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St Gabriel's Ward, St Canice's Hospital

Annual Inspection Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

ST GABRIEL'S WARD, ST CANICE'S HOSPITAL

Dublin Road, Kilkenny

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2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay
Psychiatry of later life

Conditions Attached:
None

Most Recent Registration Date:
01 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mrs Anne Donaghey

Inspection Team:
Noeleen Byrne, Lead Inspector
Damien Lanigan
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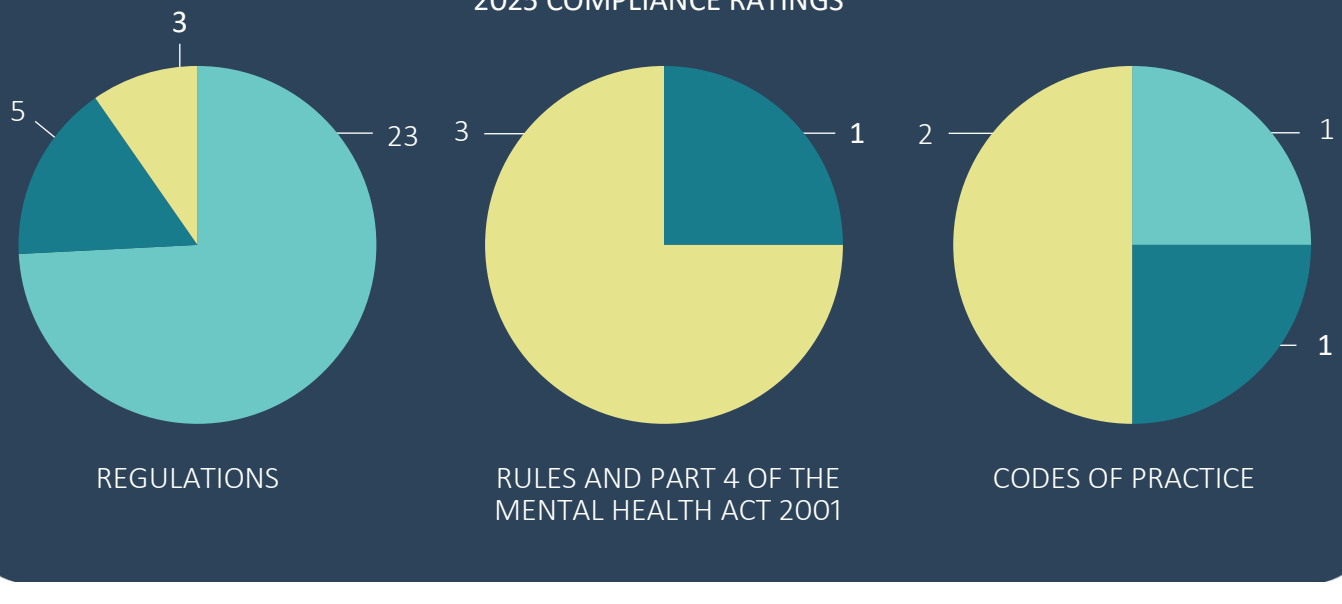
Inspection Date:
24 – 27 June 2025

Previous Inspection date:
30 April – 03 May 2024

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

Inspection Type:
Unannounced Annual Inspection

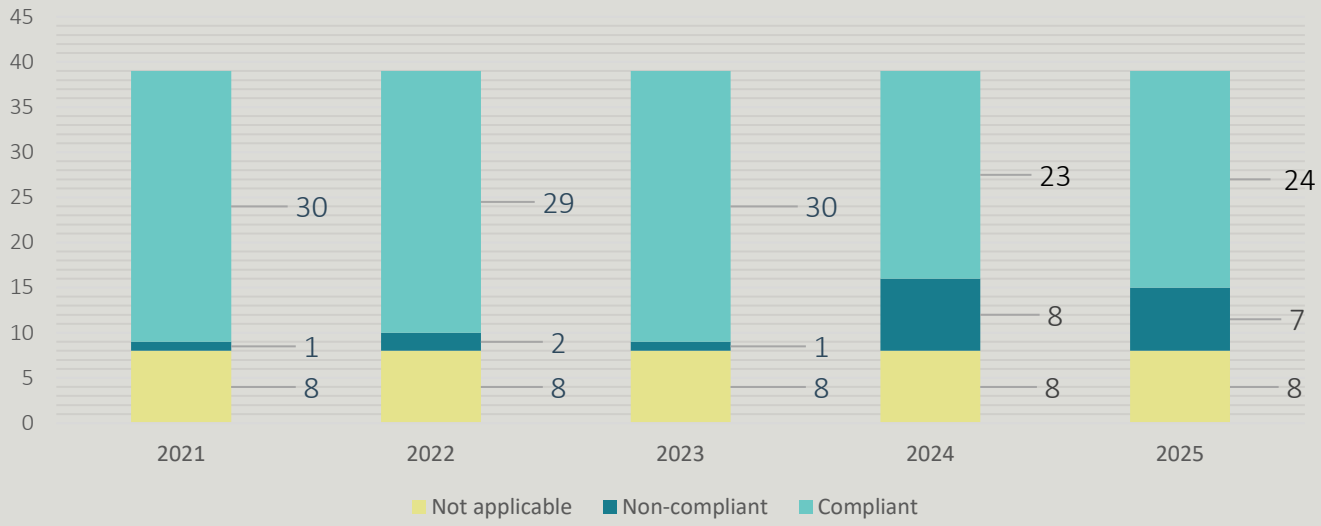
2025 COMPLIANCE RATINGS



RATINGS SUMMARY 2021 – 2025

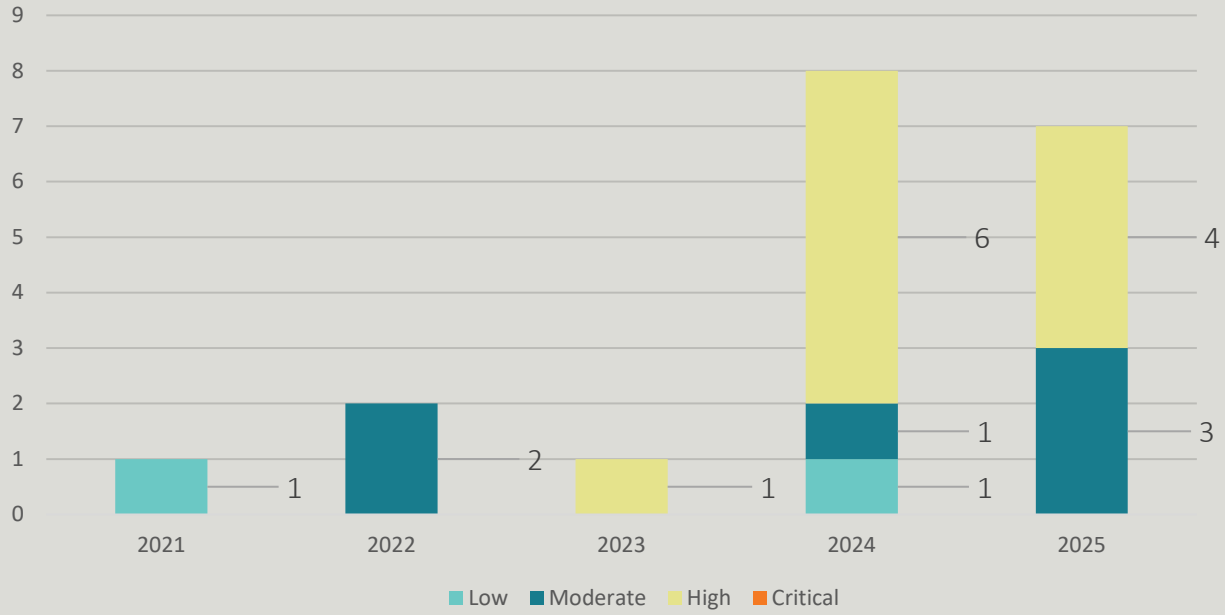
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

St Gabriel's is located on the grounds of St. Canice's Hospital in Kilkenny. The approved centre is a single-storey, brick façade building erected in the 1980s. A reconfiguration of the premises took place since the last inspection. This reconfiguration incorporated a new therapeutic activities area and a resident's day room.

The approved centre was comprised of a central nurses' office, sitting room, and day area with bedroom accommodation located on an adjacent corridor. Sleeping accommodation was in single, two, three and four-bedded rooms. Since the last inspection a private visiting area had been incorporated into two bedrooms to facilitate private family visits. Toilet and shower facilities were a mix of both en suite and communal. Toilet and shower areas had been upgraded since the last inspection, with significant investment in infection prevention and control facilities. Residents had access to a large, secure, and well-maintained garden area.

The approved centre was registered to accommodate residents for Continuing Mental Health Care/Long Stay and Psychiatry of Later Life (POLL). There were two Psychiatry of Later Life community teams that admitted residents to the approved centre, one covering Co. Carlow and one covering Co. Kilkenny. All residents in the approved centre at the time of the inspection were under the care of one consultant psychiatrist led specialist multi-disciplinary team.

Inspector of Mental Health Services Summary

The findings contained in this report pertain to the inspection dates from 24th to 27th June 2025.

There was an increase in compliance with the minimum standards as set out in the Mental Health Act (Approved Centres) Regulations 2006, and Rules and Codes of Practice developed by the Mental Health Commission, observed on this inspection. An overall compliance rate of 74% was achieved in 2024 and this increased to 77% in 2025. The compliance deficits identified related to premises, therapeutic services, risk management, individual care plans, staffing, admission transfer and discharge, and mechanical restraint.

There were many encouraging findings during the inspection. The additional space for therapeutic/recreational activities was open, however the ligature risks had not been assessed. The service committed to finishing this work and minimising any ligature points as a matter of urgency and ensuring this new space was safe for all residents.

Staff training was at 100% for all five mandatory training courses; there was a designated space for end-of-life care, and feedback from relatives of residents indicated high levels of satisfaction with care and treatment provided in the approved centre.

There was strong commitment to provide an excellent service to residents and family members confirmed that every effort was made to ensure their relatives were well cared for. The approved centre had commenced addressing deficits identified during the inspection of the approved centre.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**15**
Number of detained patients	0
Number of wards of court	0
Number of residents under the Assisted Decision Making Act	0
Number of children	0
Number of residents in the approved centre for more than 6 months	12
Number of patients on Section 26 leave for more than 2 weeks	0

Compliance summary

	2021	2022	2023	2024	2025
% Compliance	97%	94%	97%	74%	77%

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.

- **Regulation 09: Recreational Activities**
  - New Activities Area – Refurbishment of office and turned into a new activities Area for St. Gabriel's which includes:
    - New family/ engagement room/ cinema room (installation of new
    - projector)
    - New Sensory Room
    - New Hairdressers Room
    - New office for activities team
    - New CNM2s office
    - New equipment storage
    - New Common Area for engagement and therapy
    - Purchased pictures, plants and other décor items
  - Orientation Board – New daily display of orientation pictures i.e. Day, Month, Weather.
  - Café Scene and seating area for families opposite to seasons wall to enable families to admire their loved one's work

- **Regulation 14: Care of the Dying**
  - Involvement of community palliative care team in end of life care planning.
  - A dedicated end of life bedroom.

3.0 Governance

The approved centre was part of Carlow/Kilkenny/South Tipperary Integrated Healthcare Area. There was one Executive Management Team (EMT) which had overall responsibility for governance of the organisation. The EMT met monthly and comprised of heads of disciplines, the head of service, the area lead for mental health engagement, the finance manager, and the general manager. Agenda items such as service development and strategy, mental health engagement, finance/resources, recruitment and retention, performance, quality/service improvement, regulatory compliance, and items escalated from the Quality and Safety Executive committee (QSEC) were discussed at these meetings.

A Quality and Safety Executive Committee (QSEC) held monthly meetings and issues were escalated to EMT as requires. The QSEC meeting discussed regulation and compliance, staff training, clinical audit and quality improvements, mental health service user engagement and recovery, health and safety, policies and procedures, compliments and complaints, incidents/near misses, and risk management. The members completed an overview of the serious incidents reported within the approved centre and reviewed any issues identified as part of their risk management processes. There was a local Quality and Patient Safety Committee (QPSC) sub-group of the QSEC, which was the governance and decision-making forum for St Gabriel's Ward. Meeting minutes recorded discussion about regulatory compliance and monitoring, health and safety, risk management, infection prevention and control, policies and procedures, and quality initiatives.

The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded using a standardised template and risk rated and uploaded to the National Incident Management System (NIMS) system. The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had a local risk register that was maintained by senior managers and reviewed at the QSEC. Not all risks were identified, assessed, treated, reported, and monitored. In one case there was no risk assessment of a resident on admission and one case there was no risk assessment of suitability of mechanical restraint.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of clinical staff was insufficient to meet the residents' needs as there was no occupational therapist in the approved centre. The approved centre had two multi-disciplinary teams. They included psychiatry, nursing, social work, and psychology staff. Health care professionals, including physiotherapy, dietetics and speech and language therapy were also accessible to residents. All healthcare staff were up to date with mandatory training in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001.

Heads of discipline from nursing, medical, occupational therapy, and psychology completed and returned a Mental Health Commission Governance Questionnaire. Clinical heads of discipline outlined clear strategic goals for the service and systems to monitor goal progression. These disciplines reported having formal structures and processes in place for monitoring staff performance and professional development. All

disciplines had formal and informal clinical supervision arrangements in place where appropriate. Annual staff training plans were completed to identify and address training needs.

Operational risks identified by staff included: ongoing poor investment at national level in psychiatric services, increased administrative workload due to regulatory and good practice guidance, recruitment and retention of staff, difficulty attending mandatory training and Continuing Professional Development (CPD) due to work pressures. The identified risks were effectively mitigated by escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, regular family engagement and support, suggestion boxes, process were utilised to support service improvement. There was access to a complaints management process, however the log of complaints had not recorded any complaints since 2019.

The progression and development of various quality initiatives in the approved centre was a standing agenda item at the Quality Patient Safety Committee (QPSC). The new therapeutic and recreational space was open; however, a ligature audit of risks was not complete. A programme of clinical audit was implemented by the multi-disciplinary team throughout the service. The QSEC provided a multi-disciplinary approach to policy development, review, approval, and dissemination and all policies were up to date at the time of inspection.

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 21: Privacy	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Code of Practice on the Use of Physical Restraint	✓	Compliant

4.2 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2021		2022		2023		2024		2025	
Regulation 15: Individual Care Plans	✓		✓		✓		✓		✗	Moderate
Regulation 16: Therapeutic Services	✓		✓		✓		✓		✗	High
Regulation 22: Premises	✗	Low	✗	Moderate	✓		✗	High	✗	Moderate
Regulation 26: Staffing	✓		✓		✓		✓		✗	High
Regulation 32: Risk Management Procedures	✓		✗	Moderate	✓		✗	High	✗	Moderate
Rules Governing the use of Mechanical Means of Bodily Restraint	✓		✓		✓		✗	High	✗	High
Code of Practice: Admission, Transfer and Discharge to and from an Approved Centre	✓		✓		✓		✓		✗	High

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

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in 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 Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents. The inspection team spoke with family members who were the advocates for their loved ones in the approved centre. The feedback was entirely and overwhelmingly positive in its nature.

Three relatives of residents spoke with members of the inspection team. They were very complimentary about the care provided and said the staff were excellent. Residents were comfortable and able to maintain their privacy in their bedrooms. There was a homely feeling and staff gave great attention to detail. All relatives were very complimentary about how the staff communicated with them, any query was dealt with immediately, they were kept up to date with resident's care plan and encouraged to input into the care plan. There was a good range of therapies and the chiropodist came in regularly. Residents that were able were brought for a drive with stops for coffee or an ice cream.

No residents chose to complete a questionnaire on this occasion

5.2 Advocacy

Residents had access to SAGE advocacy service.

6.0 Feedback Meeting

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

- Acting Clinical Director
- Consultant Psychiatrist
- Registered Proprietor Nominee
- Area Director of Nursing
- Compliance Officer
- Risk Manager
- Assistant Director of Nursing x 2

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

7.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Six ICPs were inspected. The ICPs were a composite set of documents which addressed the resident's goals and resources 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 and uninterrupted and were not amalgamated with progress notes.

The ICPs were developed by the MDT following a comprehensive assessment of the resident within seven days of admission. The ICPs was discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

Five of the ICPs specified the care and treatment required. In the ICP of one resident, the care and treatment was not updated, the use of mechanical restraint was not documented in the ICP.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all individual care plans specified the care and treatment required as one individual care plan did not reflect the use of mechanical restraint.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Social work and psychology provided one to one therapeutic services that were appropriate for residents. There was no occupational therapy (OT) programme or service on offer to residents within the approved centre. There was regular music therapy and dog therapy.

The approved centre arranged therapeutic services for residents when the services was not provided internally. External services were provided by an approved, qualified health professionals. Examples of these included speech and language therapy (SLT), physiotherapy, seating assessments, dietetics and podiatry services.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident as there was no occupational therapy programme or service on offer to residents within the approved centre, 16(2).

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Residents all had access to personal space and their own bed area. The approved centre (AC) contained a large Day Room, a separate sitting area in the reception and separate quiet sitting room. The internal temperature for both communal spaces and bedrooms were kept within a suitable range. Rooms were well ventilated and fully furnished to reduce excess noise. Internal lighting met the needs of both residents and staff, while signage and sensory aids were provided to support resident orientation needs. All bathroom, shower, toilet and single bedroom locks had an override function. Hazards were identified and minimised throughout the AC.

There was no evidence that the ligature points were minimised to the lowest practicable level, based on risk assessment. The ligature audit completed in April 2025, did not include any assessment or risk rating of any of the ligatures risk in the new therapeutic area, nor all the ancillary rooms in this area, such as the toilets, hairdresser room and the quiet room.

The AC was overall kept in a good state of repair, and there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Rooms were centrally heated to no more than 43°C and the water temperature in taps did not exceed 50°C. Current national infection control guidelines were followed.

There was a sufficient number of toilets and showers for all residents, with an assisted. The AC had both a designated cleaning room and a designated sluice room. All resident bedrooms were appropriately sized and furnished. The AC provided assisted devices and equipment to address resident needs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre environment was developed and maintained with due regard to the safety and well-being of residents in that the minimisation of ligature points was not to the lowest practicable level as a result of lack of risk assessment, 22(3).

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 July 2024, and included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

There were two Psychiatry of Later life (POLL) multi-disciplinary teams (MDT) admitting to the approved centre, one from Kilkenny and one from Carlow. These included psychiatry, nursing, social work and psychology. There was no occupational therapy (OT) service in the AC at the time of inspection due to the OT being on maternity leave. Cover for the OT could not be arranged due to the OT manager also being on leave. There was phone and email access to a pharmacist based in St. Luke's Hospital, but no pharmacy service in St. Gabriel's Ward.

It was documented that an appropriately qualified staff member was on duty at all times. All staff members were fully trained in the following areas: Fire Safety, Basic Life Support, Management of violence and Aggression, The Mental Health Act 2001, Safeguarding and Children First. The approved centre (AC) made sure that staff had access to training and educational materials, as well as all relevant mental health documentation, including the Mental Health Act 2001.

Staff Training Record

Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing	15	100%	15	100%	15	100%	15	100%	15	100%	15	100%
Medical	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Occupational Therapist	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Social Worker	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents in that there was no occupational therapist in the approved centre, 26(2).

Regulation 32: Risk Management Procedures

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in July 2024, and outlined the roles and responsibilities for risk management, including:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The responsibilities of the multi-disciplinary team.
- The person responsible for the completion of six-monthly incident summary reports.
- A defined quality and safety oversight and review structure as part of the governance process for managing risk.

The policy also included:

- The process for identifying, assessing, treating, reporting and monitoring risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling specific risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register.
- The record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies, including the roles and responsibilities of key staff, the sequence of required actions, the process for communication and escalating emergencies to management.
- The process for the protection of children and vulnerable adults within the care of the approved centre.

Responsibilities were allocated at management level and throughout the approved centre. The person with responsibility for risk was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were documented in the risk register as appropriate.

However, not all Clinical risks were identified, assessed, treated, reported, and monitored. In the case of one resident who was mechanically restrained (MR), there was no risk assessment of the safety and suitability of the MR for the person undertaken.

In the case of one resident who was admitted there was no risk assessment completed on admission. Individual risk assessments were completed prior to and during, resident transfer and discharge, and in conjunction with medication requirements or administration.

A new therapeutic and activities area had opened and staff had identified ligatures and mitigated the risk by ensuring a staff member was always present. These risks were not appropriately reported as they had not been included in the ligature audit or included on the risk register.

Corporate risks were identified, assessed, treated, reported and monitored by the approved centre, then documented in the risk register.

Multi-disciplinary teams (MDT) were involved in the development, implementation, and review of individual risk management processes. Residents or their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

All incidents were recorded and risk-rated in a standard format. Clinical risks were reviewed by an MDT regularly, with a corresponding record of the review and actions taken.

There was an emergency plan in place which was known to staff and included evacuation procedures.

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

a) **Not all individual resident's clinical risks were identified, assessed, treated, reported, and monitored in accordance with the approved centres policy, for one resident there was no risk assessment on admission and for one resident there was risk assessment of the safety and suitability of mechanical restraint, 32(2)(a).**
b) **Not all health and safety risks were reported and monitored by the approved centre in accordance with relevant legislation, 32(2)(a).**

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

Section 69: The Use of Mechanical Restraint

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Evidence of Implementation: The clinical files of three persons who had been mechanically restrained for enduring harm to themselves or others were inspected.

Two of these files were fully compliant. In the case of the two compliant episodes, the mechanical restraint was used to address an identified clinical need or risk. Mechanical restraint was only used when less restrictive alternatives were not deemed suitable and where a risk assessment of the safety and suitability of the mechanical restraint for the person was undertaken. The risk assessment specified the monitoring arrangements and frequency of mechanical restraint which were implemented during the use of mechanical restraint. A copy of the risk assessment was available to the inspectors.

The risk assessment was reviewed and updated regularly in accordance with the resident's individual care plan (ICP). The multi-disciplinary team (MDT) developed a plan of care for each person restrained by mechanical means.

Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of the consultant psychiatrist (CP) responsible for the care and treatment of the person or the duty CP. The clinical file contained a contemporaneous record that specified:

- That there was an enduring risk of harm to the person or to others.
- The type of mechanical restraint being used.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The multi-disciplinary review and oversight committee undertook a review of all persons at the approved centre who were the subject of Part 4 of these rules in the previous quarter to determine the appropriateness of the use of this restrictive practice. This review outlined the arrangements that are in place at the approved centre to reduce or, where possible, eliminate the use of mechanical restraint as it related to Part 4 of these Rules.

The committee met at least quarterly and determined if there was compliance with the rules on the use of mechanical restraint and with the approved centre's own policies and procedures relating to mechanical restraint, for each episode reviewed. The committee also assured the registered proprietor nominee that each use of mechanical restraint accorded with the Mental Health Commission's rules, and produced a report following each meeting of the review and oversight committee.

The registered proprietor notified the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the format and timeframes specified by the Mental Health Commission.

In the case of the third clinical file, the use of mechanical restrain in this instance was the use of both a lap belt and bed rails for a resident. This use of mechanical restraint was not ordered by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person. Additionally, there was no risk assessment done for the resident, and the MDT did not develop or a review a care plan for the resident. Finally, the clinical file did not contain a contemporaneous record that specified the type of mechanical restraint, the duration of the restraint, or the duration of the order or the review date.

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

a) **In the case of one resident, the use of mechanical means of bodily restraint namely a lap belt and bed rails for enduring risk of harm to self or others was not ordered by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person, 10.3.**
b) **In the case of one resident where the use of mechanical means of bodily restraint namely a lap belt and bed rails for enduring risk was applied. A risk assessment of the safety and suitability of the Mechanical Restraint for the person did not take place and did not specify the monitoring arrangements and frequency which are implemented during its use, was not reviewed and updated regularly - at least quarterly - in line with the person's individual care plan, 3.3.**
c) **In the case of one resident, the multi-disciplinary team did not develop a plan of care for that person restrained by mechanical means to include information on attempts to reduce or eliminate the use of restraint for the person, 10.2(ii).**
d) **In the case of one resident, the clinical file did not contain a contemporaneous record that specified, the type of mechanical restraint, the duration of the restraint, the duration of the order or the review date, 5.7.**

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable on inspection. Please see ***Section 4.3: Areas that were not applicable on this inspection****.>>*

10.0 Inspection Findings – Codes of Practice

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

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

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

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

*Please 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.*

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Processes:
The approved centre had separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in September 2022, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in August 2022, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in April 2024, included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policy/policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family history, medical history, current and historic medications, social and housing circumstances, current mental health state, and all other relevant information. A full physical examination was carried out. A key worker system was in place, and a family member or carer was involved in the admission process with the resident's consent. The clinical file contained no risk assessment for the resident.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse or other risks and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, their key worker, relevant members of the resident's multi-disciplinary team (MDT) and representative, where appropriate. The resident had no next of kin.

The discharge assessment addressed the resident's psychiatric and psychological needs and included a current mental state examination, a comprehensive risk assessment and risk management plan, and social and housing needs. The discharge was coordinated by the key worker. A preliminary discharge summary was sent to the relevant healthcare provider and a comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge and outstanding health or social issues. It provided follow-up arrangements, names and contact details of key people for follow-up and risk issues such as signs of relapse. Carers and advocates were involved in the discharge process, where appropriate. Once again, the resident had no next of kin.

The approved centre was non-compliant with this code of practice because in one clinical file the admission assessment did not have a documented risk assessment, 15.3.

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 : 10006907		**The registered proprietor did not ensure that all individual care plans specified the care and treatment required as one individual care plan did not reflect the use of mechanical restraint.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The use of Mechanical restraint will be reflected in the resident's ICP's	Audit	Achievable + realistic	30/03/2026	MDT
Preventative Action	Clinical staff are made aware of the requirement to reflect the use of Mechanical restraint in the resident's ICP.	Audit	Achievable + realistic	30/03/2026	MDT

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10006908		**The registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident as there was no occupational therapy programme or service on offer to residents within the approved centre, 16(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Two Occupational therapists aligned to community teams and who provide cross cover to the approved centre are on maternity leave and are due to return to work in July 2026. The service was unsuccessful in sourcing six month OT maternity leave cover for this leave. Occupational Therapy seating and physical assessments and interventions are provided via a contracted service.	Audit	Barriers to implementation include unavailability of staff to provide maternity leave cover (short- term temporary positions)	31/07/2026	Head of Service OT Manager
Preventative Action	The service is unsuccessful in sourcing OT maternity leave cover for this post. Cross cover arrangements will resume in July 2026.	Audit	Barriers to implementation include unavailability of staff to provide maternity leave cover (short-term temporary positions)	31/07/2026	Head of Service OT Manager

Regulation 22: Premises					
Reason ID : 10006909		The registered proprietor did not ensure that the approved centre environment was developed and maintained with due regard to the safety and well-being of residents in that the minimisation of ligature points was not to the lowest practicable level as a result of lack of risk assessment, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The Approved Centres ligature audit is updated to include identified risks in all areas of the Approved Centre.	Ligature audit.	Achievable + realistic	30/03/2026	Ward management
Preventative Action	The Approved Centres ligature audit is updated to include identified risks in all areas of the Approved Centre.	Ligature audit	Achievable + realistic	30/03/2026	Ward Management

Regulation 26: Staffing					
Reason ID : 10006910		The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents in that there was no occupational therapist in the approved centre, 26(2).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Two Occupational Therapist who are aligned to community teams and who provide cross cover to the approved centre are currently on maternity leave and are due to return from leave in July 2026. The service was unsuccessful in providing maternity leave cover for these posts. Occupational Therapy seating and physical assessments and interventions are conducted via a contracted service.	Audit of staffing	Barriers to implementation include unavailability of staff to cover maternity leave (short-term temporary cover).	31/07/2026	Head of Service. OT manager
Preventative Action	The service was unsuccessful in sourcing maternity leave cover for these post. Cross cover arrangements will resume in July 2026	Audit of staffing	Barriers to implementation include unavailability of staff to cover maternity leave. (short-term temporary cover).	31/07/2026	Head of Service

Regulation 32: Risk Management Procedures					
Reason ID : 10006905		**Not all individual resident's clinical risks were identified, assessed, treated, reported, and monitored in accordance with the approved centres policy, for one resident there was no risk assessment on admission and for one resident there was risk assessment of the safety and suitability of mechanical restraint, 32(2)(a). Not all health and safety risks were reported and monitored by the approved centre in accordance with relevant legislation, 32(2)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Risk assessment on admission and risk assessment of the safety and suitability of mechanical restraint will take place and will be recorded in the clinical file.	Audit	Achievable + realistic	30/03/2026	Clinical staff
Preventative Action	Clinical staff are made aware of their requirement to conduct a risk assessment on admission and a safety + suitability risk assessment as part of the Rule governing mechanical restraint.	Audit	Achievable + realistic	30/03/2026	Clinical staff

Rules Governing the Use of Mechanical Means of Bodily Restraint					
Reason ID : 10006901		**In the case of one resident, the use of mechanical means of bodily restraint namely a lap belt and bed rails for enduring risk of harm to self or others was not ordered by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person, 10.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All mechanical restraints for enduring risk of self harm will be ordered by a registered practitioner under the supervision of a consultant psychiatrist.	Audit	Achievable and realistic	30/03/2026	Medical staff
Preventative Action	The ordering of restrictive practices will be reviewed at the weekly MDT meeting to ensure its completeness and compliance with the Rules governing its use..	Audit	Achievable and realistic	30/03/2026	MDT
Reason ID : 10006902		**In the case of one resident where the use of mechanical means of bodily restraint namely a lap belt and bed rails for enduring risk was applied. A risk assessment of the safety and suitability of the Mechanical Restraint for the person did not take place and did not specify the monitoring arrangements and frequency which are implemented during its use, was not reviewed and updated regularly - at least quarterly - in line with the person's individual care plan, 3.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A risk assessment of safety and suitability of mechanical restraint, specifying monitoring arrangements and frequency of implementation will be reviewed and updated at least quarterly.	Audit	Achievable + realistic	30/03/2026	MDT

Preventative Action	The ordering of restrictive practices will be reviewed at the weekly MDT meeting to ensure their completeness and compliance with the Rules governing their use.	Audit	Achievable + realistic	30/03/2026	MDT
Reason ID : 10006903		**In the case of one resident, the multi-disciplinary team did not develop a plan of care for that person restrained by mechanical means to include information on attempts to reduce or eliminate the use of restraint for the person, 10.2(ii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A plan to include information on attempts to reduce or eliminate the use of restraint will form part of all mechanical restraint orders.	Audit	Achievable + realistic	30/03/2026	MDT
Preventative Action	The use of restrictive practices will be reviewed at the weekly MDT meeting to ensure their completeness and compliance with the Rule governing their use.	Audit	Achievable + realistic	30/03/2026	MDT
Reason ID : 10006904		**In the case of one resident, the clinical file did not contain a contemporaneous record that specified, the type of mechanical restraint, the duration of the restraint, the duration of the order or the review date, 5.7.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Contemporaneous records that specifies the type of mechanical restraint, the duration of the restraint, the	Audit	Achievable + realistic	30/03/2026	MDT

	duration of the order and the review date will be contained in the clinical file.				
Preventative Action	The use of restrictive practices will be reviewed at the weekly MDT meeting to ensure their completeness and compliance with the Rule governing their use.	Audit	Achievable + realistic	30/03/2026	MDT

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10006900		**In the clinical file the admission assessment did not have a documented risk assessment, 15.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All admissions will have a documented risk assessment,	Audit	Achievable + realistic	30/03/2026	NCHD's Consultants
Preventative Action	Clinical staff are made aware of their requirement to conduct a risk assessment on admission.	Audit	Achievable + realistic	30/03/2026	NCHD's Consultants

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.

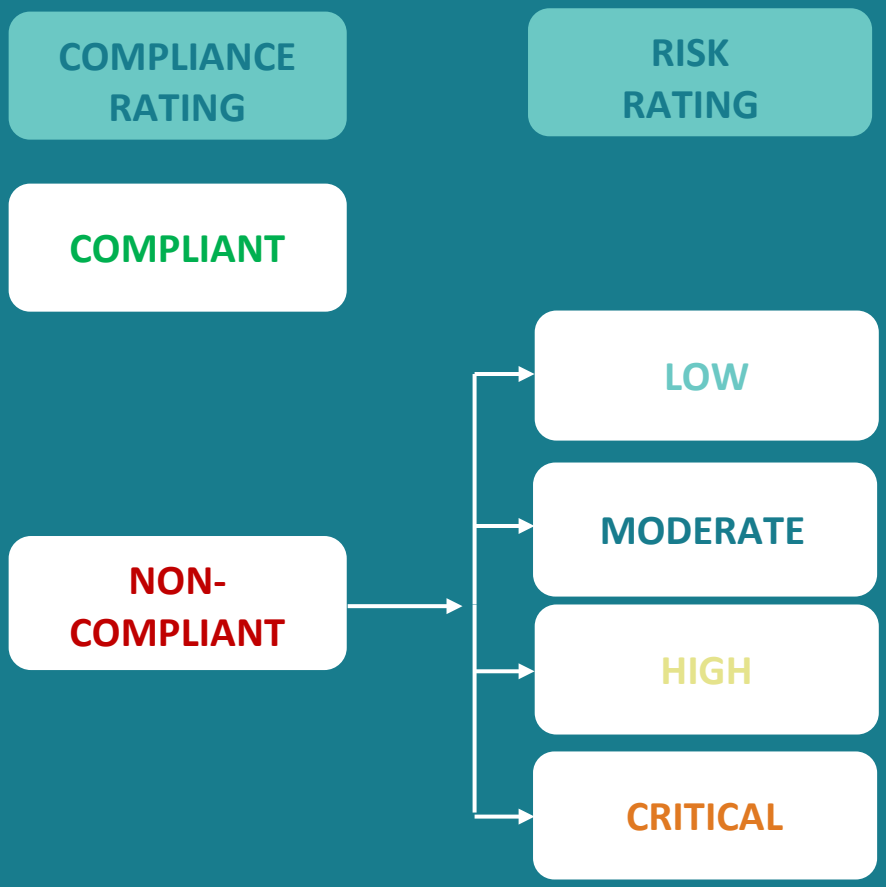
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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