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Department of Psychiatry, Connolly Hospital

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHAITRY, CONNOLLY HOSPITAL

Blanchardstown, Dublin 15

Date of Publication:
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2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care

Conditions Attached:
None

Most Recent Registration Date:
07 December 2024

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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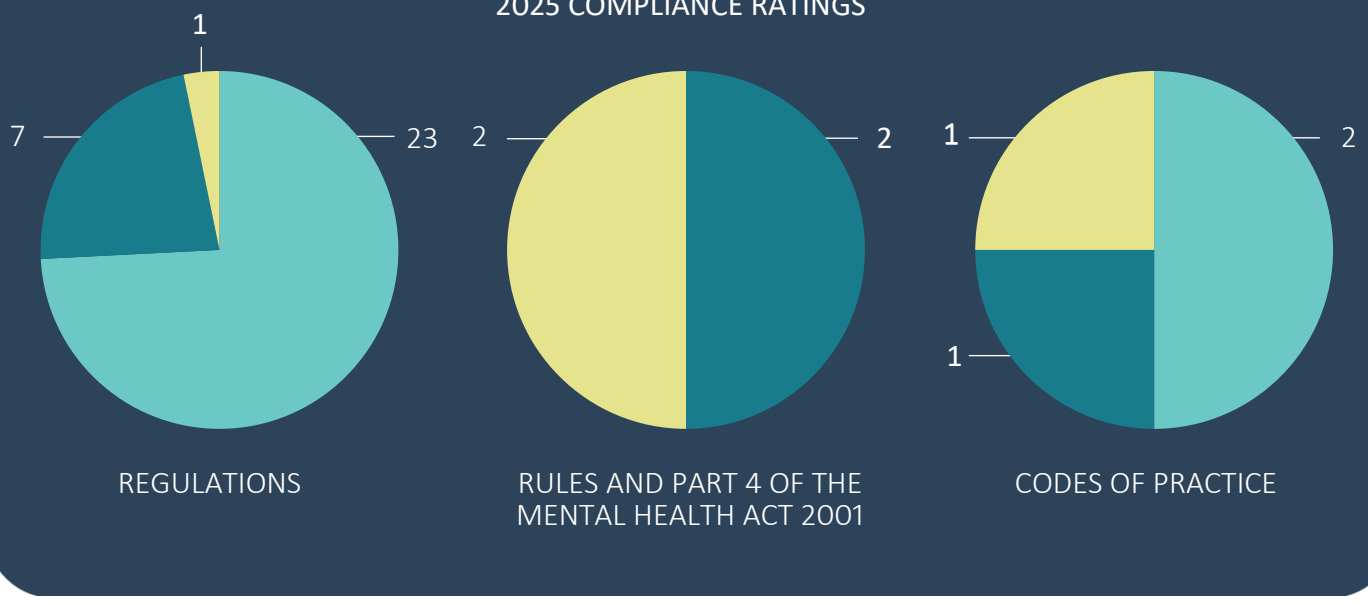
Inspection Date:
10 – 13 June 2025

Previous Inspection date:
17 – 20 September 2024

Inspection Type:
Unannounced Annual Inspection

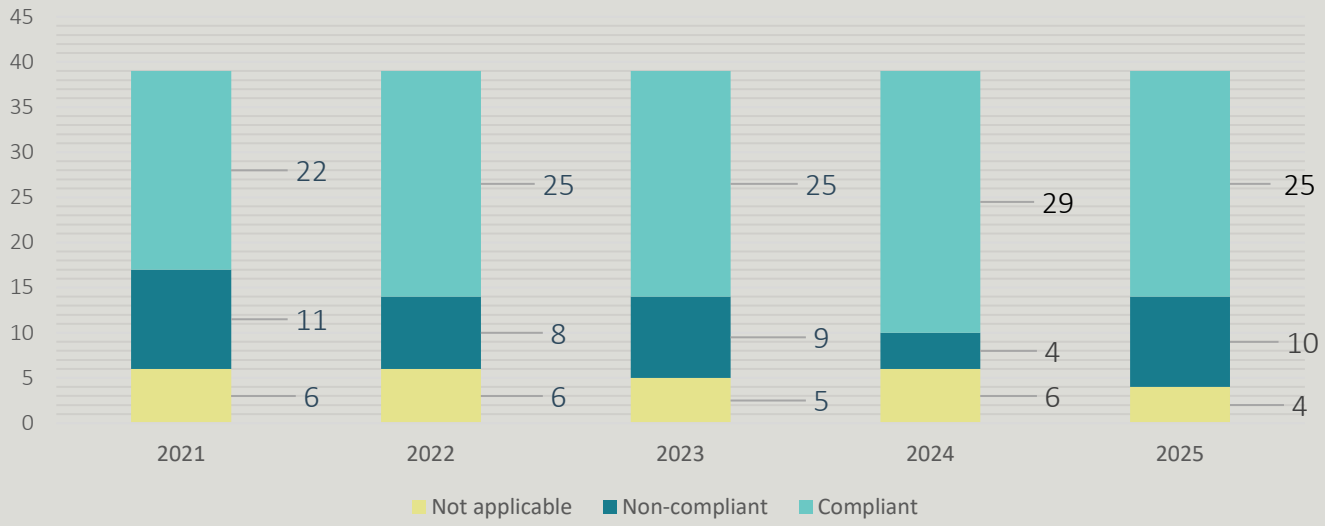
2025 COMPLIANCE RATINGS



RATINGS SUMMARY 2021 – 2025

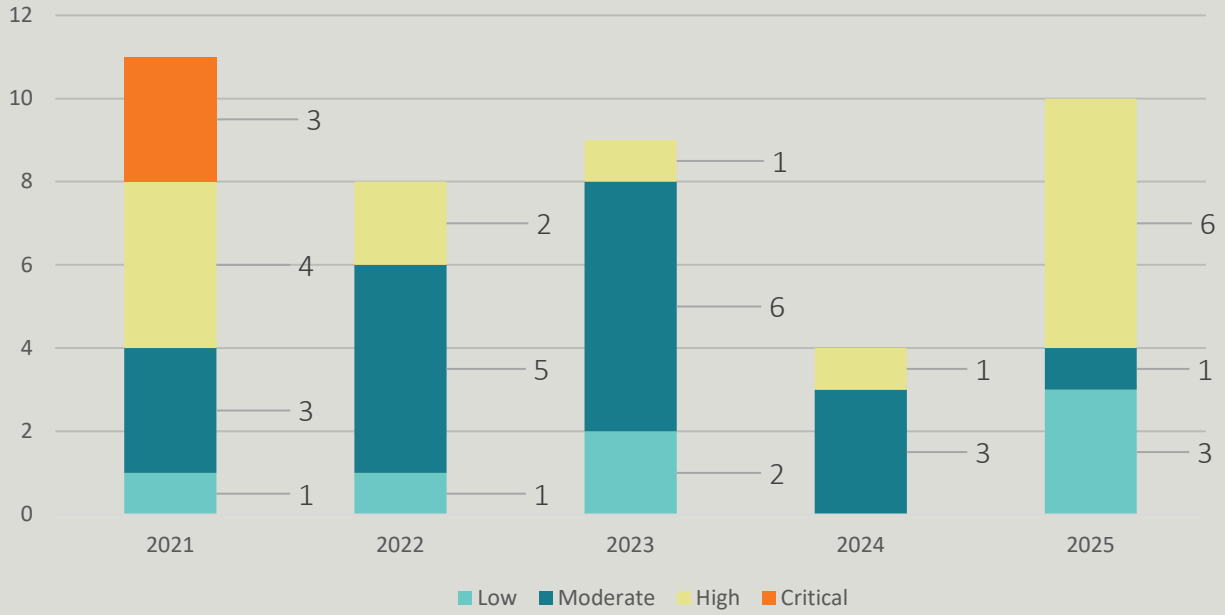
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2021 – 2025



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2021 – 2025



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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

The Department of Psychiatry (DOP) is located on the lower ground floor of Connolly Hospital, Blanchardstown. Access to the approved centre is by swipe card or by request, which is facilitated by security staff. A long corridor with staff offices, a tribunal room, and a family visiting room led to two wards, Ash Ward and Pine Ward, to the left of the corridor, and to a therapies department, at the end of the corridor. The therapies department included a recreational room, an arts and crafts room, a 'MySpace (sensory) Room', an occupational therapy kitchen and a garden.

The approved centre is registered for 47 beds with the Mental Health Commission. At the time of the inspection, the approved centre was working with an operations capacity of 42 beds due to the ongoing refurbishment works. Residents were accommodated within three wards. Both Ash and Pine Wards had accommodation for 21 residents each. Pine ward bed capacity was reduced to 16 at the time of inspection to facilitate ongoing refurbishment works. A High Dependency Unit (HDU) was located between Pine and Ash wards. The HDU had accommodation for five residents, within five single bedrooms, and incorporated a seclusion room, a day room, dining room and a newly constructed external courtyard.

Resident accommodation on both Ash and Pine Wards consisted of a mix of three single rooms, two with en suite bathrooms, three double rooms, with en suite bathrooms, and three four-bedded rooms. Residents in Ash ward and Pine ward had shared access to a large courtyard. Both wards had three small multi-purpose day rooms and a dining room. At the time of the inspection these rooms were only operational on Ash ward due to ongoing works. Residents in Pine ward were relocated to the therapeutic area during daytime hours to facilitate building works, and to ensure minimum disruption to residents' therapeutic schedule.

Inspector of Mental Health Services Summary

The inspection of the Department of Psychiatry (DOP),Connolly Hospital was unannounced and occurred over a four-day period, from the 10th to 13th of June 2025 inclusive. This summary reflects the findings at the time of the inspection.

In 2024, the service was non-compliant with four areas of regulation. In 2025, there was an increase in the rate of non-compliance, ten regulatory areas were found to be non-compliant, with three recurring non-

compliances: Regulation 22: Premises, Regulation 15: Individual Care Plans (ICP), and the Rule Governing the Use of Seclusion. Major refurbishment of the Approved Centre continued, which was nearing the final stages.

Most clinical documentation inspected was of a very high standard, however, there was an omission in documentation in one episode of Physical Restraint and in two episodes of seclusion. Six individual care plans inspected did not meet the required standard. No occupational therapy (OT) resource was available to provide identified interventions. Two OT positions were vacant at the time of inspection. No OT resource to provide identified interventions or an appropriate alternative were identified.

The inspection was very well co-ordinated by staff and management in the approved centre. Many aspects of service provision exceeded the minimum standards set out in mental health legislation. Areas of good practice included the identification of significant reduction of restrictive practices and seclusion within Dublin North City Adult Mental Health Services from 2022 to 2024, with a poster developed by senior management to demonstrate this. The management and staff of the approved centre demonstrated a commitment to providing a quality service through the implementation of quality initiatives, and a regular audit schedule.

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**37**
Number of detained patients	11
Number of wards of court	0
Number of residents under the Assisted Decision Making Act	0
Number of children	0
Number of residents in the approved centre for more than 6 months	6
Number of patients on Section 26 leave for more than 2 weeks	0

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	67%	76%	74%	88%	71%

Conditions of registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

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

- Nursing clinical leadership programme for Clinical Nurse Mangers (CNM) began in 2024 to support CNMs in their role.

- RAID training has been provided for staff. RAID: Reinforce Appropriate, Implode Disruptive, is a positive psychology least restrictive practice approach for working with people who exhibit challenging behaviours.

- REIS (Residential environmental impact) Actions and recommendations, in line with ward upgrade included furniture for High Dependency Unit and dining room. New Artwork was displayed in Pine and Ash wards and in the quiet/sensory spaces.

- Admission, transfer and discharge summaries tracking and safety project were completed by administration.

- Mental health engagement forum currently being piloted in the approved centre facilitated by mental health engagement lead.

3.0 Governance

The Dublin North City Mental Health Services (DNCMHS) Management team were responsible for the overall governance and operation of the approved centre, with the exception of Estates and fire maintenance which was the responsibility of the Board of Connolly Hospital. The DNCMHS Management Team convened monthly. This meeting was chaired by the Executive Clinical Director. All clinical heads of department were represented and standing agenda items included; service planning, quality and patient safety, human resources, finance, communications, regulation and compliance. Feedback from committees such as Quality and Patient Safety committee, (QPSC) drugs and therapeutics committee, health and safety committee and research and ethics committee also formed part of the agenda.

The Quality and Patient Safety Committee (QPSC) met monthly. Agenda items included discussions in relation to; service user experience, quality indicators and outcome measures, quality improvement initiatives and plans, audit and report recommendations and planning. Other agenda items included; meeting national standards, guidelines, policies, and risk management processes. All incidents, near misses, risk assessment and the risk register were also discussed and reviewed. Quality and safety reports from committees were reviewed, as were reports for mandatory education and training for staff.

The Compliance committee met monthly to discuss adherence to the Mental Health Commission rules and regulations within the approved centre. Quality initiatives and ongoing improvements to the approved centre were presented at this meeting. Practices within the approved centre in relation to each of the rules and regulations were reviewed to identify areas of further development. There were a number of working committees that supported and enhanced continuous quality improvement. These included; quality and safety, drugs and therapeutics, ethics committee, risk management, health and safety, and staff health and wellbeing. The quarterly Quality and Safety Walk Round (QSWR) had been paused during the current phase of refurbishment works.

There were key personnel with responsibility for risk management in the approved centre. The approved centre also had support of a quality and patient safety advisor. The person with overall responsibility for risk was identified and known by staff. Incidents were recorded and risk-rated on the National Incident Management System (NIMS) using National Incident Report Forms (NIRF) and were reviewed by the risk manager and QPSC as appropriate, to identify any trends or patterns occurring in the service. Each discipline identified risks facing their respective departments. Challenges in relation to recruitment due to current pay and numbers strategy process were identified.

Nine consultant led teams based in four catchment areas, Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. This comprised of two rehabilitation teams and seven community mental health teams. The liaison psychiatry service, within Connolly Hospital Blanchardstown, also had admitting rights to the approved centre. At the time of inspection, the numbers and skill mix of staff were not sufficient to meet the resident's needs. This was due two vacancies within the occupational therapy department which led to no occupational therapy being provided to residents within the approved centre. Two psychologists, one assistant psychologist and one psychologist in training provided therapeutic services

and programmes in the approved centre. Community-based social workers provided one to one intervention on an in-reach basis. A full-time pharmacy post had been approved, and recruitment had commenced for this role. The majority of staff had completed mandatory training. Those who had not yet completed the training or were awaiting refresher courses were scheduled to complete trainings on a specified date.

One young person was admitted to the approved centre since the last inspection. In this incident the young person was accommodated briefly within the approved centre and swiftly transited to an appropriate Child and Adolescent Mental Health (CAMHS) facility. A rights-based approach to the admission was ensured. All necessary resources were provided to safeguard the child, and advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre. The young person was admitted in transit to a CAMHS facility for a brief period and all necessary resources were provided to ensure protection of their human rights.

Major refurbishment works, with phase six of a seven phase project, concentrated in Pine ward, continued at the time of inspection. Extensive and continuous planning to ensure minimal disruption to residents during the refurbishment works continued. Residents from Pine ward, where building works were taking place, relocated to the therapies area during the day. Staff ensured that health and safety risks were managed throughout this transition.

A representative from Peer Advocacy in Mental Health was available to the residents of the approved centre. Service user input into the approved centre was enhanced by the Area Lead for Mental Health Engagement who had input into the approved centre governance processes. Resident community meetings, suggestion boxes, and engagement with the complaints process were utilised to maximise resident feedback to management. The process for making a complaint was publicly displayed and available to residents and family members.

4.0 Compliance

4.1 Compliant areas on this inspection

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

Regulation/Rule/Act/Code		2025
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed Circuit Television	✓	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 32: Risk Management Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Code of Practice: Admission of Children	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

4.2 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2021		2022		2023		2024		2025	
Regulation 15: Individual Care Plan	✓		✗	Moderate	✗	Moderate	✗	Moderate	✗	High
Regulation 16: Therapeutic Services	✓		✓		✗	Moderate	✓		✗	High
Regulation 21: Privacy	✗	Moderate	✗	High	✓		✓		✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	High	✗	High
Regulation 23: Medication	✗	Moderate	✓		✓		✓		✗	High
Regulation 26: Staffing	✗	Critical	✗	Low	✗	Moderate	✓		✗	High
Regulation 31: Complaints Procedures	✓		✓		✓		✓		✗	Low
Rules Governing the Use of Seclusion	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	Low
Part 4 Consent to Treatment		N/A		N/A	✓			N/A	✗	High
Code of Practice on the Use of Physical Restraint	✓		✓		✗	Moderate	✓		✗	Low

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

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of 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 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.

The inspection team met with six residents. Residents reported that they felt safe, and that nursing staff were approachable. Residents reported that the Individual care plan (ICP) process was explained to them, they attended their ICP meeting with their multi-disciplinary team, and they received a copy of their ICP. Further feedback was that the premises was clean, food was lovely, and kitchen staff ordered whatever was requested by the resident. All interviewed residents, apart from those in the High Dependency Unit (HDU) shared a room, and although they said it was fine, they would prefer their own room. However, they, felt safe and used the curtain around their bed to maintain privacy.

Some improvements were suggested by the residents. Three residents suggested that there could be more exercise, sports, or activity groups, and the availability of gym equipment. Other suggestions included more talking group sessions, more information in relation to admission process and a number of residents commented that they did not have access to an occupational therapist.

Two completed questionnaires were received. A positive aspect of the resident's experience was that staff were available to listen and always used the residents name when addressing them, which was positive for the resident. Another comment was that although staff tried their best, there was no supply of arts and crafts and not enough activities during the day. One resident commented that sometimes it is not clear who you can make complaints to.

On a scale of 1-10, with 1 being poor and 10 being excellent, the overall experience of care and treatment was rated 10 out of 10 by both respondents.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

6.0 Feedback Meeting

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

- Registered Proprietor Nominee
- Area Director of Nursing
- Assistant Director of Nursing x 2
- Clinical Nurse Manager 3
- Occupational Therapy Manager
- Principal Psychologist
- Principal Social Worker
- Mental Health Act Administrator
- Quality & Patient Safety Advisor
- Head of Service

Apologies received from Acting Clinical Director.

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

7.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Ten ICPs were inspected. The ICPs were a composite set of documents which addressed the resident's goals, mental health care and treatment needs, based on a multi-disciplinary team (MDT) assessment of the person and where practicable, in consultation with them. The documents within the ICPs were identifiable, uninterrupted and were not amalgamated with progress notes.

Of the ten ICPs examined, nine were developed within seven days of the resident being admitted. All ten ICPs were developed by a MDT. The ICPs were discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

The ICPs identified appropriate goals for the resident, the care and treatment required to meet the goals, and the responsibilities for implementing the care and treatment. The ICPs did not identify the resource required to meet residents' occupational therapy needs. Two Occupational Therapy (OT) posts were vacant at the time of inspection, and no in-reach, or cross cover for either vacancies was provided to address identified interventions needed, and no appropriate alternative was identified.

In one ICP the resident's goals were identified but were not reviewed weekly in an acute setting. Following review, six ICPs were not updated to reflect changes to care and treatment.

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

a) **Six individual care plans were not updated contemporaneously following review to reflect changes to the resident's goals, treatment, care and required resources.**
b) **One care plan was not developed within seven days of admission.**
c) **One care plan contained goals that were not reviewed by the multi-disciplinary team.**
d) **The individual care plans did not identify the resources required to provide the care and treatment.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre did not provide therapeutic services and programmes that met the assessed needs documented in residents' individual care plans. Unmet needs for occupational therapy were identified in individual care plans. Two Occupational Therapy (OT) posts were vacant at the time of inspection and no in-reach or cross cover for either vacancies was provided.

The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Therapeutic services and programmes included individual and group-based psychology interventions such as; behavioural support plans, psychology groups, behavioural family therapy and carer support. Community-based social workers provided individual interventions on an in-reach basis.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, as unmet Occupational Therapy needs were documented in four residents individual care plans, 16(1).

Regulation 21: Privacy

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

Residents were called by their preferred name based on their self-identification. Staff appeared and dressed professionally and interacted with residents in a professional, engaging and compassionate manner. Staff showed discretion when discussing the resident's condition or treatment needs. Permission was sought before entering a resident's room

Bed screening was used in shared rooms to ensure residents' privacy was not compromised. Observation panels on treatment room doors and bedroom doors had blinds, curtains or opaque glass. Rooms were not overlooked by public areas.

Noticeboards did not detail resident names or other identifiable information. Residents were facilitated to make private phone calls. All residents wore clothes that respected their privacy and dignity.

All bathrooms, showers and toilets had locks on the inside of the door, except where there was an identified risk to a resident. Locks had an override function. However, single bedrooms had a barrel lock with key access. Residents did not have access to a key to lock door from inside the bedroom.

The approved centre was non-compliant with this regulation because single bedrooms did not have a lock on the inside of the bedroom door.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents in the approved centre had access to personal space and adequate communal rooms. There was suitable and sufficient heating in day areas and in bedrooms. All private and communal areas were sized and furnished to remove excessive noise. Lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs.

Work to upgrade the window system was ongoing, however, not all rooms were ventilated at the time of inspection.

Residents had space to move about, including outdoor spaces. Residents in Ash Ward had access to the main courtyard, while residents from Pine Ward have access to the therapies garden whilst works were ongoing. Hazards were minimised in the approved centre.

Ligature points were not minimised to the lowest practicable level, based on risk assessment. Some high risk ligature points remained from the previous inspection.

Overall, the approved centre was kept in a good state of repair. However, the bathroom flooring in both Ash and Pine wards were awaiting an upgrade in shower rooms. The garden in the therapies corridor had benches that required painting, and the walls required both power hosing and painting.

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

a) **All rooms did not have sufficient ventilation at the time of inspection, 22(1)(b).**
b) **All ligature points had not been minimised to the lowest practicable level, based on risk assessment, 22(3).**
c) **The approved centre was generally kept in a good state of repair externally and internally however, the therapy corridor garden required wall and furniture repainting. Bathrooms awaiting renovation had stained flooring and paint damage to radiators, 22(3).**

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

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had appropriate and suitable practices and written operational policies relating to:

- Ordering medicines.
- Storing medicines.
- Administering medicines to residents

The policy was last reviewed in October 2023. The process for prescribing medication for High Dose Anti-Psychotic Treatment (HDAT) was not included within the medication management policy.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident. The MPARs of ten residents were inspected. The MPARs recorded allergies and sensitivities to any medication, or recorded that the resident had no allergies. The MPARs detailed medication administration routes, a record of all medications administered to the resident and a clear date of discontinuation for each medication. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was recorded. In one MPAR there was no signature present from the medical practitioner for one entry.

Medication was appropriately stored. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication was stored securely. Schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.
For residents on high dose antipsychotic treatment (HDAT), there was no regular review by a pharmacist nor six monthly assessment of the following: Glucose regulation (Fasting glucose / HbA1c) Blood lipids ECG Prolactin.

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

a) **A medication had been administered without a medical prescriber signature for a period of nine days, 23(1).**
b) **Residents on high dose anti-psychotics were not regularly reviewed by a pharmacist, 23(1).**

c) **The process for prescribing medication for High Dose Anti-Psychotic Treatment (HDAT) was not included within the medication management policy, 23(1).**

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in April 2024, and included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty at all times. The numbers and skill mix of staffing however, was not sufficient to meet resident needs. Two occupational Therapy (OT) posts were vacant at the time of inspection.

Nine teams had admitting rights into the approved centre. These teams were staffed by medical, nursing, occupational therapy, social work and psychology staff. At the time of the inspection there were two vacancies on the occupational therapy team. No in-reach or cross cover for either vacancies was provided. Two senior psychologists, one psychology assistant and one psychologist in training were based in the approved centre. Social work provided an in-reach service. The majority of staff had completed mandatory training. Those who had not yet completed the training or were awaiting refresher courses were scheduled to complete trainings on a specified date.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre (AC).

The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory areas:

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (53)	46	87%	42	80%	47	89%	53	100%	53	100%	53	100%
Consultant (13)	12	92%	12	92%	13	100%	12	92%	12	92%	12	92%
Medical (19)	18	95%	18	95%	18	95%	19	100%	19	100%	19	100%
Social Worker (9)	9	100%	9	100%	9	100%	9	100%	9	100%	9	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
HCA (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure the numbers and skill mix of staffing was sufficient to meet resident needs, as no occupational therapist was available within the approved centre, 26(2).

Regulation 31: Complaints Procedures

NON-COMPLIANT

Risk Rating LOW

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the:

- Making of complaints.
- Handling of complaints.

The policy was last reviewed in May 2024.

A nominated person was responsible for dealing with all complaints and was available to the approved centre. The approved centre's processes for managing complaints were well publicised and accessible to residents and their representatives. This included providing information about the complaints' procedure to the resident and their representative at admission or soon thereafter. The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family and next-of-kin were informed of all methods by which a complaint could be made. Not all minor complaints were documented.

The approved centre was non-compliant with this regulation because not all minor complaints relating to the approved centre were recorded, 31(6).

8.0 Inspection Findings – Rules

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

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

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating LOW

INSPECTION FINDINGS

Processes:

The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated May 2025.
The approved centre had separate written policies in relation to the use of seclusion, the training of staff in relation to the use of seclusion, and the use of CCTV for observing residents in seclusion. The policies had been reviewed in May 2025

The policies addressed the following:

- Who may initiate, and who may carry out, seclusion
- The provision of information to the person which must include information about the person's rights, presented in accessible language and format
- The safety, safeguarding and risk management arrangements that must be followed during any episode of seclusion.

Training and Education:
There were policies for staff to read and understand.
There was a written record to indicate that staff involved in seclusion had read and understood the policies. The training record was available to the inspector. A record of attendance at training in the use of seclusion was maintained.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Seclusion facilities were furnished, maintained and cleaned in such a way that ensured the person's inherent right to personal dignity and privacy was respected. All furniture and fittings in the seclusion room were of such a design and quality as not to endanger the safety of the person in seclusion.

Three episodes of seclusion were reviewed on inspection. Orders for seclusion were appropriately initiated, carried out, renewed and ended. The resident being secluded was assessed and monitored, and their dignity and safety were respected. In two episodes, the resident's representative was informed of the seclusion, in accordance with the person's wishes. In the third episode, it was not documented if the resident's representative was informed of the episode of seclusion, nor was not it documented whether the person's representative was informed of the ending of the episode of seclusion.

The registered proprietor notified the Mental Health Commission of each episode of seclusion in the format specified by the Mental Health Commission. An in-person debrief followed every episode of seclusion. This debrief was person-centred and gave the resident the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved in their care and treatment.

Where it was the resident's wish not to engage in this debrief, that wish was respected. Appropriate emotional support was provided to the resident in the direct aftermath of the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion. Each episode of seclusion was appropriately recorded, and all relevant information was placed in the person's clinical file

Each episode of seclusion was reviewed by members of the multi-disciplinary team involved in the person's care and treatment. The review was documented and recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

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

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

a) **In one episode of seclusion, it was not recorded whether the person's representative was informed of the person's seclusion, 3.12.**
b) **In one episode of seclusion, it was not recorded whether the person's representative was informed of the ending of the episode of seclusion, 7.10.**

9.0 Inspection Findings – Mental Health Act 2001

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

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

Part 4 Consent to Treatment

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

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

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

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

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

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment, due to the fact that the full names of the medication were not listed on the form 17: *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent.*

10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

*Please see **Section 4.2: 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 LOW

INSPECTION FINDINGS

Processes:
The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated May 2025. It addressed the following:

- The provision of information to the person which should include information about the person's rights, presented in accessible language and format.
- Information regarding who can initiate and who may carry out Physical Restraint.
- Information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of Physical Restraint.

Training and Education:
There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

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

In two episodes, the orders for physical restraint were appropriately initiated, carried out and ended. The person being restrained was informed of the reasons for the restraint and the circumstances which lead to its discontinuation. They were assessed and monitored, and the Mental Health Commission was informed of the start time and date, and the end time and date of each episode of seclusion.

In one episode of physical restraint (PR), whether or not the resident was informed of the reasons for PR was not noted in their clinical file. Similarly, the reason for ending PR was not noted in the clinical file.

An in-person debrief followed the episodes of physical restraint, where appropriate. This debrief was person-centred and gave the person the opportunity to discuss the restraint with members of the multi-disciplinary team (MDT) involved in their care and treatment. Where it was the person's wish not to engage in this debrief, that wish was respected. The person's individual care plan was updated to reflect the outcome of the debrief and in particular, their preferences in relation to restrictive interventions.

Appropriate emotional support was provided to the person in the direct aftermath of the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the restraint. Each episode

of physical restraint was recorded and all relevant information was placed in the person's clinical file.

All episodes of physical restraint were appropriately recorded. Each episode of physical restraint was reviewed by members of the MDT involved in the person's care and treatment and documented in the clinical file as soon as practicable and no later than five working days after the episode of physical restraint. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

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 because one resident was not informed of the reasons for, and the circumstances which lead to the discontinuation of, physical restraint, 3.8

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

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

Regulation 15: Individual Care Plan					
Reason ID : 10006574		**Six individual care plans were not updated contemporaneously following review to reflect changes to the resident's goals, treatment, care and required resources.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Each team were notified of the error and requested to correct same going forward- each team were requested to review the care plans to ensure that the goals identified were appropriate.	Monthly ICP audits	Achievable and realistic.	25/07/2025	Clinical Director
Preventative Action	An ICP training day for MDT members was facilitated and delivered on the 16th June 2025. Feedback indicated improved understanding and awareness of ICP goal and completion. It highlighted the need for the ICP to reflect changes to the	Monthly ICP audits Feedback gathered after ICP training day Weekend checklists	Achievable and realistic.	27/02/2026	All heads of discipline

	resident's goals, treatment, care and required resources during monthly consultant meeting minutes. A working group was developed in order to ensure standards wre improved within the DOP and ICP champion initiative is currently underway. Weekend checklists as part of nursing metrics reviewed and updated to strengthen ICP checks.				
Reason ID : 10006575		**One care plan was not developed within seven days of admission.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	it was highlighted to the treating team that each resident must have a ICP created within 7 days of their admission	Monthly audits	Achievable & realistic	27/06/2025	Clinical Director
Preventative Action	An ICP training day for MDT members was facilitated and delivered on the 16th June 2025. Feedback indicated improved	Monthly ICP audits	Achievable & realistic	27/06/2025	All heads of discipline

	understanding and awareness of ICP goal and completion. It highlighted the need for the treating team that each resident must have a ICP created within 7 days of their admission, specifically highlighted the requirement during public holidays. A working group was developed in order to ensure standards were improved within the DOP and ICP champion initiative is currently underway. Weekend checklists reviewed and updated.				
Reason ID : 10006576		**One care plan contained goals that were not reviewed by the multi-disciplinary team.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	
Corrective Action	Each team were notified of the error and requested to correct same going forward and to ensure that each care plan completed was reviewed by the MDT.	Monthly ICP audits	Achievable & realistic	27/06/2025	Clinical Director

Preventative Action	An ICP training day for MDT members was facilitated and delivered on the 16th June 2025. Feedback indicated improved understanding and awareness of ICP goal and completion. It highlighted the need for the treating team to ensure that each care plan was reviewed and updated accordingly including MDT representation. A working group was developed in order to ensure standards wre improved within the DOP and ICP champion initiative is currently underway. Weekend checklists reviewed and updated.	Monthly ICP audits	Measurable & realistic.	27/06/2025	All Heads of Discipline
Reason ID : 10006577		**The individual care plans did not identify the resources required to provide the care and treatment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is an occupational therapist available within the approved centre	In place	Achievable/Realistic National shortage of Occupational Therapists	30/06/2025	Occupational Therapy Manager

Preventative Action	OT available in the approved centre	OT in the approved centre	Achievable/Realistic National shortage of OTs	30/06/2025	Occupational Therapy Manager

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10006578		**The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, as unmet Occupational Therapy needs were documented in four residents individual care plans, 16(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Risk was updated to the Risk Register. Residents now have access to Occupational Therapist	Implemented	Achievable	30/06/2025	Occupational Therapy Manager
Preventative Action	Occupational Therapist in the approved centre	Implemented	Achievable National shortage of OT's	30/06/2025	Occupational Therapy Manager

Regulation 21: Privacy					
Reason ID : 10006569		**Single bedrooms did not have a lock on the inside of the bedroom door.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The privacy and dignity of patients is respected at all times. Meetings held with Estates to scope and source appropriate replacement locks for the inside of doors in the single rooms in Ash & Pine Units	Annual premises audit, on going consultation with HSE Estates	Achievable and realistic based on funding approval and consideration to lead time for delivery of goods	30/09/2026	Service Manager Assistant Director of Nursing Registered proprietor nominee
Preventative Action	The privacy and dignity of patients will continue to be respected at all times. Meetings with Maintenance replacement of the single bedroom barrel locks in doors with appropriate locks for use by patients inside of the bedroom doors.	On going consultation with HSE Estates, on-site meetings, All regulations are discussed at DOP monthly Compliance Meeting Development of risk assessments for clinical risk profiles where there is an identified risk to a resident	This is achievable based on funding approval and sourcing materials	01/10/2026	Service Manager Assistant Director of Nursing Registered Proprietor Nominee

Regulation 22: Premises					
Reason ID : 10006579		**All rooms did not have sufficient ventilation at the time of inspection, 22(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Programme of capital works underway. The replacement of the existing windows with custom-engineered windows designed to facilitate effective bio directional air flow ensure that all rooms will have adequate ventilation	GANT chart with milestones and deliverables	Achievable/Realistic	14/11/2025	Service Manager, Registered Proprietor Nominee, Assistant Director of Nursing
Preventative Action	Upon completion of the existing windows with custom-engineered windows designed will facilitate effective directional air flow which will ensure that all rooms will have sufficient ventilation	Upon completion will be for review at the monthly compliance meetings; Included for review in Quality Patient Safety walkabouts	Achievable/Realistic	15/11/2025	Service Manager, Registered Proprietor Nominee, Assistant Director of Nursing
Reason ID : 10006580		**All ligature points had not been minimised to the lowest practicable level, based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The DOP windows upgrade works will reduce some of the identified risks to the lowest practicable level based on assessment. ligature audit circulated	Annual Ligature Audit.	Achievable and Realistic	26/06/2026	Service Manager, ADON, CNM3s and CNM2

	to all relevant clinical staff to ensure awareness of all known risks and ensure effectiveness of compensatory factors are in place. Specific				
Preventative Action	To ensure that all ligature points are minimised to the lowest practicable level, based on risk assessment and ligature audit tool. Further funding commensurate will be sought to address outstanding risks as outlined in the ligature audit.	Annual ligature Audtit.	Achievable and Realistic.	29/06/2026	Service Manager, ADON, CNM3, CNM2, General Manager/RPN
Reason ID : 10006581		**The approved centre was generally kept in a good state of repair externally and internally however, the therapy corridor garden required wall and furniture repainting. Bathrooms awaiting renovation had stained flooring and paint damage to radiators, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The therapy corridor garden wall, furniture works and the bathrooms programme of works for stained flooring and paint damage discussed with Estates/Maintenance,	Monthly compliance meetings in the DOP which attended by either Service manager and General Manager/Registered proprietor nominee.	Achievable/Realistic	27/03/2026	Service Manager, Registered Proprietor Nominee/General Manager

	funding approved, on programme schedule, awaiting start date.				
Preventative Action	The approved centre has implemented an ongoing programme of maintenance to ensure is in good state of repair externally and internally.	Monthly compliance committee meetings. QIP walkabouts Premises Audit.	Achievable and realistic.	30/03/2026	Service Manger, General Manager/Registered Proprietor Nominee

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10006583		**A medication had been administered without a medical prescriber signature for a period of nine days, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The prescription was reviewed by the medical prescriber at the time of the inspection once the error was identified. The error was corrected promptly. The medical prescriber was provided feedback on safe prescribing practice and requested to reflect on their performance with supervision of their consultant psychiatrist.	Measurable - MPAR audits	Achievable	27/06/2025	Clinical Director
Preventative Action	Pharmacist in post since October 2025 and providing MPAR screening. Pharmacist involved in review of prescribing practice to inform educational and improvement needs. Summary document highlighting commonly occurring issues in preparation and to be	Measurable by Regulation 23 audits which feed back into compliance meeting, pharmacist in attendance. Weekly checks in nursing metrics.	Achievable	20/03/2026	Pharmacist Clinical Director

	presented at post graduate teaching program to medical prescribers. Feedback provided to all consultants at consultant meeting by CD about prescribing error.				
Reason ID : 10006584		**Residents on high dose anti-psychotics were not regularly reviewed by a pharmacist, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Pharmacist was not in post in order to review residents on high dose antipsychotics until October 2025. Pharmacist is now in post and initiating HDAT review for residents of relevance. Need for HDAT monitoring was reinforced to all clinicians via post grad teaching program and consultant meetings.	Regulation 23 audits, which feed into compliance committee, were updated to include pharmacist review of residents prescribed HDAT.	Achievable and realistic.	27/02/2026	Pharmacist Clinical Director
Preventative Action	Pharmacist was not in post in order to review residents on high dose antipsychotics until October 2025. Pharmacist is now in	Regulation 23 audits, which feed into compliance committee, were updated to include pharmacist	Achievable and realistic.	27/02/2026	Pharmacist Clinical Director

	post and initiating HDAT review for residents of relevance. Need for HDAT monitoring was reinforced to all clinicians via post grad teaching program and consultant meetings. SOP in development for pharmacist regular reviews to be implemented by end Q1 2026.	review of residents prescribed HDAT.			
Reason ID : 10006585		**The process for prescribing medication for High Dose Anti-Psychotic Treatment (HDAT) was not included within the medication management policy, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The medicines management policy was updated to include the process for prescribing medication for High Dose Anti-Psychotic Treatment (HDAT) and will be ratified at December 2025 compliance committee.	Medicines Management policy updated.	Achievable and realistic.	12/12/2025	Clinical Director
Preventative Action	The DNC&W MHC Policy committee are currently updating the medicines	Progress monitored through DNC&W policies committee and Drugs and Therapeutics	Achievable and realistic	30/04/2026	Clinical Director Pharmacist ADON Executive Clinical Director

	management policy to standardise and share the policy across the two approved centres within DNC&W .	Committee and feeding into the DNC&W mental health management team.			

Regulation 26: Staffing					
Reason ID : 10006582		**The registered proprietor did not ensure the numbers and skill mix of staffing was sufficient to meet resident needs, as no occupational therapist was available within the approved centre, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is an occupational therapist available within the approved centre	In place	Achievable/Realistic National shortage of Occupational Therapists	30/06/2025	Occupational Therapy Manager
Preventative Action	OT available in the approved centre	OT in the approved centre	Achievable/Realistic National shortage of OT's	30/06/2025	Occupational Therapy Manager

Regulation 31: Complaints Procedures					
Reason ID : 10006570		**Not all minor complaints relating to the approved centre were recorded, 31(6).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The approved centre has implemented the HSE Your Service Your Say Policy and procedure. In accordance with the policy verbal or informal complaints are documented as far as is reasonably practicable. In particular, where a verbal or informal complaint indicates that a particular trend is emerging, where there is a risk to patient and staff health and safety, and/or where possible quality improvements are required, these complaints should be documented and are analysed by the compliance committee to identify the root causes of the subject matters and actions that are required for	All regulations are discussed at monthly compliance committee meetings, where any outstanding issues are discussed and actions required assigned to the relevant person. Minor complaints logs to be checked at Quality and Safety Walkaround.	Achievable and realistic	20/06/2025	CNM2 CNM3 ADON

	improvement. The minor complaint logs on the wards were not being updated, particularly those received through community meetings. It was noted at the time of feedback that all patient feedback is discussed directly through the compliance meeting for the appropriate remedial actions. All staff were reminded to record all minor complaints received as far as reasonably practical, including those received through community meetings in the complaints logs.				
Preventative Action	All complaints, whether oral or written, are investigated promptly and handled appropriately and sensitively. Nurse management reviewed the complaints process and amended	Monthly compliance committee meeting will review and discuss all JSF regulations and issues raised at community meetings are also fed into this forum for discussion and review. This	Achievable and Realistic	30/01/2026	Nurse in Charge/CNM2 MDT members CNM3 ADON

	community meeting template to clearly identify reporting structures should any complaints be raised outside the already well established process. All staff were reminded to log all minor complaints received as far as reasonably practical, including those received through community meetings in the complaints logs.	meeting is attended by the General Manager/ RPN, a service management representative and chaired by Clinical Director of the approved centre. Complaints logs to be checked also during Quality and Safety Walk Around.			

Rules Governing the Use of Seclusion					
Reason ID : 10006572		**In one episode of seclusion, it was not recorded whether the person's representative was informed of the person's seclusion, 3.12. In one episode of seclusion, it was not recorded whether the person's representative was informed of the ending of the episode of seclusion, 7.10.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In this single episode of seclusion where it was not recorded whether the persons representative was informed of the person's seclusion or the ending of the seclusion. It was reviewed by oversight committee. Those who were involved in this episode were provided training and education to reinforce that the person's representative needs to be informed of the incident of and ending of seclusion and regarding the documentation that is required.	Each and every episode of restrictive practice is audited in conjunction with the rules and regulations of seclusion and discussed at oversight committee.	Achievable and Realistic	24/07/2025	ADON/CNM3 Clinical Director.
Preventative Action	Provision of educational sessions to all MDT staff regarding the rules governing the use of Seclusion and	Each and every episode of restrictive practice is audited in conjunction with the rules and regulations of seclusion	Achievable and realistic	27/03/2026	CNM3/ADON Clincial Director.

	the necessary documentation required for same. Feedback given in the consultant meeting to all consultant psychiatrists to highlight the importance of informing a person's representative of the incident and ending of seclusion episode. Strengthening of restrictive practice champion initiative with increased number of restrictive practice champions and responsibility for audit of episodes of restrictive at ward level in real time enhanced. Updating of restrictive practice forms to clarify action owner for notification of person's representative of incident and ending of episode of seclusion.	and discussed at quarterly oversight committee. Action owners are identified during oversight committee as persons responsible for ensuing compliance.			

Part 4 of the Mental Health Act 2001: Consent to Treatment					
Reason ID : 10006571		**The full names of the medication were not listed on the form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The full names of the medication were not listed on the form 17:Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) - Unable to Consent for one patient at the time of inspection. The RCP was made aware of this at the time of inspection and corrected the form immediately. The CD reinforced with the RCP the correct practice and reviewed the reason for the error with the RCP, who provided reassurance of reflecting on their practice and learning from the error. The RCP assured and confirmed that the resident had been	The incorrect form was completed at the time of inspection.	Achievable.	11/06/2025	Clinical Director

	informed of the names of medications at the time of the completion of the form 17 despite the names being omitted on the form 17 when completed.				
Preventative Action	Consent to treatment audits monthly by clinical director. Highlighting of need for listing of names of medications on form 17:Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) - Unable to Consent by Clinical Director to all RCPs in DOP occurred at consultant meeting in November 2025 and by email to all RCPs not in attendance.	Monthly consent to treatment audits feeding back to compliance committee meeting.	Achievable.	21/11/2025	Clinical Director.

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10006586		**One resident was not informed of the reasons for, and the circumstances which lead to the discontinuation of, physical restraint, 3.8**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified episode of physical restraint which had no clear documentation to indicate the reasons for, and the circumstances which lead to the discontinuation of physical restraint was reviewed and educational sessions provided to the staff involved with emphasis on including evidence that this was discussed with the resident an clearly documented in the clinical file for all further episodes.	Each and every episode of restrictive practice is audited for compliance. This is then discussed at restrictive practice oversight committee where persons are identified as responsible to ensuring compliance to same are discussed.	Achievable.	17/11/2025	ADON CNM3 CNM2 MDT members
Preventative Action	Provision of educational sessions to all MDT staff regarding the code of practice on the use of physical restraint and the necessary communication and	Every episode will be audited with results discussed at the oversight committee meeting chaired	Achievable and realistic.	27/03/2026	MDT ADON CNM3 CNM2

	documentation required for same. Strengthening of restrictive practice champion initiative with increased number of restrictive practice champions and responsibility for audit of episodes of restrictive at ward level in real time enhanced.				

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.

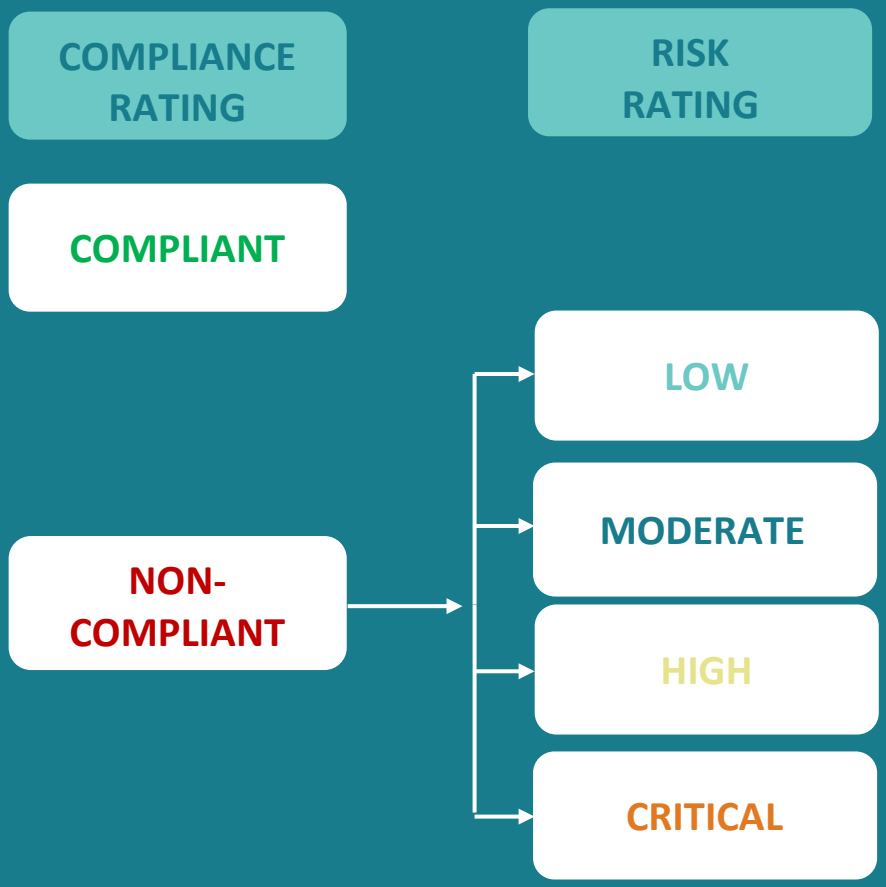
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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