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An Coillín

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

AN COILLÍN

Westport Road, Castlebar, Co. Mayo

Date of Publication:
31 August 2026

ID Number: AC0080

2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay

Conditions Attached:
None

Most Recent Registration Date:
16 May 2025

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Steve Jackson

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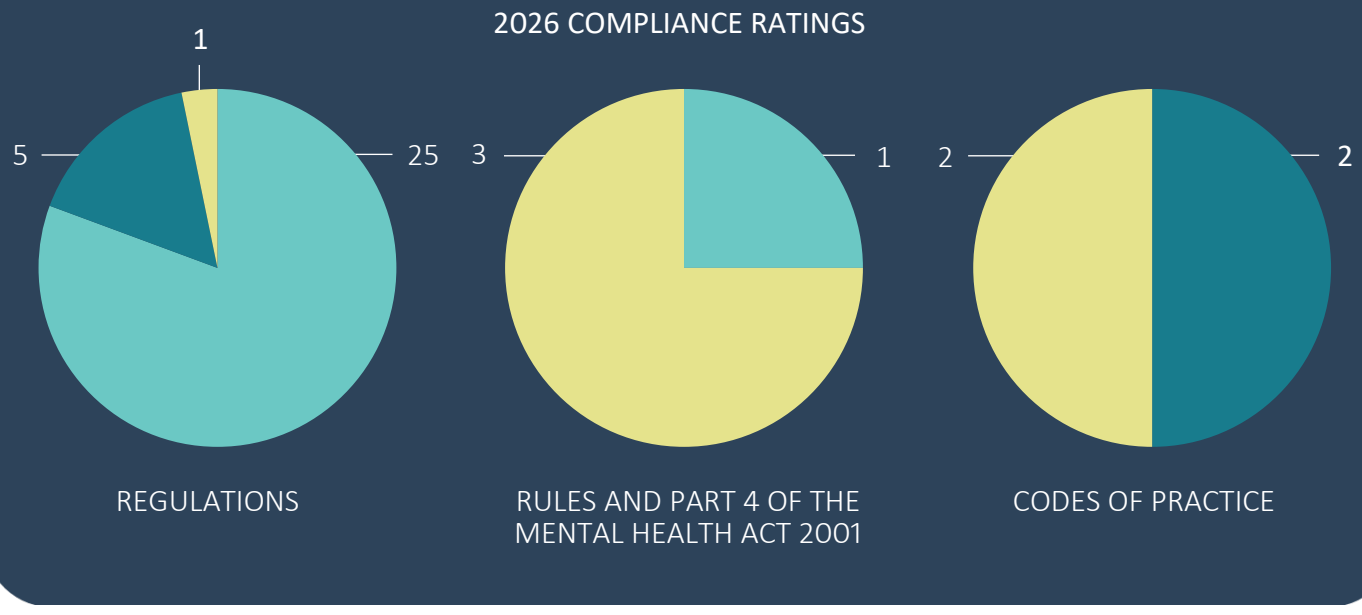
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
10 – 13 March 2026

Previous Inspection date:
11 – 14 March 2025

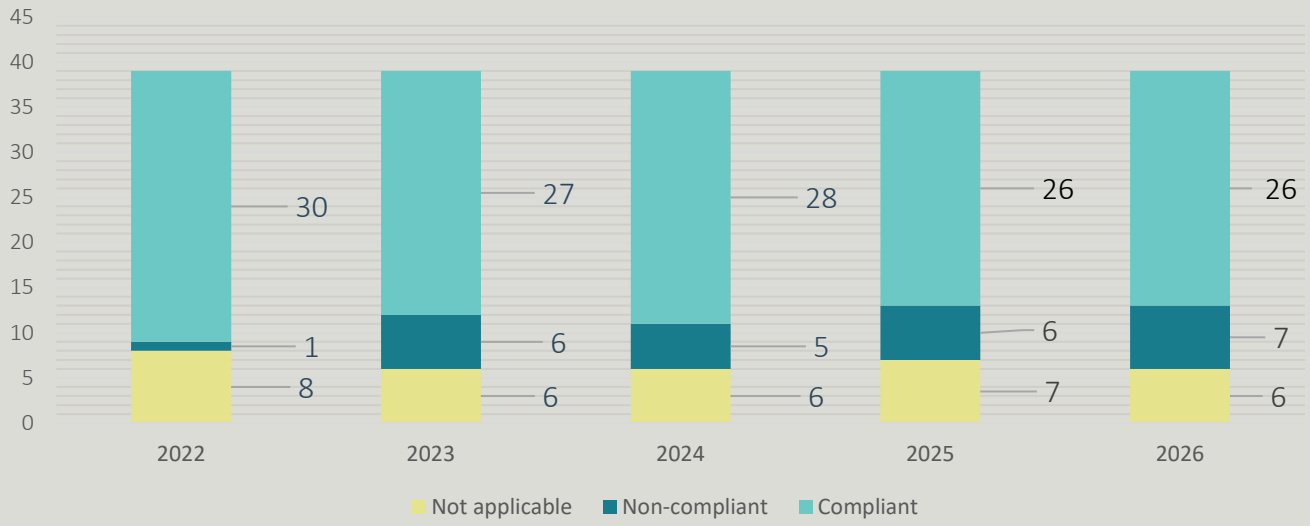
Inspection Type:
Unannounced Annual Inspection



RATINGS SUMMARY 2022 – 2026

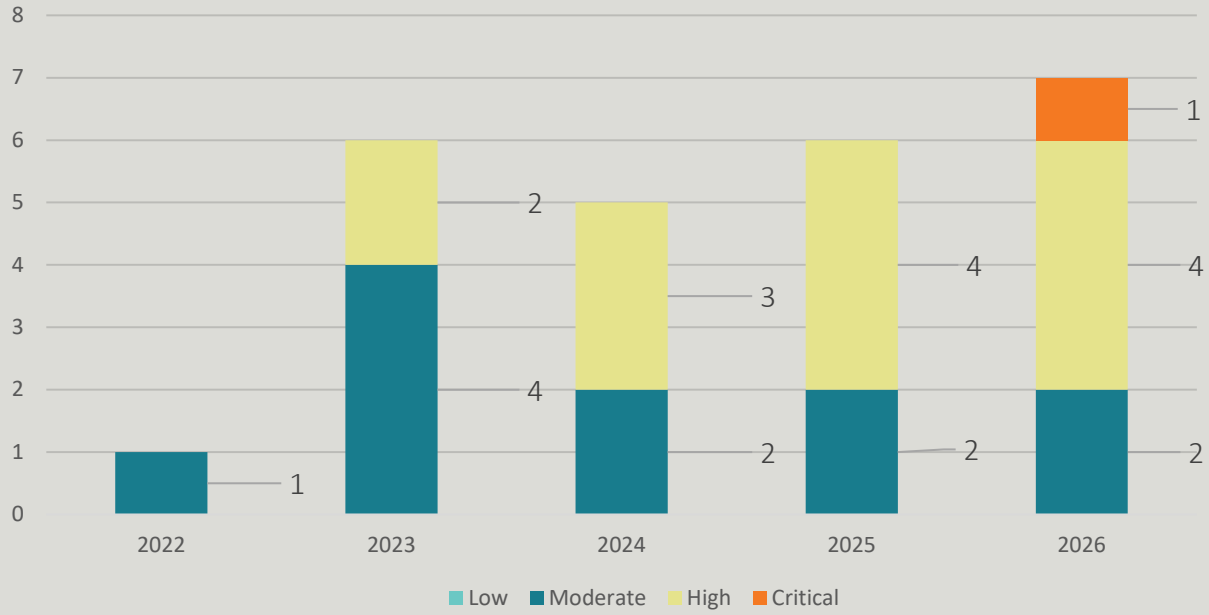
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2022 – 2026



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 2022 – 2026



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

1.1 Description of Approved Centre

An Coillín approved centre is located on the campus of the former St. Mary's Psychiatric Hospital in Castlebar. The centre was registered for 18 beds, with residents supported by a single multi-disciplinary team specialising in mental health rehabilitation. The approved centre was a single-storey building comprising of a combination of single en suite bedrooms and shared rooms of up to four beds. Bedrooms were personalised with photographs, artwork and personal belongings.

Communal facilities included a day room, dining room, activities room, occupational therapy kitchen, oratory, visitor's room, foyer area (also used as a secondary quiet sitting space) and an enclosed garden. The central sitting room was bright, frequently used and provided a focal point for residents' daily activities, opening out onto the outdoor garden area. Resident artwork and information on activities and events were displayed throughout the centre, contributing to a warm and personalised atmosphere.

The physical condition of the premises required attention. While some improvements to common areas had been undertaken since the previous inspection, the premises overall required substantial renovation and refurbishment in order to meet regulatory requirements.

The garden area required improvement. Trip hazards and general wear and tear were observed in outdoor spaces. Although upgrades were planned, the garden required repair and redevelopment to ensure safety and to provide a suitable outdoor environment for residents.

1.2 Inspector of Mental Health Services Summary

The unannounced inspection of An Coillín was carried out over four days and this summary reflects the findings observed during that period only. The inspection process was well coordinated and facilitated by local management and staff, whose engagement with the inspection was constructive and professional. The findings of this inspection indicated that overall compliance had reduced since the previous year, with a number of recurring issues identified.

Seven areas of non-compliance with regulatory requirements were identified. Regulation 22: Premises was a recurring area of non-compliance over a number of years and, due to the continued lack of sufficient progress and the associated risks identified, was escalated to a critical risk rating. This directly linked to risk management concerns, particularly in relation to fire safety. While improvements were noted in training, particularly fire safety training, the condition of the physical environment continued to present risks that required prioritised attention.

The decommissioning of the psychology post for the approved centre was an issue of concern, impacting the therapeutic needs of residents. This was a recurring non-compliance since 2022 and it was acknowledged that efforts had been made at local level to address this issue. The challenges arising from the national position were recognised; however, the absence of a dedicated psychology post continued to adversely affect the delivery of comprehensive care.

The inspection found that residents received a good standard of care and treatment. Staff were observed to interact with residents in a respectful, compassionate and engaging manner. The existing multi-disciplinary team was skilled, cohesive and committed, working collaboratively with residents to support care needs and meaningful engagement, providing a positive foundation for ongoing service improvement.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***18***
Total number of residents	**17**
Number of detained patients	3
Number of wards of court	4
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	17
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	97%	82%	88%	81%	79%

1.5 Conditions of registration

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

1.6 Ongoing escalation and enforcement actions at time of inspection

None.

1.7 Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice 10000398	*20 March 2026*	*Following the annual regulatory inspection of 10 to 16 March 2026, the approved centre was found non-compliant with 7 regulations and 1 of these, Regulation 22; Premises was risk rated as critical.*	*The approved centre submitted plans to address Regulation 22: Premises in the approved centre. The MHC continues to engage with the HSE on this matter, and this enforcement action remains open.*

2.0 Governance

The body governing An Coillín was the Health Service Executive (HSE) Health Region, West and North-West. The Health Region management structure replaced previous Community Healthcare Organisation (CHO) and Hospital Group structures. Operational responsibility had been moved from the HSE Centre to the Health Regions and Integrated Healthcare Areas. An Coillín was under the Integrated Healthcare Area of Mayo.

The governance and oversight of Mayo Mental Health Services (MMHS) remained with two core forums: the MMHS Area Management Team (AMT) and the MMHS Quality and Patient Safety Committee (QPSC) with meetings scheduled monthly. The MMHS AMT meetings were attended by the Executive Clinical Director (ECD), Registered Proprietor, Business Manager, Acting Area Director of Nursing, Principal Social Worker, Principal Psychologist Manager, Occupational Therapy Manager, Area Lead for Mental Health Engagement, Senior Executive Officer Finance Department, and Human Resources Manager. The MMHS QPSC meetings were attended by the ECD, Business Manager, General Manager, QPS Advisor, Acting Area Director of Nursing, Principal Social Worker, Occupational Therapy Manager, Principal Psychologist Manager, Area Lead for Mental Health Engagement, and Health & Safety Manager. Sub-committees including the Health and Safety Committee, the Policies, Procedures, Protocols and Guidelines (PPPG) Steering Group, the Drugs and Therapeutics Committee, the Infection Prevention Control Committee and the Multidisciplinary Team Operational Group reported to the monthly AMT and QPSC meetings. The Rehab and Recovery Multidisciplinary Team Operational Group met monthly and received updates from quarterly Therapeutic Groups meetings and the rollout of the new policy portal. Rolling items for discussion included staff training, health and safety, risk management, reduction of restrictive practices, referrals, building works and maintenance. A multidisciplinary approach was fostered within governance structures and clinical care and an ethos of continuous quality improvement was evident.

The Quality and Patient Safety Committee monitored and maintained the Area Mayo Mental Health Services risk register. Minutes of QPSC meetings documented discussion and review of any serious incidents that had taken place within the service. Complaints were also reviewed at this meeting. Responsibilities for risk management were allocated at management level and throughout the approved centre to ensure effective implementation. There was a quality and patient safety advisor available to the approved centre and the person with overall responsibility for risk was identified and known by all staff. The approved centre had a local risk register and defined pathways for escalation and de-escalation of risks to and from QPSC and the AMT as appropriate. The risk register contained health and safety risks, clinical risks, corporate and operational risks. Not all health and safety risks were identified, assessed, treated, reported or monitored on the risk register. Fire doors and fire equipment were not adequately maintained and there was a practice of wedging open fire doors. Governance of the fire safety processes was not effective and as a result there were not comprehensive risk management procedures in place to manage fire risk. There had been a significant improvement in fire safety training since the previous year's inspection, with the introduction of both practical and online components. This resulted in the achievement of 100% staff compliance in this area.

Health and safety risks were not adequately mitigated as not all hazards were minimised. There were uneven

paving bricks in the outdoor garden area, constituting a trip risk. There were temporary bollards available, however, these were not utilised to reduce the trips and falls risk to residents.

The condition of the overall premises was non-compliant with regulatory requirements and was deemed a critical risk. The facility was not maintained in an adequate state of repair, with multiple recurring maintenance issues that had not been addressed. These included defects such as broken window handles, damaged shower screens, faulty taps, cracked or missing tiles and stained and damaged flooring. Concerns were also identified in relation to cleanliness and hygiene. There was a persistent and offensive odour of smoke, attributed to residents smoking indoors, alongside visible evidence of smoking-related debris and damage throughout the premises, including cigarette burns on flooring. The approved centre did not have a structured or routine maintenance schedule in place, nor were there adequate records maintained of maintenance requests or the completion of works. The standard of the environment was unacceptable and did not support residents in living in a safe, comfortable, and dignified setting.

Any individual resident related risks were discussed by the multidisciplinary team. Incidents were recorded and risk-rated on the National Incident Management System (NIMS) and were reviewed as appropriate to identify any trends or patterns occurring in the service. Serious Reportable Incidents (SREs) were discussed and investigated by the Serious Incident Management Team (SIMT). There were clearly defined processes and procedures for learning from any near misses or incidents occurring in the approved centre. A program of auditing was conducted to assess compliance with regulatory standards and drive service improvements. Organisational structures of leadership and the lines of authority and accountability were clearly identifiable within the approved centre.

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

The approved centre had a full complement of nursing and medical staff. However, the number and skill mix of staff was not fully appropriate to the assessed needs of residents. There was one decommissioned psychology post for the approved centre. While a psychology referral protocol has been in place since the previous inspection, the provision of psychology services to the approved centre was limited. As a result, psychology input was provided only where deemed strictly necessary and was not sufficient to meet the complex psychological needs of residents. There was no psychology representation at multidisciplinary team (MDT) meetings or care planning meetings. This limited the team's capacity to identify and address residents' psychological needs within a coordinated, trauma-informed framework. There was evidence of an unmet psychology need for one resident who was on a psychology waiting list at the time of inspection. Risks identified on the provision of therapeutic services to residents due to psychology staff shortages were documented on the local risk register, however, these appeared to be beyond the approved centre's management control due to the HSE's Pay and Numbers Strategy in July 2024 which resulted in the approved centre's psychology post being decommissioned. This shortfall impacted the approved centre's ability to deliver comprehensive, multidisciplinary and needs-led care, and remained a matter of concern in ensuring that residents' psychological and therapeutic needs were adequately met.

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

There was a notable reduction of restrictive practice use in the approved centre. There was one episode of physical restraint since the last inspection, and the approved centre did not use mechanical restraint. There were policies in place for the use of restrictive practices and a policy for the reduction of the use of restrictive practices. There was an oversight and review committee which met every three months to review any episodes of restrictive practice should they occur. A report was provided to the registered proprietor following each meeting.

The inspection found that staff within the approved centre demonstrated a strong commitment to quality improvement and the delivery of high standards of care.

3.0 Compliance

3.1 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		2026
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 15: Individual Care Plan	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	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 31: Complaints Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Part 4 Consent to Treatment	✓	Compliant

3.2 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 2022 and 2026 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2022		2023		2024		2025		2026	
Regulation 16: Therapeutic Services and Programmes	✓		✗	Moderate	✗	High	✗	High	✗	High
Regulation 21: Privacy	✓		✓		✓		✓		✗	Moderate
Regulation 22: Premises	✗	Moderate	✗	High	✗	High	✗	High	✗	Critical
Regulation 26: Staffing	✓		✗	Moderate	✗	Moderate	✗	High	✗	High
Regulation 32: Risk Management Procedures	✓		✗	High	✗	High	✗	High	✗	High
Code of Practice on the Use of Physical Restraint		N/A	✓		✗	Moderate		N/A	✗	Moderate
Code of Practice on the Admission Transfer and Discharge	✓		✓		✓		✓		✗	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.

3.3 Areas that were not applicable on this inspection

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

4.0 Service-user Experience

4.1 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, in paper or by QR code, 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' consent, 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.

Two residents availed of the opportunity to meet with the inspection team during the inspection and three completed questionnaires were also received from residents.

All three residents who completed the feedback questionnaires responded positively across all areas assessed. Residents reported that they were supported to understand what was happening on admission, including clear information regarding their diagnosis, care and treatment, medication and care planning processes. They confirmed involvement in goal setting and demonstrated awareness of their care team, including their named keyworker, and who to approach if they had any concerns or worries.

Residents indicated satisfaction with the availability of leisure activities and talking therapies, and all reported that staff communicated with them in a respectful and supportive manner. Privacy and dignity were consistently upheld, and residents felt able to maintain contact with family, friends, and advocates. All respondents stated that they felt safe within the approved centre and were aware of how to provide feedback or make a complaint if needed.

In terms of overall experience, two residents rated the service as 10 out of 10, and one resident rated it as 9 out of 10. Across all three completed questionnaires, residents expressed a high level of satisfaction with the service, with particular emphasis on the quality of care and the positive relationships with staff. Individual nursing staff were highlighted as particularly valued, and the only recommendation for service improvement was to retain the current nursing team.

Two residents participated in interviews as part of the inspection process and provided generally positive but mixed feedback on their experience within the approved centre.

One resident reported having access to a private single room, while the other was in shared accommodation. Both confirmed that they were able to meet visitors privately, either in their bedroom or in a designated visitors' room, supporting privacy and dignity. In relation to physical healthcare, residents stated that they had access to their doctor and could discuss any health concerns as needed. One resident also noted engagement with the pharmacist.

Residents spoke positively about aspects of the therapeutic programme, including participation in group activities. One resident highlighted enjoyment of the cooking group, describing themselves as a good cook, while the other acknowledged that there are good groups and opportunities to engage. There was a request for additional recreational options, such as the provision of a pool table.

Feedback regarding the environment and facilities was mixed. One resident reported an issue with low hot water pressure in their room and suggested improvements to the outdoor space, specifically the addition of a designated smoking area with seating and overhead cover. The other resident described their room as uncomfortable at times due to noise from alarms, including fire alarms or drills.

Residents' experiences of interpersonal relationships varied. While both reported positive interactions with staff, one resident indicated that they did not get on as well with other residents and felt their experience residing in the centre had declined somewhat over time. Both residents confirmed that they were able to meet with their multidisciplinary team and maintain contact with family.

Views on food differed between residents. One expressed dissatisfaction with the quality of food, while the other reported satisfaction, noting that there were different choices available and that personal preferences were catered for.

Suggestions for improvement included enhancing the quality of food, increasing the range of activities, addressing maintenance issues, improving the comfort of the environment and encouraging shared responsibility among residents for maintaining tidiness within the approved centre.

4.2 Advocacy

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

The report highlighted a number of positive aspects of the service. Residents were described as engaging in a range of meaningful activities, including cookery, baking, colouring and gardening, and enjoyed access to comfortable communal spaces and outdoor areas. Opportunities for leave and visits from family and friends were particularly valued, as were occasional outings in the community. Improvements to the environment, such as the addition of a piano, were welcomed. In terms of care and wellbeing, residents expressed satisfaction with the support provided in accessing physical healthcare and attending appointments. The

introduction of a new catering provider was also positively received, with residents enjoying a wider variety of menu options.

Areas for improvement were identified, including a request for increased opportunities for group outings, greater access to single rooms and the provision of Wi-Fi and a quiet space for study or personal use. Some environmental and safety concerns were noted, including reports of two falls experienced by one resident. No significant concerns were raised in relation to safeguarding, consent, or restrictive practices.

The findings from the Peer Advocacy Report were broadly consistent with resident feedback received during the inspection, reflecting generally positive experiences of care alongside some areas identified for further improvement.

5.0 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
- Executive Clinical Director
- Area Director Of Nursng
- Assistant Director of Nursing
- Administrative Assistant
- Business Manager
- Maintenance Manager
- Occupational Therapy Manager
- Occupational Therapist
- Dietitian Manager
- Principal Social Worker
- Psychologist
- Consultant Psychiatrist
- Pharmacist
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Nurse Practice Development Coordinator
- Area Lead for Mental Health Engagement

Apologies

- Principal Psychologist
- Compliance Advisor

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.

6.0 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 3.1: Compliant areas on this inspection** for the list of compliant regulations on this inspection.*

*Please see **Section 3.2: Non-compliant areas on this inspection** for the list of non-compliant regulations on this inspection.*

*Please see **Section 3.3: Areas that were not applicable on this inspection** for the list of regulations that were not applicable on this inspection.*

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a 0.8 whole time equivalent occupational therapist, and occupational therapy assistant, and a 0.5 whole time equivalent social worker.

The therapeutic services and programmes available within the approved centre continued to be impacted by the decommissioning of a dedicated psychology post under the HSE Pay and Numbers Strategy. While a psychology referral protocol had been in place since the previous inspection, the provision of psychology services to the approved centre was limited and did not meet the assessed psychology needs of the residents, as documented in their individual care plans. There was evidence of an unmet psychology need for one resident who was on a psychology waiting list.

Due to a lack of psychology input, the therapeutic services provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Therapeutic services and programmes included the following:

There were one to one and, group interventions provided to residents. Weekly groups included a baking group, a cooking group, community-based activity group, and an art therapy group. The occupational therapist, social worker and nursing staff facilitated a monthly outing: gym, woodland walk, and cycling. The physiotherapist facilitated a weekly boxercise group.

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

a) **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, 16(1).**
b) **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, 16(2).**

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Residents were called by their preferred name based on their self-identification. Staff displayed professional, engaging and compassionate attributes in their interactions with residents. All bathrooms, showers and toilets and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.

Residents' privacy and dignity were not appropriately respected at all times; a noticeboard with residents' names, care and treatment was visible to anyone in the garden and a window in the visitor's room was missing a privacy screen.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the residents' privacy and dignity was appropriately respected at all times; a noticeboard with residents' names, care and treatment was visible to anyone in the garden and a window in the visitor's room was missing opaque material, a blind or curtain, 21.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms and bedrooms were provided. Heating, lighting and ventilation throughout the approved centre met all physical environmental requirements. Appropriate signage and sensory aids were provided to support residents in finding their way around the approved centre. Current national infection control guidelines were followed. Private and communal areas were suitably sized and furnished to remove excessive noise.

Not all hazards were minimised in the approved centre. As found in the previous two years' inspections as well as this 2026 inspection, the paving brick in the garden was uneven due to tree roots. The tree had been removed but the bricks had yet to be fixed. The uneven bricks were a trip hazard. There were temporary bollards available, however, these were not used to reduce the risk.

En-suite bathrooms evidenced broken shower screens, broken sink taps, and broken shower tiles.

The approved centre did not ensure that fire doors and fire equipment were maintained, one fire extinguisher had not been inspected, one double fire door did not close fully under its own weight, and it caught on the floor, the door to the visitor's room did not close fully, and fire doors were observed to be wedged open.

The approved centre was not kept in a good state of repair externally and internally. The windows were dirty externally. Window handles were missing on numerous windows. It was not possible to close the visitor's room window due to the missing handles. Flooring was damaged throughout the approved centre.

Cigarette butts were found in the egress space by the day room as well as cigarette damage to flooring in the bathroom cubicle. The smoking area and the egress space to the garden had cigarette butts on the ground and ash. This also resulted in the emergency exit doors and emergency signage being covered in a layer of residue from the smoke.

The visitor's room wall and skirting board was damaged due to a fire.

While the inspection team were provided with evidence of quarterly servicing of fire alarm and emergency lighting systems, annual servicing of fire extinguishers and annual servicing of the generator power system, there was no record of a general maintenance programme within the approved centre. Maintenance support was available, including out of hours emergency support, however there was no system to record maintenance requests and completed work.

The approved centre was not clean, hygienic and free from offensive odours. There were marks on numerous floors. There was a smell of smoke throughout the entire building including along the corridor in residents' rooms and in the day room. Residents smoked inside an internal porch area off the day room. Smoking in bedrooms was not permitted, however some residents had smoked in their bedrooms during nighttime hours. There were also concerns relating to passive smoking and the health effects on non-smokers in the approved centre.

The approved centre provided enough toilets and showers for residents, with at least one assisted toilet. The approved centre provided suitable furnishings to support resident independence and comfort, including assisted devices and equipment to address resident needs.

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

a) **The approved centre was not clean, hygienic and free from offensive odours; floorings internally were stained. Residents using the egress space between the day room and garden as a smoking area resulted in the smell of smoke lingering within the approved centre. The smell of smoke was evident throughout the approved centre including along the corridor, in residents' rooms and the day room. The smoking area and the egress space to the garden had cigarette butts on the ground and ash. This also resulted in the emergency exit doors and emergency signage being covered in a layer of residue from the smoke, 22(1).**
b) **The approved centre was not maintained in a good state of repair internally; a number of window handles were broken or missing including one window which did not function properly due to no window handles. En-suite bathrooms evidenced broken shower screens, broken sink taps, and broken shower tiles. There were cigarette burns evident on flooring in the bathroom cubicle and egress to the garden, flooring throughout the approved centre was damaged. The visitor's room wall and skirting board was damaged due to fire, 22(1).**
c) **The approved centre did not ensure all hazards were minimised as there were uneven paving bricks in the outdoor garden area, constituting a trip risk. There were temporary bollards available, however, these were not used to reduce the risk, 22(3).**
d) **The approved centre did not ensure that fire doors and fire equipment were maintained; one fire extinguisher had not been inspected, one double fire door did not close fully under its own weight and caught on the floor, the room to the visitor's room did not close fully, fire doors were regularly wedged open, 22(3).**
e) **The approved centre did not have a regular maintenance schedule and did not maintain records of maintenance requests or completion of tasks, 22(3c).**

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 October 2025 and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty and in charge at all times and this was documented. The numbers and skill mix of staffing in the approved centre was not sufficient to meet resident assessed needs. There was no psychologist in the approved centre since the psychologist post became vacant in March 2022, and was decommissioned at the end of 2023.

The Registered Proprietor ensured that staff had access to education and training through a coordinated and monitored annual training schedule and records. These were documented and up-to-date. Most staff had completed mandatory training in The Mental Health Act 2001, Basic Life Support, Fire Safety, Management of Violence and Aggression and Safeguarding. All mandated persons in the approved centre were trained in Children First. Where minor deficits arose, staff were scheduled to complete the relevant training at upcoming sessions.

The following is a table of staff showing the numbers and percentages of staff trained in the mandatory training topics at the time of inspection:

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (25)	25	100%	25	100%	25	100%	25	100%	25	100%	25	100%
Medical (3)	3	100%	3	100%	2	67%	3	100%	3	100%	3	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian (2)	2	100%	2	100%	1	50%	2	100%	2	100%	2	100%
Pharmacist (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Healthcare Assistant (10)	9	90%	10	100%	10	100%	10	100%	10	100%	10	100%
OT Assistant (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 that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre, there was no psychologist in the approved centre since the psychologist post became vacant in March 2022, 26(2).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The risk management policy was last reviewed in July 2025. The risk management policy addressed all requirements including:

- The process for identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multidisciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, and information provided was anonymised at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. The health and safety risks associated with the trip and fall hazards, in the format of raised patio slabs which were damaged by tree roots in the garden, were not removed. While the tree was removed since the last inspection, the uneven paving was not rectified. The approved centre attempted to mitigate this risk by temporary plastic fencing closing off the area, but these were removed by residents and stacked against a fence in the garden at time of inspection – which exposed residents to paving trip hazards.

The approved centre's risk management policy was not fully implemented throughout the approved centre as faulty fire doors were wedged open which compromised fire safety. Health and safety risks relating to fire safety deficits found on inspection were not identified, assessed, treated and monitored within the risk register. These faulty fire doors which were wedged open was a reoccurring issue since last year's inspection. In addition, residents were smoking inside of the approved centre.

Clinical and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate,

Individual risk assessments were completed in conjunction with admission, medication requirements or administration, and at resident transfer and resident discharge. Multidisciplinary teams were involved in the development, implementation and review of individual risk management processes. Residents and 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.

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

a) **The registered proprietor did not ensure that the approved centre's risk management policy was implemented throughout the approved centre in that risk management procedures to manage trip hazards at the approved centre did not actively reduce identified risks to the lowest practicable level of risk, 32(1).**
b) **The registered proprietor did not ensure that the approved centre's risk management policy was implemented throughout the approved centre in relation to health and safety risks relating to fire safety. Fire doors were wedged open, and residents were smoking inside the approved centre, 32(1).**

7.0 Inspection Findings – Rules

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

None of the rules were applicable on this inspection. Please see ***Section 3.3: Areas that were not applicable on this inspection*****.**

8.0 Inspection Findings – Mental Health Act 2001

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

*Part 4 of the Mental Health Act 2001 was compliant on inspection. Please see **Section 3.1: Compliant areas on this inspection**.*

9.0 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 3.2: Non-compliant areas on this inspection** for the list of non-compliant codes of practice on this inspection.*

*Please see **Section 3.3: Areas that were not applicable on this inspection** for the list of codes of practice that were not applicable on this inspection.*

Use of Physical Restraint

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated January 2026. It addressed the following:

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

The approved centre had a policy on the reduction of physical restraint which addressed the following:

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

Policies and procedures regarding staff training included:

- Who would receive training based on the identified needs of persons who are restrained and staff.
- The areas to be addressed within the training programme, which included training in:
    - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
    - Alternatives to physical restraint.
    - Trauma-informed care.
    - Cultural competence.
    - Human rights, including the legal principles of restrictive interventions.
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.
    - The monitoring of the safety of the person during and after the physical restraint.
- The mandatory nature of training for those involved in physical restraint.
- The identification of appropriately qualified persons to give the training.

Training and Education: All staff involved in physical restraint had signed to indicate that they had read and understood the policy. A record of attendance at training was maintained.

All staff who participated in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed. There had been one episode of physical restraint in An Coillín since that last inspection. This episode of physical restraint was not reviewed by the Multidisciplinary Review and Oversight Committee, to determine if the episode of physical restraint complied with the code of practice on the use of physical restraint, as well as with the approved centre's own policies and procedures relating to physical restraint.

Evidence of Implementation: One episode of physical restraint was inspected.

Orders for physical restraint: The orders for physical restraint were initiated, carried out, renewed and ended. The order confirmed that there were no other less restrictive ways available to manage the person's presentation.

There was no record to show that the person being restrained was informed of the reasons for the restraint and the circumstances which would lead to its discontinuation, as required by the approved centre's own policy on physical restraint and section 3.8 of the Code of Practice.

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

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

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

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

The person who led the physical restraint ended the restraint in this episode of physical restraint.

Ending of physical restraint: An in-person debrief did not follow the episode of physical restraint as the person declined.

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

Clinical Governance: The episode of physical restraint was appropriately recorded. The episode of physical restraint was reviewed by members of the multidisciplinary team involved in the person's care and treatment.

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

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

a) **The Multidisciplinary Review and Oversight Committee did not analyse one episode of physical restraint to determine compliance with the code of practice, and with the approved centre's own policies, 7.8.**
b) **In one episode of physical restraint, there was no record that the person was informed of the reasons for, and the circumstances which will lead to the discontinuation of physical restraint, as required by the approved centre's own policy on the use of physical restraint, and section 3.8 of the Code of Practice.**

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 March 2025, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in May 2023, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2023, included all of the policy-related criteria for this code of practice.

Training and Education: Relevant staff had read and understood the admission, transfer and discharge policies, and this was documented.

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, risk assessment, 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.

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 did include a follow up plan and documented communications with the relevant healthcare provider. The discharge plan included a reference to early warning signs of relapse.

The discharge meeting was attended by the resident, their key worker, relevant members of the resident's multidisciplinary team (MDT) and a family member or representative.

The discharge assessment addressed the resident's psychiatric and psychological needs and included a current mental state examination and a comprehensive risk assessment and risk management plan.

A preliminary discharge summary was not sent to the relevant healthcare provider within three days, and a comprehensive discharge summary was not 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 and included the names and contact details of key people for follow-up or risk issues such as signs of relapse.

Family members were involved in the discharge process.

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

a) **The preliminary discharge summary was not sent to the general practitioner within three days, 38.3.**
b) **A comprehensive discharge summary was not issued within 14 days, 38.3 (b).**

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 16: Therapeutic Services and Programmes					
Reason ID : 10007511		**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, 16(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The service user referred to psychology and on the waiting list at the time of inspection has been seen by the psychology service. There is currently no resident on the psychology waiting list. The Psychology Referral Protocol remains in place.	The residents' referral status will be reviewed and updated.	Yes	16/07/2026	Principal Psychologist Manager
Preventative Action	To address the current absence of psychology input to the Approved Centre, the Psychology Manager will commence a limited direct psychology service from the end of August 2026. This interim arrangement will remain in place until 1 December 2026 and is intended to	Limited direct psychology input will commence by 31.08.2026. Psychology referrals, assessments and interventions within the Approved Centre will be recorded and monitored	Yes	31/08/2026	Principal Psychologist Manager

	provide residents with access to psychological assessment and intervention, as appropriate, while longer-term service planning is progressed. The lack of a psychologist within An Coillin has been identified as a risk and placed on the Risk Register in An Coillin. Continued efforts have been made by Psychology Management and MMHS to recommission the psychology post. The requirement for a dedicated psychology resource for An Coillin will be raised through the Integrated Service Leads structure to support sustainable psychology provision.				
Reason ID : 10007512		**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, 16(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To address the current absence of psychology input to the Approved Centre, the Psychology Manager will commence a limited	Limited direct psychology input will commence by 31.08.2026. Psychology referrals, assessments and	Yes	31/08/2026	Principal Psychologist Manager

	direct psychology service from the end of August 2026. This interim arrangement will remain in place until 1 December 2026 and is intended to provide residents with access to psychological assessment and intervention, as appropriate, while longer-term service planning is progressed.	interventions within the Approved Centre will be recorded and monitored			
Preventative Action	The lack of a psychologist within An Coillin has been identified as a risk and placed on the Risk Register in An Coillin. Continued efforts have been made by Psychology Management and MMHS to recommission the psychology post. The requirement for a dedicated psychology resource for the Approved Centre will be raised through the Integrated Service Leads structure to support sustainable psychology provision.	Psychology provision to be included as an item for review through governance structures, i.e. Area Management Team Risks relating to psychology staffing and service provision reviewed through relevant risk registers.	Yes	01/12/2026	Principal Psychologist Manager

Regulation 21: Privacy					
Reason ID : 10007513		**The registered proprietor did not ensure that the residents' privacy and dignity was appropriately respected at all times; a noticeboard with residents' names, care and treatment was visible to anyone in the garden and a window in the visitor's room was missing opaque material, a blind or curtain, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of Inspection opaque material applied to office windows and replaced on the visitor's room window. Residents' names have been removed from noticeboard – initials are now used.	Audit of Regulation 21 Privacy.	Yes	20/03/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.
Preventative Action	Replace any opaque material if it is removed. Use initials only on notice board.	Audit of Regulation 21 Privacy.	yes	20/03/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

Regulation 22: Premises					
Reason ID : 10007514		**The approved centre was not clean, hygienic and free from offensive odours; floorings internally were stained. Residents using the egress space between the day room and garden as a smoking area resulted in the smell of smoke lingering within the approved centre. The smell of smoke was evident throughout the approved centre including along the corridor, in residents' rooms and the day room. The smoking area and the egress space to the garden had cigarette butts on the ground and ash. This also resulted in the emergency exit doors and emergency signage being covered in a layer of residue from the smoke, 22(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	FLOORING: Minor replacement works have been approved and are currently being scheduled. It is expected to have these works completed by the end of the 3rd qtr 2026 subject to contractor availability. A broader flooring replacement programme has been sought in the SHIF in a capital submission due to the scale of works required. SMOKING: Residents provided with assessment and support to reduce/stop smoking as per the ICP. A new outdoor shelter is now in place in the redesigned garden area to mitigate risks associated with passive smoking and indoor	Audit of Regulation 22 Premises.	Yes - subject to contractor availability	29/10/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

	exposure. EMERGENCY EXIT DOOR & SIGNAGE: Contract cleaning company completed deep clean of the door. Emergency signage to be replaced.				
Preventative Action	Environmental checks have been strengthened by including monitoring for smoking and ensuring fire doors are closed as part of the general observations which are completed ½ hourly. This will assist with the identification of environmental risks. Additionally, regular walk-throughs by nurse managers and monthly cleaning audits, conducted by the Infection Prevention Control Nurse and contract cleaning company manager, ensure ongoing oversight.	Environmental checks & Fire Register.	Yes	27/03/2026	Registered Proprietor, Business manager, Maintenance Manager, A/Area Director of Nursing.
Reason ID : 10007515		**The approved centre was not maintained in a good state of repair internally; a number of window handles were broken or missing including one window which did not function properly due to no window handles. En-suite bathrooms evidenced broken shower screens, broken sink taps, and broken shower tiles. There were cigarette burns evident on flooring in the bathroom cubicle and egress to the garden, flooring throughout the approved centre was damaged. The visitor's room wall and skirting board was damaged due to a fire, 22(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Windows/Handles: - A replacement programme in underway to address missing or defective handles. Works are actively progressing to ensure full safety and functionality. The Local maintenance department is currently liaising with a contractor to have these works completed in the 3rd quarter. En-suite Bathrooms: A planned programme of significant upgrade works is being developed to address defective fixtures and finishes. A SHIF application and business case has recently been escalated to the Mayo IHA office for submission to HSE Estates to secure the necessary capital investment to address the deficits identified in the recent inspection. Flooring: Minor replacement works have been approved and are currently being scheduled. It is	Audit of Regulation 22 with quarterly updates.	Yes subject to funding & contractor availability	03/07/2026	Registered Proprietor, Business manager,

	expected to have these works completed by the end of the 3rd qtr 2026 subject to contractor availability. Visitor's room: Painting contractor engaged to repaint visitor's room. Family support staff and nurse management plan to redecorate visitor's room to provide a warm welcoming atmosphere for residents, families and friends.				
Preventative Action	Regular walk arounds by nurse management to identify any premises issues. Any deficits identified are immediately escalated to the maintenance department for action.	Audit of Regulation 22 with quarterly updates.	yes	30/09/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.
Reason ID : 10007516		**The approved centre did not ensure all hazards were minimised as there were uneven paving bricks in the outdoor garden area, constituting a trip risk. There were temporary bollards available, however, these were not utilised to reduce the risk, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Uneven paving: All paving has been removed. Tarmacadam has been installed to the area and extended to include a mindfulness garden path for residents.	Audit of Regulation 22 with quarterly updates.	Yes	08/05/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

Preventative Action	Regular walk arounds by nurse management to identify any premises issues. Any deficits identified are immediately escalated to the maintenance department for action.	Audit of Regulation 22 with quarterly updates.	Yes	08/05/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.
Reason ID : 10007517		**The approved centre did not ensure that fire doors and fire equipment was maintained; one fire extinguisher had not been inspected, one double fire door did not close fully under its own weight and caught on the floor, the room to the visitor's room did not close fully, fire doors were regularly wedged open, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire Doors: Minor remedial work of the fire doors identified was undertaken by local maintenance department within 48hours of inspection. A specialist fire door inspection was requested and completed. The report has been forwarded to HSE Estates which they have accepted. A small number of fire doors were deemed beyond repair and require replacement. These doors have been ordered and are currently in fabrication by a specialist manufacturer. Installation will be	Environmental checks & Fire Register	yes	25/09/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

	undertaken by the appointed contractor on receipt of the replacement doors. A Purchase order (PO) for remedial works has now issued to the successful contractor and work is underway. Local Maintenance Manager is meeting weekly with contractors for updates. All door wedges have been removed from An Coillin. Fire Safety Equipment: The identified fire extinguisher was replaced during inspection.				
Preventative Action	Fire Safety Equipment: A weekly system of visual inspections on fire prevention equipment has been implemented which involves the PIC (Person in charge) carrying out routine visual inspection of relevant equipment and recording of findings in the HSE Fire Safety Register. Any deficits identified are	Environmental checks & Fire Register.	yes	27/03/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

	immediately escalated to the maintenance department for action. Fire Doors: All door wedges have been removed from An Coilin and weekly visual checks of fire doors completed.				
Reason ID : 10007518		**The approved centre did not have a regular maintenance schedule and did not maintain records of maintenance requests or completion of tasks, 22(3c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An annual audit of Regulation 22: Premises is conducted with the involvement of key stakeholders, resulting in the development of a maintenance schedule and action plans based on audit findings. This maintenance schedule is reviewed and updated quarterly. An annual audit of Regulation 22: Premises is conducted with the involvement of key stakeholders, resulting in the development of a maintenance schedule and action plans based on audit findings. This maintenance schedule is reviewed and	Audit of Regulation 22 with quarterly updates. Maintenance log.	yes	27/03/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

	updated quarterly. The following planned preventative maintenance (PPM) and statutory servicing activities are undertaken on a scheduled basis to ensure compliance, reliability, and the continued safe operation of building services and life safety systems: • Fire alarm system • Emergency lighting systems • Fire extinguishers • Standby power generator • Heating system • Staff panic alarm Maintenance requests are emailed to maintenance department and a log is kept by An Coillin Admin staff. This log is regularly reviewed and updated by Nurse Management and any outstanding work resubmitted to maintenance department.				
Preventative Action	An annual audit of Regulation 22: Premises is conducted with the involvement	Quarterly review and updated of premised audit completed with key stakeholders	yes	27/03/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

	of key stakeholders, resulting in the development of a maintenance schedule and action plans based on audit findings. This maintenance schedule is reviewed and updated quarterly. Staff are also required to promptly report any maintenance issues to the maintenance department as needed.	(Maintenance, Business Manager & Nurse management).			

Regulation 26: Staffing					
Reason ID : 10007519		**The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre, there was no psychologist in the approved centre since the psychologist post was decommissioned in March 2022, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To address the current absence of psychology input to the Approved Centre, the Psychology Manager will commence a limited direct psychology service from the end of August 2026. This interim arrangement will remain in place until 1 December 2026 and is intended to provide residents with access to psychological assessment and intervention, as appropriate, while longer-term service planning is progressed.	Limited direct psychology input will commence by 31.08.2026. Psychology referrals, assessments and interventions within the Approved Centre will be recorded and monitored	Yes	31/08/2026	Principal Psychologist Manager
Preventative Action	The requirement for a dedicated psychology resource for the Approved Centre will be raised through the Integrated Service Leads structure to support sustainable psychology provision	Psychology provision to be included as an item for review through governance structures, i.e. Area Management Team Risks relating to psychology staffing and service provision reviewed through relevant risk registers.	Yes	01/12/2026	Principal Psychologist Manager

Regulation 32: Risk Management Procedures					
Reason ID : 10007509		**The registered proprietor did not ensure that the approved centres risk management policy was implemented throughout the approved centre in that risk management procedures to manage trip hazards at the approved centre did not actively reduce the identified risks to the lowest practicable level of risk, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified trip hazards have been removed & tarmacadam has been installed. A mindfulness garden walk has also been installed. Risks associated with the identified trip hazards had been risk assessed and escalated to the Local Risk Register.	Audit of Regulation 32 Risk Management Procedures & Reg 22 Premises.	yes	08/05/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.
Preventative Action	All risks held on the An Coillin Risk Register are now a rolling agenda item for discussion at the monthly business meeting.	Agenda and minutes of Business meeting	yes	10/04/2026	Business manager, Nurse Manager.
Reason ID : 10007510		**The registered proprietor did not ensure that the approved centre's risk management policy was implemented throughout the approved centre in relation to health and safety risks relating to fire safety. Fire doors were wedged open, and residents were smoking inside the approved centre, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Risks: Risks associated with fire safety, fire doors and smoking were escalated to the Local Risk Register at the time of inspection. Fire Doors: All door wedges were removed	Audit of Regulation 32 Risk Management Procedures. Environmental checks & Fire Register.	yes	27/03/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

	from An Coillin. Smoking Risk: Individual risk assessments of service users who smoke have been updated to include risks associated with smoking. Individual Care Plans have also been updated to include smoking assessment & supports. A new outdoor smoking shelter is now in place in the redesigned garden area to mitigate risks associated with passive smoking and indoor exposure.				
Preventative Action	All risks held on the An Coillin Risk Register are now a rolling agenda item for discussion at the monthly business meeting. Environmental checks have been strengthened by including monitoring for smoking and ensuring fire doors are closed as part of the general observations which are completed ½ hourly. This will assist with the identification of environmental risks.	Environmental checks & Fire Register, agenda and minutes of Business meeting	yes	27/03/2026	Registered Proprietor, Business manager, Maintenance Manager, Nurse Manager.

	Weekly residents' meetings now included Smoking cessation and no smoking policy. All residents encouraged and supported to engage in smoking cessation.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10007520		**The Multidisciplinary Review and Oversight Committee did not analyse one episode of physical restraint to determine compliance with the code of practice and with the approved centre's own policies, 7.8**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The episode of physical restraint was retrospectively reviewed by Multidisciplinary Review and Oversight Committee at the Q1 meeting in April 2026	Minutes of meeting	Yes	02/04/2026	Executive Clinical Director, A/Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker, Area Lead for Mental Health Engagement & Principal Psychologist.
Preventative Action	The Multidisciplinary Review and Oversight Committee meet quarterly and review all episodes of Restrictive Practice in the Approved Centres. Physical Restraint in An Coillin is a rolling agenda item. This meeting is attended by representatives from An Coillin.	Minutes of meetings	Yes	02/04/2026	Executive Clinical Director, A/Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker, Area Lead for Mental Health Engagement & Principal Psychologist.
Reason ID : 10007521		**In one episode of physical restraint, there was no record that the person was informed of the reasons for, and the circumstances which will lead to the discontinuation of physical restraint, as required by the approved centre's own policy on the use of physical restraint, and section 3.8 of the Code of Practice.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Mayo Mental Health Physical Restraint documentation was updated during inspection, to include a prompt for staff to	Audit of COP on Physical Restraint	Yes	27/03/2026	Executive Clinical Director, A/Area Director of Nursing.

	ensure there is documentary evidence that the person was informed of the reasons for, and the circumstances which will lead to the discontinuation of physical restraint.				
Preventative Action	The Physical Restraint documentation was updated to include a prompt for staff as outlined above. Old documents removed and replaced with updated version. Audit tool updated to reflect changes. All relevant staff informed and advised of the importance of documenting that the person was informed of the reasons for, and the circumstances which will lead to the discontinuation of physical restraint.	Audit of COP on Physical Restraint	Yes	27/03/2026	Executive Clinical Director, A/Area Director of Nursing.

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10007507		**The preliminary discharge summary was not sent to the general practitioner within three days, 38.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Checks completed by the CNM3 to ensure all aspects of discharge are completed in full and all discharge summaries are sent to General Practitioners within the required 3 and 14-day timeframe.	Discharge Audit increased to quarterly.	yes	09/04/2026	ECD & A/Area DON
Preventative Action	A Learning Education Notice (LEN) reminding staff of their obligations under the Mental Health Commission's Code of Practice on Admission, Transfer and Discharge has been disseminated to relevant staff in Mayo Mental Health Services. Annual audit of COP on Discharge increased to quarterly to ensure compliance.	Quarterly audit of COP on Discharge	Yes	09/04/2026	ECD & A/Area DON
Reason ID : 10007508		**A comprehensive discharge summary was not issued within 14 days, 38.3 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Robust arrangements have been implemented to ensure all discharge summaries are completed and sent to General Practitioners	Quarterly audit of COP on Discharge	Yes	09/04/2026	ECD & A/Area DON

	within the required 3 and 14-day timeframe.				
Preventative Action	A Learning Education Notice (LEN) reminding staff of their obligations under the Mental Health Commission's Code of Practice on Admission, Transfer and Discharge has been disseminated to relevant staff in Mayo Mental Health Services. Annual audit of COP on Discharge increased to quarterly to ensure compliance.	Quarterly audit of COP on Discharge	Yes	09/04/2026	ECD & A/Area DON

Appendix 2: REGULATIONS, RULES, Part 4, 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.

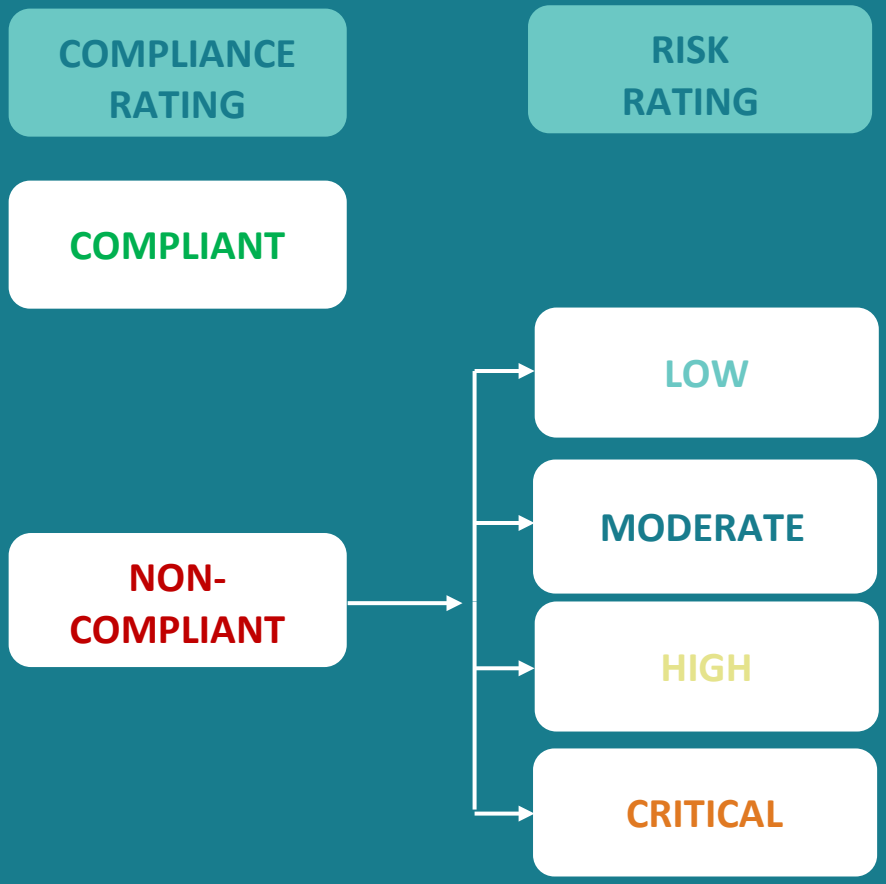
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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