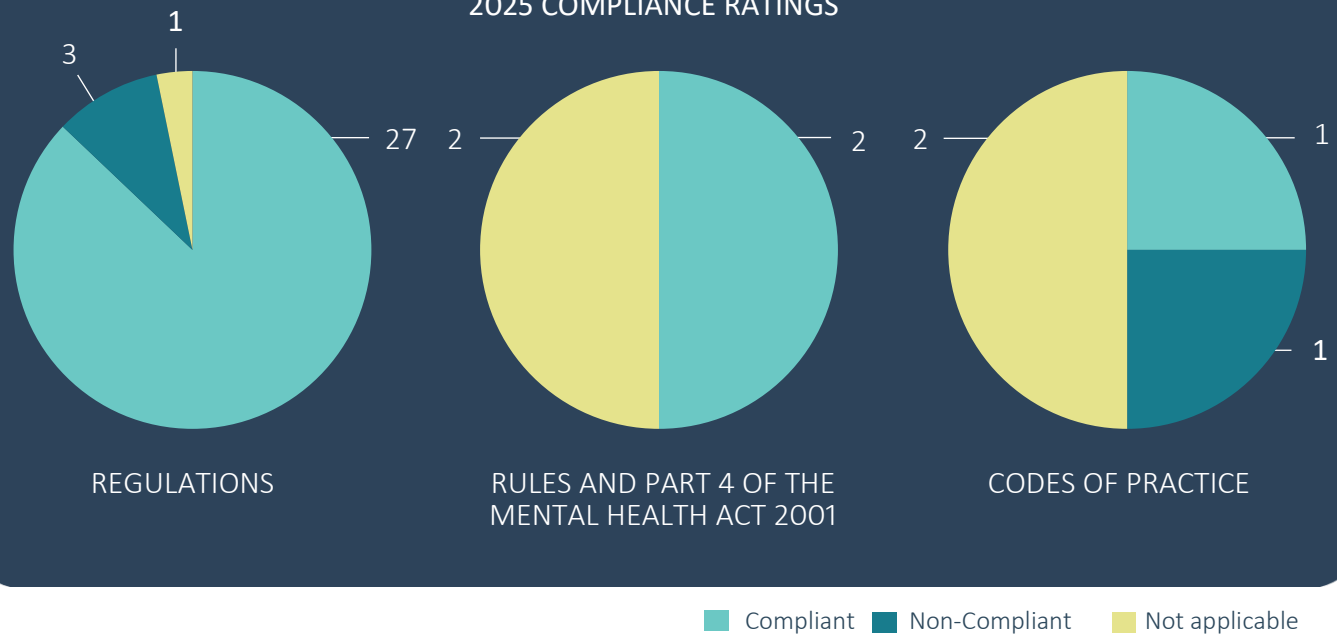
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
23 – 26 September 2025

Previous Inspection date:
N/A

Inspection Type:
Unannounced Annual Inspection

2025 COMPLIANCE RATINGS

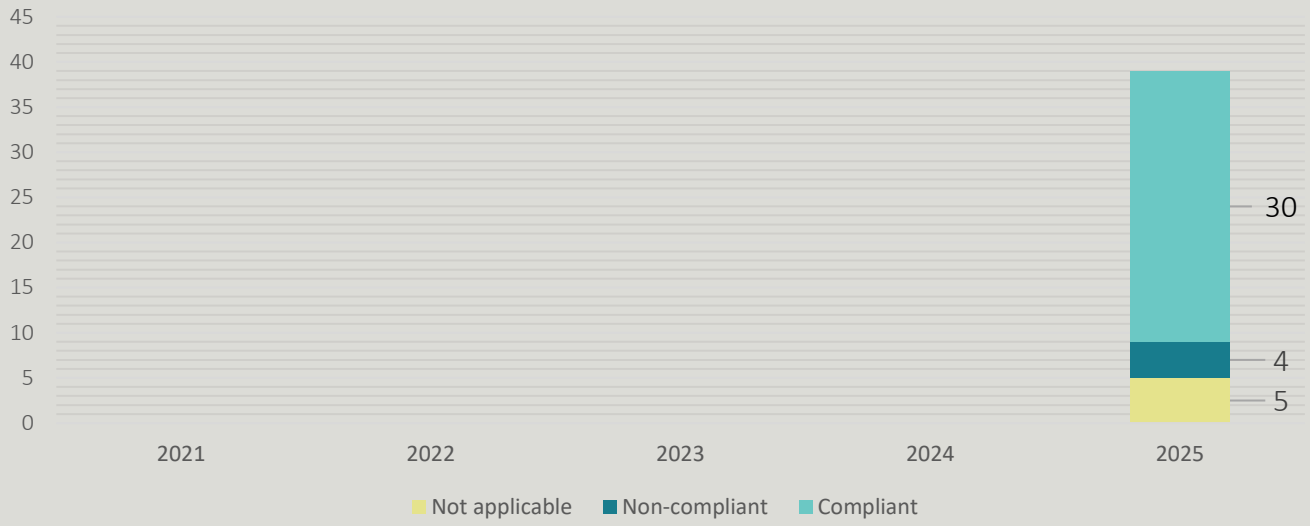


RATINGS SUMMARY 2021 – 2025

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

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2021 – 2025

Please note: **The approved centre opened for the first time in 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

Please note: **The approved centre opened for the first time in 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

Nua Healthcare Services, Gormanston, is situated on 6.5 acres of landscaped gardens in the rural townland of Gormanston, County Meath. It is a privately operated approved centre, owned and managed by Nua Healthcare.

The approved centre was registered for 25 beds for the first time in February of 2025. It was registered for continuing mental health care and mental health rehabilitation and accepted nationwide referrals from Ireland and the United Kingdom. It provided care and treatment for adult male residents with a range of severe and enduring mental health illnesses.

Nua Healthcare Services, Gormanston included 50 beds across three main units (Avoca, Boyne, and Corrib) and two step-down units (Foyle and Dargle). The step-down units were standalone units to which residents initially admitted to Boyne and Corrib units may be transferred towards the latter stages of their admission, to prepare them for discharge and support them in developing better life skills such as cooking and care of their environment. The approved centre was located on its own grounds and was surrounded by fencing.

As part of the access and egress procedures for the approved centre, all staff, and all residents were required to report to the main entrance security hut and complete the standard security procedures for entry or exit to the grounds and premises. All residents were issued personal RFID (radio-frequency identification) wristbands, which allowed free access and egress to resident areas within the unit they were admitted to, apart from other resident bedrooms, unless risk determined otherwise.

The approved centre was comprised of eight distinct buildings within a secure boundary:

- Avoca was a 20-bed unit with administration and main kitchen facilities that provided care for voluntary residents.
- Boyne was a 14-bed unit that provided care for involuntary patients.
- Corrib was a 14-bed unit that provided care for involuntary patients.
- Dargle was a 1-bed step-down standalone unit.
- Foyle was a 1-bed step-down standalone unit.
- A gymnasium.
- A multifaith building.
- An admission suite.

Each resident had their own bedroom, and each bedroom included en suite facilities and allowed for personalisation. The communal areas included internal courtyards, gardens, dining rooms, lounges, and games rooms -all designed to be bright, well-ventilated, and thoughtfully furnished. Residents had access to a range of therapeutic spaces, such as well-equipped occupational therapy kitchens, group therapy rooms, four gyms, and a multi-faith prayer room. Each unit was equipped with a kitchen, along with laundry and linen storage facilities.

The approved centre had one consultant psychiatrist led multi-disciplinary team (MDT), which consisted of a social worker, an occupational therapist, a clinical psychologist, medical staff, nursing staff, and a behavioural specialist. Admissions to the approved centre were pre-planned and by referral.

Inspector of Mental Health Services Summary

Nua Healthcare Services, Gormanston, is situated on 6.5 acres of landscaped gardens in the rural townland of Gormanston, County Meath. It is a privately operated approved centre owned and managed by Nua Healthcare Ltd. The approved centre was registered for 25 beds for the first time in February of this year.

The inspection of Nua Healthcare Services, Gormanston was unannounced and occurred over four days from 23rd to 26th September 2025. This report reflects the findings over this period only. Overall, the approved centre was spotlessly clean, well-presented and maintained throughout. It is evident that great care and consideration is given in providing a therapeutic, respectful and welcoming environment to residents.

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, met monthly and conducted unannounced inspections, with results reported to the Registered Proprietor Nominee for review and escalation as appropriate.

The inspection was very well co-ordinated by staff and management in the approved centre. The management and staff of the approved centre demonstrated a commitment to providing a quality service through the implementation of quality initiatives, investment in the physical environment, and a focus on compliance. 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 were developed with residents and their representatives. Many aspects of service provision exceeded the minimum standards set out in mental health legislation. The majority of issues identified on the walkabout and throughout the inspection were rectified during the inspection.

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

Resident Profile	
Number of registered beds	***25***
Total number of residents	**11**
Number of detained patients	7
Number of wards of court	2
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	4
Number of patients on Section 26 leave for more than 2 weeks	0

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	N/A	N/A	N/A	N/A	88%

Please note: The approved centre opened for the first time in 2025.

Conditions of registration

There were three conditions attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *The maximum number of residents that may be accommodated in the approved centre is twenty-five (25). The registered proprietor shall adhere to the admissions plan submitted to the Mental Health Commission on 14 February 2025 and shall admit residents accordingly.*	The approved centre was not in breach of Condition 1.
Condition 2: *In carrying on the business of the approved centre, 60 percent (%) of residents present in the centre at any one time must be accommodated under the Mental Health Act 2001 to 2018. For the purposes of clarity, the 60 percent shall be taken to the mean 60 percent of residents accommodated at any one time and shall not be calculated based on maximum registered occupancy.*	The approved centre was not in breach of Condition 2.

Condition 3: *The registered proprietor shall develop and implement policies and procedures to ensure that residents are informed of their rights under the Mental Health Acts 2001 to 2018. In developing these policies and procedures the registered proprietor shall have regard to the diverse communication needs of the residents who are admitted to the approved centre. This must include all differing communication needs of persons admitted, to reflect varying legislative frameworks, and which should be demonstrated to the MHC within the first 2 months of operation.*	The approved centre was not in breach of Condition 3.

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Proposal to Attach a Condition of Registration / Attachment of a Condition of Registration	*3 conditions attached to the approved centre as part of registration 19 February 2025*	***Reason for Condition 1:*** *The MHC must be assured that the number and skill mix of staff, as proposed, will materialize* and be maintained, in order to meet the needs of the proposed resident profile. ***Reason for Condition 2:*** Having regard to the proposed registered proprietor's plans to admit persons under frameworks, other than those set out under the MHAs, the MHC must be assured that the proposed service will primarily operate as an approved centre within the meaning of Section 62 and Section 63 of the Mental Health Acts being the basis for its regulatory remit. **Reason for Condition 3:** The MHC is of the opinion that this condition is required, having regard to the restrictive nature of the proposed secure environment and the likelihood that a large proportion of residents may be	***Condition 1:*** *The maximum number of residents that may be accommodated in the approved centre is twenty-five (25). The registered proprietor shall adhere to the admissions plan submitted to the Mental Health Commission on 14 February 2025 and shall admit residents accordingly.* ***Condition 2:*** *In carrying on the business of the approved centre, 60 percent (%) of residents present in the centre at any one time must be accommodated under the Mental Health Acts 2001 to 2018. For the purposes of clarity, the 60 percent shall be taken to the mean 60 percent of residents accommodated at any one time and shall not be calculated based on maximum registered occupancy.* ***Condition 3:*** *The registered proprietor shall develop and implement policies and procedures to ensure that residents are informed of their rights under the Mental Health Acts 2001 to 2018. In developing these policies and procedures the registered proprietor shall have regard to the diverse*

		subject to involuntary detention order during their stay at the proposed approved centre. The provision of information to residents, whether detained or not, in an approved centre is set out in section 4 of the Mental Health Acts 2001 to 2018 and is a basic human right.	*communication needs of the residents who are admitted to the approved centre. This must include all differing communication needs of persons admitted, to reflect varying legislative frameworks, and which should be demonstrated to the MHC within the first 2 months of operation.*

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Proposal to Attach a Condition of Registration / Attachment of a Condition of Registration	*Condition 1 revoked – 24 October 2025*	*The approved centre supplied sufficient assurances on inspection that they were meeting the requirements of Condition 1.*	

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.

- The approved centre enhanced occupational participation and recovery through the development of a library and vocational room. The dedicated library and vocational room provided residents with access to books, newspapers, and digital learning resources. Both rooms also provided a space for structured vocational sessions (e.g., computer skills, curriculum vitae workshops, online course completion) and an environment that supported both quiet reflection and group skill-building.

- The approved centre recruited a Recovery and Engagement Officer. As an 'Expert through Experience,' the Recovery and Engagement Officer was ideally placed to create a supportive and inclusive environment that empowered residents to actively engage in their recovery journey.

- The approved centre developed a new format of handover - the Situation, Background, Assessment and Recommendation handover (SBAR). Training for staff was provided by the clinical director and practice development manager on implementing the SBAR handover.

- The approved centre developed and implemented a live, user-friendly therapy scheduling system that was accessible to both staff and residents, ensuring up-to-date and clear information on individual and group therapy sessions.

- The approved centre developed and implemented a weekly newsletter. This enhanced resident engagement and communication by providing clear, accessible, and timely information to residents. The newsletter ensured that residents were informed of relevant news, upcoming activities, safety updates, and opportunities for engagement.

- A Sports Day event followed by a BBQ was organised for residents.

- Bicycles were purchased for residents. Bicycle safety inductions with a personal trainer, or other suitably qualified person, were available to residents requesting use of the bicycles.

- **Regulation 05: Food and Nutrition**
    - The approved centre had processes in place to identify and provide education and training with regard to the nutritional needs of the residents.
    - The approved centre had processes in place for the involvement of 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 09: Recreational Activities**
    - Birthday parties were held to celebrate the birthdays of each resident with a cake and finger food.
    - Residents had access to a gaming library.
    - The approved centre took into consideration residents' interests while creating a schedule of recreational activities.

- **Regulation 11: Visits**
    - The approved centre maintained physical environments and facilities that were fit for purpose, welcoming, well-decorated and well-designed.
    - The approved centre provided information about visiting in a manner which was accessible and understandable to all.

- **Regulation 12: Communication**
    - The approved centre strove to integrate technology in the services they provide, for example access to good quality Wi-Fi for all residents.

- **Regulation 15: Individual Care Plan**
    - Introduction of Recovery Star model: the Recovery Star Model was a tool used to support and measure a person's recovery journey. It was a collaborative model where a resident and their key worker jointly rated progress on a 10-point scale across 10 different domains. The individual care plan was used as an aid when conducting Recovery Star sessions as this enabled planned care to be as appropriate and up to date as possible. Individual care plans were updated to include Recovery Star actions and goals.
    - The care plan template was re-developed to be more person-centred and more easily understood. Easy Read Care Plans were developed.
    - The approved centre provided staff with training on recovery-focused care planning empowering staff to define and set appropriate recovery-focused short, medium, and long-term goals.
    - The approved centre had implemented an effective electronic care planning system.
    - The approved centre provided residents with a key worker to facilitate coordination and communication of interventions in line with their individual care plan.

- **Regulation 16: Therapeutic Services and Programmes**
    - Recycle for Recovery Scheme: Bins were put in place on wards for plastic bottles to be collected. Residents returned these while out on community leave and money was collected.
    - A wellness event for Mental Health Awareness was organised.

- **Regulation 20: Provision of Information to Residents**
    - The approved centre promoted resident advocacy groups.
    - The approved centre provided information in a manner which was accessible and understandable to all.
    - The approved centre communicated in a variety of media.
    - There was a Patient and Carer Experience Committee.

- **Regulation 21: Privacy**
    - Nua operated a diversity, inclusion and equality group for staff members and individuals.
    - The approved centre provided culturally appropriate services to ethnic minorities and marginalised communities.
    - The approved centre promoted the principles of equity, inclusion, and respect for diversity.
    - The approved centre empowered residents to manage their own lives through stronger social relationships and sense of purpose.
    - The approved centre acknowledged the evolving understanding of human rights and maintained policies and practice in line with current requirements.

- **Regulation 26: Staffing**
    - The approved centre acknowledged that staff may suffer trauma through their work and took steps to minimise the risk and manage the effect. The Employee Assistance Programme (EAP) Service was available to staff, and debriefs were offered to staff after incidents.
    - The approved centre provided and ensured that staff had undertaken training in a variety of areas. For example, but not limited to:
        - Unconscious bias, discrimination, and stigma. There was an equality and diversity group.
        - Child protection, where applicable.
        - Specific mental health therapies where applicable.
        - Specific mental health conditions.
    - The approved centre provided annual personal and professional development planning and facilitated opportunities for non-technical skills training (e.g. policy development, leadership skills, and change management).
    - The approved centre provided skilled staff to facilitate the generation of a holistic, multi-disciplinary, co-produced, individualised, and recovery-oriented care plan.

- **Regulation 27: Maintenance of Records**
    - The approved centre had processes in place for the identification of areas for improvement with regard to its own maintenance of records processes.
    - The approved centre had an integrated electronic record management system.

- **Regulation 29: Operating Policies and Procedures**
    - The approved centre had policies and procedures in place for human resource management including retention of staff.

- **Regulation 31: Complaints Procedures**
    - The approved centre had a process in place to gather feedback from families and residents.

- **Regulation 32: Risk Management Procedures**
    - The approved centre had an audit, carried out by a standard and integrated quality and safety committee, which promoted a culture of governance with benchmarking across services.
    - 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

Nua Healthcare Services, Gormanston was under the overall governance of Nua Healthcare Ltd Board of Directors who meet monthly. The Chief Operations Officer/Register Proprietor Nominee, Director of Services, Director of Admissions, Director of Transitions and Discharges, Director of Human Resources, Finance Director, Head of Quality and Safety in Intellectual Disability (ID) Services, and the Head of Quality and Safety in Mental Health Services attended the Board of Directors meeting each month.

At national level, there was a mental health governance meeting chaired by the Deputy Chief Operations Officer and attended by the Chief Operations Officer, Head of Quality and Safety, Director of Services, Director of Nursing, Risk Manager, Maintenance Manager, and Director of Admissions, Director of Transitions and Discharges. 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 SMT at the time of inspection held a clinical governance meeting monthly. Issues such as staffing and recruitment, clinical effectiveness, risk management and safety, data protection, education and training, patient and carers' experience, clinical audit and quality improvement were discussed at these meetings. Subordinate committees included a clinical effectiveness governance committee, a restrictive practice oversight and Mental Health Act compliance committee, a patient council committee, a patients and carer experience committee, and a business operations committee. All subordinate committees reported to the Clinical Governance committee.

A quality and safety meeting convened fortnightly, and standing agenda items included health and safety, policy and procedure, regulatory compliance, training and development, risk 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 a local level a governance meeting convened monthly and was attended by members of Nua Healthcare, Gormanston senior management team (SMT). Agenda items included service development and strategy, serious incidents, health and safety, quality improvement, risk management, safeguarding, and emergency planning.

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 and 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 SMT 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. The approved centre had one multi-disciplinary team which included psychiatry, nursing, occupational therapy, psychology and social work and a behavioural specialist, all of whom were based in the approved centre.

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 and family engagement in governance and quality improvement processes were facilitated throughout the service. Resident's involvement in service delivery was facilitated by service-user satisfaction surveys, and the availability of the compliment and complaints process to support service improvement. 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. Weekly 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. Residents also had access to a Recovery and Engagement Officer to facilitate a supportive and inclusive environment that empowers residents to actively engage in their recovery journey.

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (29)	29	100%	29	100%	29	100%	29	100%	29	100%	29	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Behavioural Specialist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Other (24)	24	100%	24	100%	24	100%	24	100%	24	100%	24	100%

Therapeutic Services and Programmes

Social work, occupational therapy (OT) and psychology departments offered both individual and group-based treatment programmes to residents of the approved centre. There was additional therapeutic input from a behaviour specialist, a recovery and engagement officer, personal trainers and nursing staff.

There was a bi-monthly therapeutic and recreational activities timetable focusing on rehabilitation, maintaining skills and integrating residents into the community. Residents had access to a variety of therapeutic activities in the approved centre which included; a gym, walking groups, recovery through activity groups, a goal setting group, recovery workshops, a personal trainer group, a psychology and nursing psychoeducational groups, a life skills group, a Look Good, Feel-Good self-care Group, pet therapy, a Dialectical Behavioural Therapy (DBT) group, and cycling sessions. Each discipline worked together with the residents to provide a person-centred, needs based programme for each resident.

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 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 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 22: Premises	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed-Circuit Television	✓	Compliant
Regulation 26: Staffing	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 30: Mental Health Tribunals	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 32: Risk Management Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Rule on the Use of Seclusion	✓	Compliant
Part 4 Consent to Treatment	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

4.2 Non-compliant areas on this inspection

Non-compliant areas on this inspection are detailed below, with the relevant risk rating:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2025	
Regulation 13: Searches	✗	Moderate
Regulation 19: General Health	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High
Code of Practice on the Use of Physical Restraint	✗	Moderate

Please note: The approved centre opened for the first time in 2025.

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

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of 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 directly during the inspection. The resident expressed that they believed the approved centre was clean, tidy and warm. The resident commented that the staff were lovely. The resident expressed they enjoyed having access to the gym but that there were not enough activities. The resident commented that the food in the approved centre was good and that they would love to start cooking soon.

The inspection team did not receive any completed feedback questionnaires from residents.

5.2 Advocacy

The approved centre had an advocacy service. The Irish Advocacy Network was notified that the inspection team were in the approved centre and responded that they had not yet provided a service in Nua Healthcare Services, Gormanston up to the time of the 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/Chief Operations Officer (COO)
- Deputy Chief Operations Officer (DCOO)
- Clinical Director
- Head of Quality, Safety, and Compliance
- Director of Nursing
- Quality Assurance Officer
- Operations Manager
- Occupational Therapy Manager
- Senior Clinical Psychologist
- Principal Clinical Psychologist
- Senior Social Worker

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

7.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 13: Searches

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had written operational policies and procedures on the searching of a resident, their belongings and their environment, carrying out searches with the consent of a resident and carrying out searches in the absence of consent, and the policy requirements relating to the finding of illicit substances. The policy was last reviewed in September 2025.

The search policy did not clearly state which staff members may carry out searches. The resident search policy and procedure was communicated to all residents. Relevant staff could articulate the searching processes as set out in the policy.

The clinical files of three residents were inspected in relation to search processes in the approved centre. The resident being searched was informed of what was happening during the search and why. Resident consent was sought prior to all searches. The request for consent and the received consent were documented for every search of a resident and for every property search. The following deficits were found on inspection:

- In one search, the search was carried out by a member of the security team, not a clinical staff member. Therefore the search was conducted by a staff member who was not appropriately qualified.
- In two searches, there was no documentation to indicate that the search had been carried out with due regard for the resident's privacy or dignity.
- In one search, there was no documentation to indicate that the resident had been given the opportunity to feedback regarding their experience of the search in relation to privacy and dignity.

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

a) **The search policy did not clearly state which staff members may carry out searches, 13(1).**
b) **In one case a search was carried out by a member of the security team, not a clinical staff member. Therefore, the search was conducted by a staff member who was not appropriately qualified, 13(6).**

c) **In two cases there was no documentation to indicate that the search had been carried out with due regard for the resident's privacy or dignity, 13(7).**
d) **In one case there was no documentation to indicate that the resident had been given the opportunity to feedback regarding their experience of the search in relation to privacy and dignity, 13(9).**

Regulation 19: General Health

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre has written operational policies and procedures for responding to medical emergencies. The policy was last reviewed in June 2025.

The approved centre had an emergency trolley and staff always had access to an automated external defibrillator (AED). Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Four clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessment documented a physical examination, blood pressure, smoking status, dental health, medication review, and body mass-index and weight. However, in one out of the four files inspected, the resident's family history personal history or nutritional status was not assessed or documented, and this went against the approved centre's own policy.

The four resident files inspected were of residents receiving antipsychotic medication. There was an annual assessment completed in each case of: glucose regulation, blood lipids, electrocardiogram heart assessment, and prolactin levels.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents had access to national screening programmes according to age and gender, and as applicable including retina check (for people with diabetes) and bowel screening.

The approved centre was non-compliant with this regulation because one resident did not receive an adequate six-monthly physical assessment. Within the six-monthly assessment: the resident's family history, personal history or nutritional status was not assessed or documented, and this went against the approved centre's own policy, 19(1)(b).

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

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, prescribing, storing and administration of medicine. The policy was last reviewed in June 2025, and included the following requirements: the processes for the storing and administration of resident medication, and the process for prescribing resident medication in relation to High-Dose Anti-psychotic Treatment (HDAT).

The policy did not include the process for ordering resident medication.

All residents had a Medication Prescription and Administration Record (MPAR). Ten MPARs were examined on inspection. All MPARs contained the administration route for the medication, a record of any allergies or sensitivities to any medications, including if the resident has no allergies and a clear record of the date of discontinuation for each medication.

The approved centre did not always have appropriate and suitable practices relating to the administration of medicines to residents because a record of all medications administered to the resident was not recorded in all MPARs.

Entries in the MPARs were legible and included the signature of the medical practitioner for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. All medication was stored appropriately. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

For residents on high dose antipsychotic treatment (HDAT), there was not a regular review by a pharmacist and six monthly assessment.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing and administration of medicines to residents for the following reasons:

a) **The registered proprietor has not ensured that the policy contained a process for ordering resident medication, 23(1).**
b) **The registered proprietor had not ensured that a record of all medications administered to the resident was maintained as there were a number of omissions in relation to medication administration, 23(1).**
c) **For all residents on high dose antipsychotic treatment (HDAT), there was not a regular review by a pharmacist, 23(1).**

8.0 Inspection Findings – Rules

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

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedure on the Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions. The policy was last reviewed in June 2025.

The policy included certain components such as:

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

The policy and procedure on the Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions, did not include:

- The provision of information to the person including information about the person's rights, presented in accessible language and format.

Policies and procedures regarding staff training included:

- Who would receive training based on the identified needs of persons who are restrained and staff.
- The monitoring of the safety of the person during and after the physical restraint.
- The mandatory nature of training for those involved in physical restraint.

The policies and procedures regarding staff training did not include the following:

- The identification of appropriately qualified persons to give the training.
- The areas to be addressed within the training programme, as follows:
    - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
    - Alternatives to physical restraint, Trauma-informed care, Cultural competence.
    - Human rights, including the legal principles of restrictive interventions.
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.

Training and Education: All staff involved in physical restraint had signed to indicate that they had read and understood the policy. A record of attendance at training was maintained. All staff who participated in the use of physical restraint had received the appropriate training in its use and in the related policies

and procedures.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed. A multi-disciplinary review and oversight committee met at least quarterly, and determined if each episode of physical restraint reviewed complied with the code of practice on the use of physical restraint, as well as with the approved centre's own policies and procedures relating to physical restraint. The committee identified and documented areas for improvement and the actions, the persons responsible and the timeframes for completion of any actions. The registered proprietor nominee was assured that each use of physical restraint was in accordance with the Mental Health Commission's code of practice. And the committee produced a report following each meeting.

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

Orders for physical restraint: The orders for physical restraint were initiated, carried out, renewed and ended. The order confirmed that there were no other less restrictive ways available to manage the person's presentation. The person being restrained was informed of the reasons for the restraint and the circumstances which would lead to its discontinuation.

The relevant section of the clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint as soon as was practicable and no later than three hours after the conclusion of the episode of physical restraint.

Each episode of physical restraint in the clinical practice form was signed by the consultant psychiatrist (CP) or the duty CP within 24 hours.

Dignity and safety: The person's representative was informed of the restraint or not, in accordance with the person's wishes, and an explanation was entered in their clinical file. The Mental Health Commission was informed of the start time and date, and the end time and date of each episode of physical restraint.

The person being restrained was assessed and monitored. The safety of the persons being restrained was assured as all staff involved in the three episodes of physical restraint had undertaken appropriate training in accordance with the approved centre's policy.

The person who led the physical restraint ended the restraint in the three episodes of physical restraint.

Ending of physical restraint: Appropriate emotional support was provided to the person following each of the episodes of physical restraint. An in-person debrief did not follow any of the episodes of physical restraint as the patient refused to engage in the de-brief, and declined the opportunity for a de-brief, in all three episodes, and this was documented in clinical files.

Clinical Governance: All episodes of physical restraint were appropriately recorded. Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) involved in the person's care and treatment within five working days of the restraint.

However, in one episode of physical restraint the MDT did not record the actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person as part of the MDT review of that episode of physical restraint.

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

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

a) **The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not address the provision of information to the person, which should include information about the person's rights, presented in accessible language and format, 7.2(a)(i).**
b) **The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not address information regarding the safeguarding arrangements that should be followed during any episode of physical restraint, 7.2(a)(iii).**
c) **The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not address the areas to be addressed within the training programme as specified in the code of practice, 8.2(b)(i), (ii), (iii), (iv), (v) and (vi).**
d) **The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not identify appropriately qualified person(s) to give the training, 8.2(c).**
e) **In one episode of physical restraint the multi-disciplinary team did not record the actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person as part of the multi-disciplinary team review of that episode of physical restraint, 7.4.**

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 13: Searches					
Reason ID : 10006807		**The search policy did not clearly state which staff members may carry out searches, 13(1). In one case a search was carried out by a member of the security team, not a clinical staff member. Therefore, the search was conducted by a staff member who was not appropriately qualified, 13(6).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Search Policy was updated to include staff members who may carry out searches in line with Regulation 13 (1). Internal audits in place carried out by the Nurse Management Team and QA in relation to Search paperwork. All Clinical staff have read and signed off on the updated Search policy. Induction Training has been updated to include information around searches and	The DON, ADON will monitor this action on an ongoing basis. QA Department will audit while on site visits.	No barriers to implement and all actions to address concerns are in place.	17/02/2026	Director of Nursing (DON). Assistant Director of Nursing (ADON).

	whom can complete same.				
Preventative Action	Search Policy was updated to include staff members who may carry out searches in line with Regulation 13(1). Internal audits in place carried out by the Nurse Management Team and QA in relation to Search paperwork. All Clinical staff have read and signed off on the updated Search policy. Induction Training has been updated to include information around searches and whom can complete same.	The DON and ADON will monitor on an ongoing basis. QA Department will complete audits while on site visits.	There have been no barriers to implementation. The action is completed and has ongoing monitoring as outlined above.	17/02/2026	Director of Nursing (DON). Assistant Director of Nursing (ADON).
Reason ID : 10006809		**In two cases there was no documentation to indicate that the search had been carried out with due regard for the resident's privacy or dignity, 13(7). In one case there was no documentation to indicate that the resident had been given the opportunity to feedback regarding their experience of the search in relation to privacy and dignity, 13(9).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Search Documentation was updated to include confirmation that there was regard for	The DON and ADON, will monitor this action on an ongoing basis. QA Department will	No barriers to implement and all actions to address concerns are in place.	17/02/2026	Director of Nursing (DON). Assistant Director of Nursing (ADON). QA Department.

	Residents' privacy and dignity in line with Regulation 13(7). Search Documentation was updated to include a space to gather feedback from the Resident in relation to their views on the search process in line with Regulation 13(9).	complete audits while on site visits.			
Preventative Action	Search Documentation was updated to include confirmation that there was regard for Residents' privacy and dignity in line with Regulation 13(7). Search Documentation was updated to include a space to gather feedback from the Resident in relation to their views on the search process in line with Regulation 13(9). All clinical staff have read and signed off on the new search policy. - Ongoing	The Clinical Director, DON and ADON, will monitor and complete internal audits on an ongoing basis. QA Department will complete audits while on site.	The action is completed and there is no barrier to implementation. Ongoing monitoring in place.	17/02/2026	The Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON).

	internal Auditing in place completed by the Nurse Management Team and QA.				

Regulation 19: General Health					
Reason ID : 10006806		**One resident did not receive an adequate six-monthly physical assessment. Within the six-monthly assessment: the resident's family history, personal history or nutritional status was not assessed or documented, and this went against the approved centre's own policy, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following on from the non-compliance in relation to Reg 19 – A spreadsheet has been implemented identifying when all healthcare reviews are due. Clinical Director and Director of Nursing met with GP to review 6-monthly medicals, and briefed GP to ensure all paperwork is completed in line with the Judgment Support Framework. Nurse Management Team/Doctors have implemented internal Audit Checks on Regulation 19. QA Team complete internal audits on Regulation 19. GP completes onsite reviews with a member of the	The Clinical Director, DON, ADON and Junior Dr will monitor this action on an ongoing basis as part of quality checks in place. QA Department will complete audits while on site visits.	No barriers to implement and all actions to address concerns are in place.	17/02/2026	Clinical Director. Consultant Psychiatrist. Junior Doctors. GP. Director of Nursing (DON). Assistant Director of Nursing (ADON). QA Department.

	nursing team and the Junior Dr.				
Preventative Action	Following on from the non-compliance in relation to Reg 19 – A spreadsheet has been implemented identifying when all healthcare reviews are due. Clinical Director and Director of Nursing met with GP to review 6-monthly medicals and briefed GP to ensure all paperwork is completed in line with the Judgment Support Framework. Nurse Management Team/Doctors have implemented internal Audit Checks on Regulation 19. QA Team complete internal audits on Regulation 19. GP completes onsite reviews with a member of the nursing team and the Junior Dr.	The Clinical Director, DON, ADON and Junior Dr will monitor and complete internal audits on an ongoing basis. QA Department will complete audits while on site visits.	The action is completed and has ongoing monitoring as outlined above.	17/02/2026	The Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON). Junior Dr.

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10006811		**The registered proprietor has not ensured that the policy contained a process for ordering resident medication, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Policy and Procedure on Ordering, Prescribing, Storing, and Administration of Medicines was updated to include the process for ordering Residents Medication - 23(1).	Ongoing Policy Reviews take place, which are completed by Management Team. Quality Assurance Team continue to audit while on site visits. Quarterly Policy Review Meetings.	No barriers to implementation, action as outlined above closed out.	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON).
Preventative Action	Ongoing Policy Reviews take place, which are completed by Management Team. Quality Assurance Team continue to audit while on site visits. Quarterly Policy Review Meetings.	The Clinical Director and Director of Nursing/Assistant Director of Nursing will monitor this action on an ongoing basis	There has been no barrier to implementation and this has now been completed. On going monitoring in place.	17/02/2026	Clinical Director Director of Nursing (DON). Assistant Director of Nursing (ADON). Quality Assurance Team
Reason ID : 10006812		**The registered proprietor had not ensured that a record of all medications administered to the resident was maintained as there were a number of omissions in relation to medication administration, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ways of working were reviewed by the Management Team. A Digicare Administration Guide	Medication audits completed by Nurse Management at a minimum of monthly, to ensure that	No barriers to implementation, actions as above complete and monitoring is ongoing	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON). Clinical Nurse

	was created to ensure all team members are documenting medications administered in a consistent manner, and there are no omissions in relation to medication administration, 23(1). Guide was released to all Clinical team members in November 2025 and on an ongoing basis to new team members. This is now included in local induction.	documentation is consistent. QA Department complete regular audits and support visits.			Lead. Quality Assurance Team (QA).
Preventative Action	Ways of working were reviewed by the Management Team. A Digicare Administration Guide was created to ensure all team members are documenting medications administered in a consistent manner, and there are no omissions in relation	Medication audits completed by Nurse Management at a minimum of monthly, to ensure that documentation is consistent. QA Department will complete audits while on site visits.	No barriers to implementation, actions as above complete and monitoring is ongoing.	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON). Clinical Nurse Lead. Quality Assurance Team (QA).

	to medication administration, 23(1). Guide was released to all Clinical team members in November 2025 and on an ongoing basis to new team members. This is now included in local induction.				
Reason ID : 10006813		**For all residents on high dose antipsychotic treatment (HDAT), there was not a regular review by a pharmacist, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Pharmacist reviewed medications for all Residents. This took place on 24th September. Quarterly reviews have been scheduled. Admission SOP was updated to include liaising with Pharmacist when a new admission is confirmed, this ensures all medications are reviewed within the first week of admission by the Pharmacist, and HDAT identified with	Clinical Director and Director of Nursing/Assistant Director of Nursing to monitor this action on an ongoing basis. QA Department to audit while on site visits.	No barriers to implementation, action is ongoing and in place.	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON). Deputy Chief Operating Officer.

	Consultant Psychiatry sign off.				
Preventative Action	Scheduled quarterly Pharmacist visits on site which includes an open clinic for both Residents and Clinicians to discuss any queries or concerns, in relation to medication prescribing and administration. Admission SOP has been updated to include liaising with Pharmacist when a new admission is confirmed, this ensures all medications are reviewed within the first week of admission by the Pharmacist, and HDAT identified with Consultant Psychiatry sign off. Medication reviews for all Residents completed by the Pharmacist on a quarterly basis (including review of HDAT).	The Clinical Director and Director of Nursing/Assistant Director of Nursing will monitor this action on an ongoing basis. QA Department will audit while on site visits.	There has been no barrier to implementation. The action has now been completed and will be monitored on an ongoing basis.	17/02/2026	Clinical Director. Pharmacist. Director of Nursing (DON). Assistant Director of Nursing (ADON).

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10006814		**The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not address the provision of information to the person, which should include information about the person's rights, presented in accessible language and format, 7.2(a)(i). The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not address information regarding the safeguarding arrangements that should be followed during any episode of physical restraint, 7.2(a)(iii). The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not address the areas to be addressed within the training programme as specified in the code of practice, 8.2(b)(i), (ii), (iii), (iv), (v) and (vi) The Prevention and Management of Violence and Aggression: Restrictive and Non-Restrictive Interventions policy did not identify appropriately qualified person(s) to give the training, 8.2(c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Policy and Procedure on Physical and Mechanical Restraint was updated to address: The provision of information to the person, which includes information about the person's rights, presented in accessible language and format, 7.2(a)(i). The information regarding the safeguarding arrangements that	Quarterly Policy Reviews in place. Management Team continue to complete quality checks. QA Department continue to conduct audits on site visits.	No barriers to implementation – action as outlined above has been completed	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON).

	should be followed during any episode of physical restraint, 7.2(a)(iii). The areas to be addressed within the training programme as specified in the code of practice, 8.2(b)(i), (ii), (iii), (iv), (v) and (vi)				
Preventative Action	Quarterly Policy Reviews in place. Management Team continue to complete quality checks. QA Department continue to conduct audits on site visits.	QA team will complete regular audits on COP for Physical Restraint. Management Team continue to complete quality checks. Quarterly Policy Reviews in place.	No barriers to implementation, policy working group now in place.	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON). Quality Assurance Team (QA).
Reason ID : 10006818		**In one episode of physical restraint the multi-disciplinary team did not record the actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person as part of the multi-disciplinary team review of that episode of physical restraint, 7.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Multi-Disciplinary Team (MDT) Reviews do take place after each episode of physical restraint. As part of the MDT Review following the episode of physical	Clinical Director, Director of Nursing and Assistant Director of Nursing to regularly monitor this action. QA Department will continue to	No barriers to implementation.	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director of Nursing (ADON).

	restraint, any actions decided upon and follow-up plans to eliminate, or reduce restrictive interventions for the Resident will be documented within the meeting minutes. - A Delegated Person will be identified in these reviews to update care plan. - Prompt to update ICP has also been added to the debrief form in the Restraint Management Booklet. - Further quality checks will be completed on all paperwork; including triangulation with ICP, completed within one week post restraint by ADON or delegate other.	complete audits on site visits.			
Preventative Action	Multi-Disciplinary Team (MDT) Reviews do take	Action to be regularly monitored by Clinical Director,	No barriers to implementation. Actions as	17/02/2026	Clinical Director. Director of Nursing (DON). Assistant Director

	place after each episode of physical restraint. As part of the MDT Review following the episode of physical restraint, any actions decided upon and follow-up plans to eliminate, or reduce restrictive interventions for the Resident will be documented within the meeting minutes. - A Delegated Person will be identified in these reviews to update care plan. - Prompt to update ICP has also been added to the debrief form in the Restraint Management Booklet. - Further quality checks will be completed on all paperwork; including triangulation with ICP, completed within one week	Director of Nursing and Assistant Director of Nursing.	outlined above complete and monitoring in place.		of Nursing (ADON). Quality Assurance Team (QA).

	post restraint by ADON or delegate other.				

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.

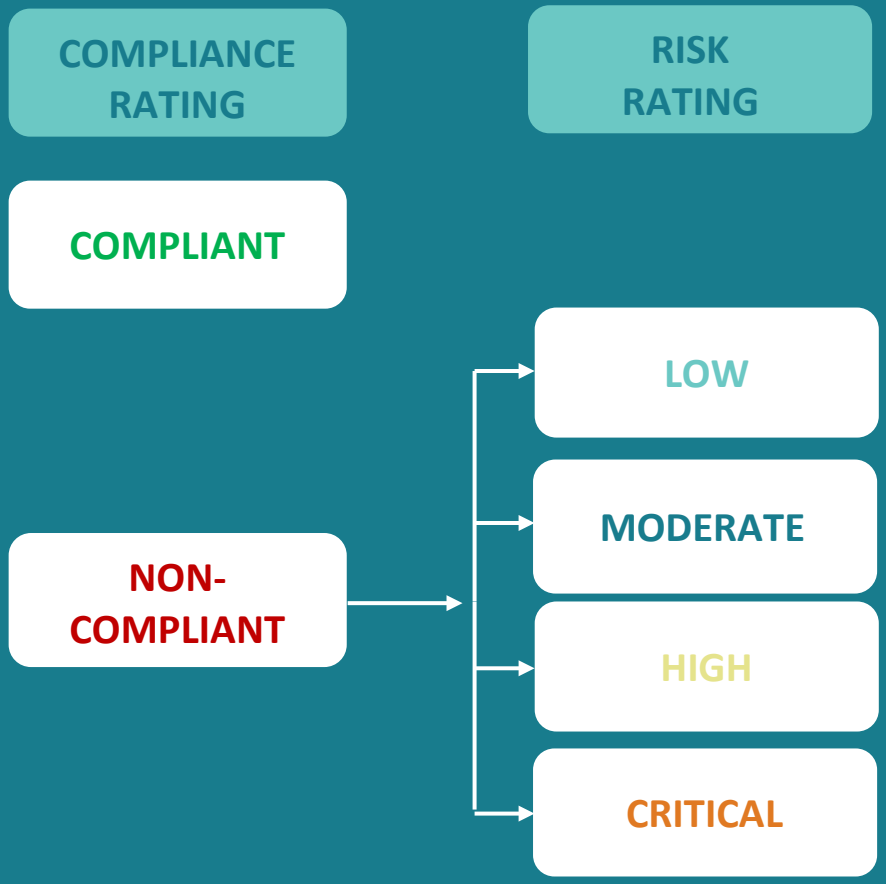
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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