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Acute Psychiatric Unit, Tallaght Hospital

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

ACUTE PSYCHIATRIC UNIT, TALLAGHT HOSPITAL

Tallaght University Hospital, Tallaght, Dublin 24

Date of Publication:
31 August 2026

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2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life

Conditions Attached:
Yes

Most Recent Registration Date:
01 March 2026

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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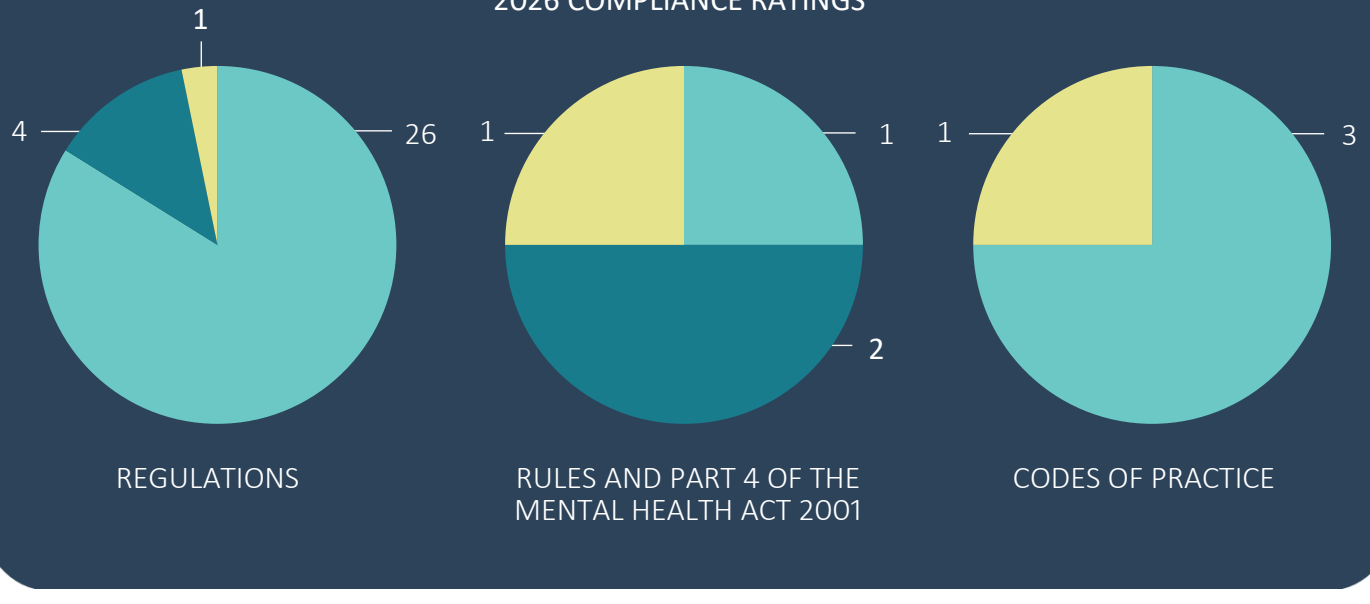
Inspection Date:
21 – 24 April 2026

Previous Inspection date:
13 – 16 May 2025

Inspection Type:
Unannounced Annual Inspection

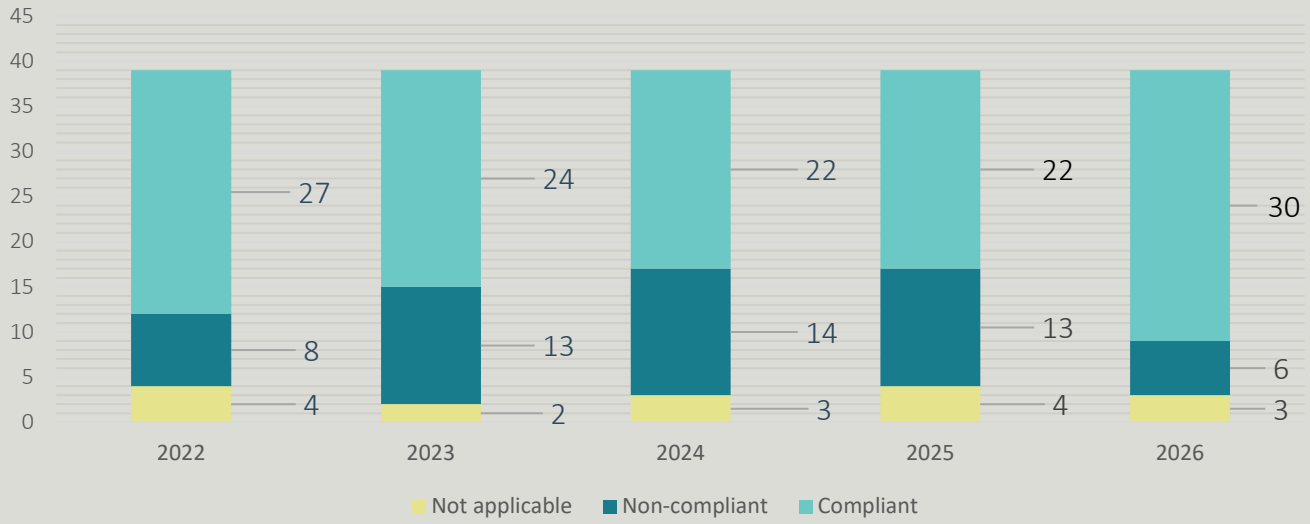
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

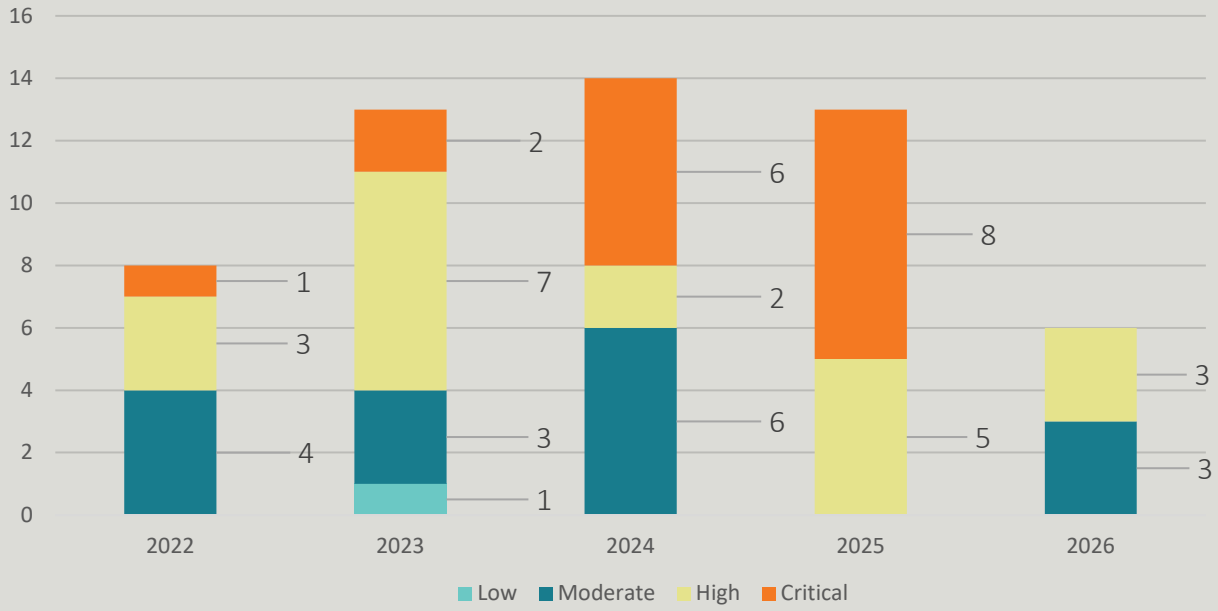
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Located on the ground floor of Tallaght University Hospital, the approved centre consisted of three units; Cedar Unit, a 23-bed female admission unit, Rowan Unit, a 23-bed male admission unit and Aspen Unit, a six-bed mixed gender High Observation Unit. At the time of inspection, Aspen Unit was closed for refurbishment as part of a phased renovation of the approved centre.

The accommodation facilities on each of the three units consisted of shared six-bed or four-bed bedrooms, with a limited number of single bedrooms. Cedar and Rowan units had access to a shared corridor which contained a dining room, laundry room, and a variety of multi-functional rooms, including the following: a games room, family room and reading room. An art room, a therapy room, and a sensory room were available for therapeutic activities. Residents also had access to garden space.

Residents were under the care of 15 different multi-disciplinary teams including 11 general adult teams and four specialist teams. The general adult teams were designated according to geographical areas and included three sector teams for the Clondalkin area, three sector teams for the Tallaght area, three sector teams for the Ballyfermot and Lucan areas, and two sector teams for the Crumlin/Walkinstown area. The four specialist teams included one team specialising in Psychiatry of Later Life, one team specialising in Rehabilitation, and two teams specialising in mental health for people with Intellectual Disability.

1.2 Inspector of Mental Health Services Summary

The inspection of the Acute Psychiatric Unit (APU) Tallaght was unannounced and occurred over four days from 21 April to 24 April 2026. This report reflects the findings at the time of inspection.

Overall, the findings of the 2026 annual inspection demonstrated an improvement in compliance with regulatory requirements. In 2025, the inspection of the approved centre found thirteen non-compliances, including eight critical breaches of regulation. In 2026, this decreased to six areas of non-compliance. The Rules Governing the Use of Seclusion, Regulation 21: Privacy, Regulation 22: Premises, Regulation 27: Maintenance of Records, and Regulation 32: Risk Management Procedures, were all reoccurring areas of non-compliance, however the risk rating applied to each breach of regulation and rule decreased in 2026. Part 4 Consent to Treatment was also found to be non-compliant with a moderate risk rating. The approved

centre had implemented several measures to address the areas of non-compliance identified in the 2025 annual inspection. Eight of the thirteen non-compliances from 2025 were assessed as compliant in 2026, and no regulation, rule, or Part 4 of the Mental Health Act (2001), was risk rated critical.

A coordinated response had been undertaken at clinical and managerial levels to improve the quality of care delivered to the residents of APU Tallaght. This involved a review of governance structures within the approved centre, and the processes underlying service delivery. Renovation works to address ligature risks, patient safety and privacy were underway, and a detailed plan of phased works and completion dates were in place. Significant improvements had been achieved since the 2025 annual inspection, which demonstrated a commitment from staff at all levels to implement new ways of working. Continued momentum is required to consolidate progress to date and to build on the level of compliance achieved on this year's inspection.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***52***
Total number of residents	**44**
Number of detained patients	14
Number of wards of court	0
Number of residents under the Assisted Decision-Making Act	0
Number of children	0
Number of residents in the approved centre for more than 6 months	3
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	77%	65%	67%	63%	83%

1.5 Conditions of registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *Condition 1: The registered proprietor shall implement the actions specified in the most recent Management of Actions & Reporting Template (MART) submitted to the Mental Health Commission by the HSE on 1 December 2025. The registered proprietor shall submit updates on the implementation of the plan in the form and frequency prescribed by the Commission.*	The approved centre was not in breach of Condition 1 at the time of inspection.

1.6 Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice 10000367	*23/05/2025*	• *Regulation 15: Individual Care Plan (ICP).* • *Regulation 16: Therapeutic Programmes and Services.* • *Regulation 21: Privacy.* • *Regulation 22: Premises.* • *Regulation 26: Staffing.* • *Regulation 27: Maintenance of Records.* • *Regulation 32: Risk Management Procedures.* • *Rules Governing the use of Seclusion.*	*The MHC notes the positive developments with the MART and Medication Management Policy review.* *As per the new condition of registration of 1 March 2026, the MART is now part of the condition rather than this IAN.*
Regulatory Compliance Meeting 10000283	*16/07/2025*	*The MHC decided to communicate its concerns around sustained areas of non-compliance and risk.* *Areas of repeated non-compliance:* • *Regulation 15: ICP (non-compliant on last 5 inspections) – last 2 years has been critical, 2025 Critical rating.* • *Regulation 16:Therapeutic services & programmes – 2025 Critical rating.* • *Regulation 22: Premises – 2025 Critical rating.*	*QIP submitted and actions followed up through IAN 10000367.*

		• *Regulation 26: Staffing – 2025 Critical rating – last 2 years.* • *Regulation 23: Ordering, prescribing, storing and administration of medicines – 2025 High rating.* • *Regulation 32: Risk management procedures – 2025 Critical rating – last 3 years.* • *COP on the use of physical Restraint – 2025 Critical rating.* • *Rules governing use of seclusion (non-compliant for past 6 years) – 2025 Critical rating.* • *Trends in the restrictive practices were also on the agenda.*	
Proposal to Attach a Condition of Registration / Attachment of a Condition of Registration	*1 March 2026*	*Condition 1: The registered proprietor shall implement the actions specified in the most recent Management of Actions & Reporting Template (MART) submitted to the Mental Health Commission by the HSE on 1 December 2025. The registered proprietor shall submit updates on the implementation of the plan in the form and frequency prescribed by the Commission.*	*New condition continued on from last condition. As of 1st April 2026, 88% of actions were complete and 12% were outstanding.*

1.7 Escalation and enforcement actions commenced following this inspection

None.

2.0 Governance

In 2024, the HSE was restructured and was divided into six new HSE Health Regions, each consisting of Integrated Healthcare Areas (IHA); this replaced the former hospital groups and Community Healthcare Organisation (CHO) structure. The Acute Psychiatric Unit (APU) Tallaght, formerly part of Dublin South, Kildare and West Wicklow (DSKWW) CHO, was located within the IHA of Dublin Southwest and within the wider HSE Dublin and Midlands Health Region. The transition to the new management structure was ongoing at the time of inspection.

A meeting of the CHO DSKWW Executive Management Team was convened monthly and was chaired by the Head of Service, Mental Health. Agenda items included regulatory compliance; human resources/operational processes; finance; estates; IHA structure; and quality, safety and service improvement (QSSI). The DSKWW Mental Health Services Quality and Patient Safety Committee met quarterly and was chaired by the Executive Clinical Director. Areas addressed within this forum included governance; risk management; incidents; health and safety; infection prevention control; safeguarding; complaints/compliments; local QSSI update; compliance; and training. At local level, four distinct committees reported to the APU Senior Management Team, which convened monthly, namely the Unit Operations committee; Compliance committee; QSSI committee, and the Integrated APU/TUH Facilities committee. Several previously established sub-committees were reconfigured to report to these four committees, including: Policies; Restrictive Practice Reduction and Oversight; Individual Care Planning; Electroconvulsive Therapy; Medications Management; Therapeutic Services and Programmes; Safewards; Safeguarding; Incident Review; Maintenance; and a Nutrition and Hydration Steering Group. Clearly defined reporting and communication pathways were in place. A governance improvement project had commenced since the last inspection. As part of the project, a review of existing governance arrangements was examined including committee structures, membership, terms of reference and escalation pathways. A revised governance structure was developed, and implementation of identified actions was ongoing.

In 2025, the inspection of the approved centre found thirteen non-compliances, including 8 critical breaches of regulation. An Immediate Action Notice (IAN) following the 2025 annual inspection was issued by the Mental Health Commission to the service, requiring immediate actions to address continued high levels of non-compliance. A HSE Management Action Report Template (MART) was subsequently developed by the service to address all areas of non-compliance identified in the 2024 and 2025 annual inspections. Implementation of the MART was underway within the APU Tallaght, with active support and resource allocation provided by management of the service, leading to a significant improvement in compliance in 2026. Phase-one of planned construction works was nearing completion, and a detailed plan of phased works and completion dates was provided to the inspection team. Although the approved centre was non-compliant with Regulation 22: Premises, the approved centre was not in breach of the existing condition of registration. This was due to the commencement of renovation works to address ligature risks, patient safety and privacy.

Regulation 32: Risk Management Procedures was found non-compliant and was risk rated high. Although improvements in relation to risk management were identified on this inspection, the risk management

procedures did not actively reduce identified risks to the lowest practicable level. There was an ongoing safety risk to residents associated with hazards present in seclusion rooms on both Rowan and Cedar wards. The seclusion room on Cedar ward was previously decommissioned and was reopened for use while works to Aspen ward were taking place. Actions required to address the risk involved capital works to renovate seclusion areas. This work had commenced and was ongoing at the time of inspection. However, there were no specific precautions in place to control this risk.

Heads of discipline had received training in risk management, incident management and health and safety. A risk advisor was available to the approved centre and persons with responsibility for risk were known by staff. The approved centre had a local risk register which contained health and safety risks, clinical risks and corporate risks. The risk register contained control measures in place to mitigate the risks identified, along with further actions required. There was a process to escalate risks, as necessary, to the Head of Service risk register.

Incidents were reported and risk assessed using the National Incident Management System (NIMS) and all clinical incidents were reviewed by the multi-disciplinary team. The approved centre implemented the HSE Incident Management Framework, as required. However, one Category 2 incident was not reviewed in line with the approved centre's incident management policy. The incident was not notified to the Mental Health Commission (MHC) in line with both the approved centre policy and MHC Guidance on Quality and Safety Notifications. At the time of inspection, the incident was retrospectively notified to the MHC, and an appropriate review of the incident was scheduled.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. All heads of discipline had defined strategic aims in relation to the approved centre. All disciplines had a system in place for supervision or professional development planning with staff. Clinical staff providing care and treatment to residents of the approved centre included nursing, consultant psychiatrists, non-consultant hospital doctors, social work, occupational therapy, psychology, and speech and language therapy. Residents also had access to a dietitian and a pharmacist. Since the last inspection, a dedicated psychologist was recruited for the approved centre, and a vacant occupational therapy post had been filled. A staff training schedule was in place, and most staff had completed the required mandatory training. Where minor deficits arose, staff were scheduled to complete the relevant training at upcoming sessions.

APU Tallaght continued to report a high number of restrictive practices since the last inspection. A Restrictive Practice Reduction and Oversight Committee was in place. Several recommendations from this committee were identified, and an action plan was developed with timelines and responsibilities allocated. Recommendations focused on strengthening leadership, staff education, therapeutic environments, and patient-centred care. Implementation of the action plan had commenced and was ongoing at the time of inspection.

The approved centre had developed quality initiatives across many of the inspected regulations at the time of inspection. Quality improvement projects were informed by self-assessment of the Mental Health Commission's National Quality Framework (2023). Examples of quality improvement identified on inspection included a newly established Garda Liaison Clinic, which was held monthly within the approved centre. The

clinic provided access for residents to community-focused services offered by An Garda Síochána, and an opportunity for discussion and information sharing. A consultation with service users who attended APU Tallaght within the past 36 months was undertaken from October 2025 to March 2026, by the Area Lead for Mental Health Engagement. The consultation report together with recommendations was made available to management and staff of the approved centre. At the time of inspection, the establishment of a co-production working group including staff and service users was in progress to support implementation of the recommendations.

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

2.1 Therapeutic Services and Programmes

Therapeutic Services and Programmes
The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Two occupational therapists (OTs) co-ordinated and facilitated the therapeutic programme in the approved centre. The OT attended weekly care planning meetings and provided individual functional assessments. Therapeutic programmes included a music therapist twice a week and an art teacher once a week which was co-facilitated by the OT. The OT also provided weekly groups on cookery, planning ahead, and Recovery Through Activity. Recreational activities such as Fitness Coach, Zumba, and yoga were facilitated by external facilitators. The clinical psychologist carried out individual assessments and interventions. The dietitian and speech and language therapist provided individual assessments and care plans for residents when required. For residents with communication challenges, the speech and language therapist facilitated card and board games to promote communication and social connection. The social work team delivered one to one interventions, and a group on discharge planning every two weeks.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Residents had been referred to orthopaedics, physiotherapy, infection prevention and control, and tissue viability when required.

2.2 Staff Training Record

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (48)	43	90%	43	90%	44	92%	48	100%	48	100%	48	100%
Medical (42)	39	93%	39	93%	41	98%	41	98%	40	95%	42	100%
Occupational Therapist (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Social Worker (12)	12	100%	12	100%	12	100%	12	100%	12	100%	11	92%
Psychologist (10)	10	100%	10	100%	10	100%	10	100%	10	100%	10	100%
Speech and Language Therapist (2)	1	50%	2	100%	2	100%	2	100%	2	100%	2	100%
Healthcare Assistant (3)	3	100%	2	66%	3	100%	3	100%	3	100%	2	66%

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 16: Therapeutic Services and Programmes	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed-Circuit Television	✓	Compliant
Regulation 26: Staffing	✓	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
Rule on the Use of Electro-Convulsive Therapy	✓	Compliant
Code of Practice on the Use of Physical Restraint	✓	Compliant
Code of Practice: Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	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 21: Privacy	✗	Moderate	✗	High	✓		✗	Critical	✗	Moderate
Regulation 22: Premises	✗	Critical	✗	Critical	✗	Critical	✗	Critical	✗	High
Regulation 27: Maintenance of Records	✓		✓		✗	Moderate	✗	Critical	✗	Moderate
Regulation 32: Risk Management Procedures	✗	Moderate	✗	Critical	✗	Critical	✗	Critical	✗	High
Rule on the Use of Seclusion	✗	High	✗	High	✗	Critical	✗	Critical	✗	High
Part 4 Consent to Treatment	✗	High	✓			N/A		N/A	✗	Moderate

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

3.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of 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 no children had been admitted to the approved centre since the last inspection, 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' permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

Ten residents spoke with members of the inspection team. Overall residents identified a number of positive aspects in relation to their experience of the approved centre. Engagements with staff were described as positive, with residents stating that staff were friendly and approachable. Residents reported involvement in care planning and meeting regularly with their MDT. Most residents were happy with the quality and choice of food available, one resident reported that they did not like the food. One resident commented that they were not happy with the experience of sharing a bedroom with other residents due to noise levels. Areas for improvement noted by residents included the need for a more varied activity timetable, with suggestions including arts and crafts, fitness classes and gardening activities. Some residents stated that more nursing staff were required to talk to and to accompany residents to the coffee shop. Two residents would like more snacks or sandwiches to be provided to residents in the evenings.

Five service user experience questionnaires were completed and returned to the inspection team:

- One completed questionnaire answered one of the eighteen questions only, with the resident stating that they were happy with the information they were given about their diagnosis, care and treatment. The other four respondents also answered yes to this question.
- Two residents reported that staff members explained what was happening in a way they could understand upon arrival to the approved centre, while two residents reported that they could not remember.
- Three residents stated that medication had been explained to them in a way they could understand, while one resident answered no to this question.
- Three residents were familiar with their individual care plan, and all four residents reported that they

were involved in setting goals.

- Two residents knew who the members of the multi-disciplinary team were, while two residents indicated that they did not. Three out of four residents knew who their keyworker was.
- All four residents indicated that they were able to discuss worries or concerns with a member of staff.
- Three residents reported that there were enough leisure activities during the day, while one resident felt that there weren't enough.
- All four residents reported that there were enough talking therapies if needed.
- Three respondents were happy with how staff talked to them, while one did not answer this question.
- One resident felt that their privacy and dignity were respected, while one resident did not. One resident responded 'neither yes or no' and one respondent did not answer this question.
- Two residents reported that they were able to communicate freely with family, friends or advocates. One respondent answered 'no' to this question and one respondent did not answer this question.
- Two residents felt safe when in the approved centre, while one resident answered, 'neither yes or no'. One respondent did not answer this question.
- Three residents reported that they felt able to give feedback to staff and to make complaints freely, while one resident did not answer this question.
- Respondents were asked to rate their overall experience (one = poor, ten = excellent). Two residents rated their experience as ten, one resident rated their experience as nine, and one resident provided an overall rating of eight.

4.2 Advocacy

The approved centre had access to an advocacy service, and the inspectors received a report from the Peer Advocacy in Mental Health (PAMH) representative. Resident feedback detailed in the report included the following:

Positive aspects of the service as reported by residents:

- Residents reported that they felt cared for and benefited from their stay in the APU Tallaght. Residents stated that nursing staff were respectful, supportive, and kind in their interactions with them, taking time to listen and respond to worries and concerns; staff were protective of confidentiality and were discreet when discussing aspects of their care with residents.
- Residents who participated in activities particularly enjoyed drumming sessions, reporting it as a positive way to vent frustrations.
- Most service users were aware of their rights and how to make complaints should they wish to do so.
- Several residents remarked that they were more meaningfully involved in their individual care plans (ICP) than has been the case on previous admissions. They stated that the multi-disciplinary team (MDT) encouraged them to participate in MDT meetings, that their views were respected, and that their ICP's aligned with their personal recovery goals.
- Most residents were satisfied with the food provided.
- Recent painting and refurbishments have refreshed and improved the overall appearance of the units

according to residents. However, service users would like to see more attractive planting and a more regular cleaning schedule.

- Residents were satisfied with the information provided on their diagnosis, treatment, and care. They stated that the information received was conveyed to them in non-clinical language that was easy to understand.

Areas in need of improvement as reported by residents:

- Residents reported a lack of privacy and secure storage for personal belongings in the multi-bedded rooms. Residents also stated that on occasion they had to wait for staff to be available to access items from the unit storerooms.
- Residents stated that there were not enough interesting and fun activities to pass the time and give structure to their day.
- Residents reported slow response times for completion of maintenance work.
- Some residents felt that their ICP's were not tailored to their individual needs and preferences. Residents also stated that the therapeutic services they needed to achieve and sustain their recoveries were not always available to them.
- Residents reported that they did not always feel safe on the unit.
- Some residents stated that the ongoing closure of Aspen ward for renovations had created challenges due to the presence of higher acuity residents on Cedar and Rowan wards. However, residents also reported that staff were highly visible on the unit and reassuring when approached about their concerns.
- Some residents reported difficulties around timely responses to requests to meet with their social workers.

Overall, the peer advocate described a collaborative approach that was supportive of the work of the Peer Advocacy in Mental Health service. Staff of the approved centre met with the advocate regularly and were receptive to and appreciative of the advocate's feedback. A consultation room was made available for the advocate and residents to meet in private.

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
- Clinical Director
- General Manager Compliance
- Area Director of Nursing
- Director of Nursing
- Occupational Therapy Manager
- Principal Psychologist
- Principal Social Worker
- Area Lead for Mental Health Engagement
- Assistant Director of Nursing
- Assistant Director of Nursing Compliance
- Clinical Nurse Manager III
- Clinical Nurse Manager III Compliance
- Clinical Specialist Speech and Language Therapist
- Clinical Nurse Manager II x 2
- Integrated Service Lead

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 21: Privacy

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Residents in the approved centre were called by their preferred name based on their self-identification. Staff displayed professional, engaging and compassionate attributes in their interactions with residents. Staff ensured discretion when discussing the resident's condition or treatment needs, and sought the resident's permission before entering their room, as appropriate.

Three single bedrooms did not have locks on the inside of the door. Work to the doors was due to be completed as part of the ongoing renovation works in the approved centre. Residents had access to a property room which was locked and to lockable storage lockers.

Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

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

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times, as three bedrooms did not have locks on the inside of the door.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents in the approved centre had access to personal space and appropriately sized communal rooms. There was suitable and sufficient heating in bedrooms and day areas. Rooms were ventilated and suitably sized and furnished to remove excessive noise or acoustics. Sufficient spaces were provided for residents to move about, including outdoor spaces.

The registered proprietor did not ensure that the conditions of the physical structure and the overall approved centre environment were maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, as high-risk ligature anchor points were not minimised to the lowest practicable level, based on risk assessment. Ligature reduction works were ongoing at the time of inspection.

Not all hazards were minimised as there were hard and sharp edges in the seclusion room in Cedar and Rowan Units.

The approved centre was not kept in a good state of repair externally and internally. Several fire doors were in need of replacement or repair.

Current national infection control guidelines were not followed as three clinical waste bins were located in general patient areas.

The approved centre had a designated sluice room, and a designated cleaning room, as appropriate.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet per floor. Other assisted devices and equipment were available if required, including assisted toilet seats, wheelchairs, a hoist, and high/low-rise beds in both Rowan and Cedar Units.

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

a) The registered proprietor did not ensure that the conditions of the physical structure and the overall approved centre environment was maintained with due regard to the specific needs of residents and the safety and wellbeing of residents as high risk ligature anchor points were not minimised to the lowest practicable level, based on risk assessment, 22(3).

b) The registered proprietor did not ensure hazards, including hard and sharp edges, were minimised as there were hard and sharp edges in the seclusion room in Cedar and Rowan, 22(3).
c) The registered proprietor did not ensure that the approved centre was kept in a good state of repair externally and internally, as several fire doors were in need of replacement or repair, 22(3).
d) The registered proprietor did not ensure current national infection control guidelines were followed as three clinical waste bins were located in general patient areas, 22(3).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Written policies and procedures were available in relation to the creation of records; access to records; retention of records; and the destruction of records. The approved centre policy on the maintenance of records was dated October 2024.

All resident records were physically stored together, where possible. Records were appropriately secured throughout the approved centre from loss or destruction, tampering and unauthorised access or use.

Not all residents' records were in good order and used in accordance with national guidelines and legislative requirements. In two residents' property lists, two resident identifiers were not used, only one. In seven individual care plans, the full name of each member of the multidisciplinary team was not recorded. In one set of seclusion records, there were writing errors in the 15-minute observations. Writing had been crossed out and was not initialled by staff.

Resident records were reflective of the residents' current status and the care and treatment being provided.

Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

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

a) **The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness as they were not used in accordance with national guidelines and legislative requirements. Two resident identifiers were not on two residents' property lists, 27(1).**
b) **The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness as they were not used in accordance with national guidelines and legislative requirements. In seven individual care plans the full name of each member of the multi-disciplinary team were not recorded, 27(1).**
c) **The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness as they were not used in accordance with national guidelines and legislative requirements. Writing errors in 15 minutes observations for a resident who was in seclusion had been crossed out and had not been initialled by staff, 27(1).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written risk management policy dated April 2025. The policy included requirements relating to the roles and responsibilities for risk management and the implementation of the risk management policy within the approved centre; the process of identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre; and the methods for controlling specified risks.

Responsibilities were allocated at management level and throughout the approved centre. The person with responsibility for risk was identified and known by all staff.

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

Not all health and safety risks were identified, assessed, treated, reported and monitored by the approved centre. There were hazards present in the seclusion rooms in both Rowan and Cedar Units. Actions required to address the risk involved renovation works, and this work was ongoing at the time of inspection but there were no specific precautions in place to control the risk.

Individual risk assessments were completed prior to and during the following: resident seclusion; physical restraint; specialised treatments such as electro-convulsive therapy; resident admission; resident transfer; resident discharge; and in conjunction with medication requirements or administration.

One serious incident involving a resident was not managed in line with the approved centre's incident management policy. The incident was not notified to the Mental Health Commission, in line with the Mental Health Commission's Guidance on Quality and Safety Notifications and in line with the approved centre's own policy.

The approved centre had an emergency plan that specified responses by approved centre staff to possible emergencies. The emergency plan incorporated evacuation procedures.

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

a) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre, as one serious incident was not reviewed in line with the approved centre policy, 32(1).**
b) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre, as precautions were not in place to control all identified risks, 32(1).**

7.0 Inspection Findings – Rules

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

*Please see **Section 3.1: Compliant areas on this inspection** for the list of compliant rules on this inspection.*

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

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated April 2025. The policy addressed:

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

The approved centre had a written policy on the reduction of the use of seclusion which had been reviewed in November 2023. The policy addressed:

- How the approved centre aims to reduce or, where possible eliminate, the use of seclusion.
- 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 will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion.

The approved centre had a policy and procedures for training all staff involved in seclusion. The policy addressed:

- Who will receive training based on the identified needs of persons who are secluded and staff.
- The areas to be addressed within the training programme.
- The identification of appropriately qualified person(s) to give the training.
- The mandatory nature of training for those involved in seclusion.

Training and Education: There was a written record indicating that all staff involved in the use of seclusion had read and understood the policies. The training record was available to the inspection team.

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

Evidence of Implementation:

Seclusion facilities: Two seclusion rooms were operational within the approved centre at the time of inspection. The seclusion rooms allowed for staff to be able to clearly observe the person within the seclusion rooms. The rooms had externally controlled heating and air conditioning, which enabled those observing the person to monitor the room temperature. Both seclusion rooms had ready access to sanitary facilities. The rooms were large enough to support the person and team of staff who may be

required to use physical interventions during transition to seclusion.

Seclusion facilities were not furnished and maintained in such a way that ensures the person's inherent right to personal dignity and ensured that the person's privacy is respected as the integrated blinds on doors and windows in seclusion rooms were not operational.

The construction of the seclusion rooms was not designed to withstand high levels of violence with the potential to damage the physical environment as the window in each room was large and not designed to withstand high levels of violence. A ligature point and an electrical fixture were observed within the rooms.

One seclusion room was not in an area away from communal sitting rooms and sleeping accommodation.

All furniture and fittings in the seclusion rooms were not of such a design and quality as not to endanger the safety of the person in seclusion as there were sharp edges present at the time of inspection.

Orders for Seclusion: Two episodes of seclusion were inspected. In each episode, seclusion was initiated by a registered medical practitioner (RMP) and/or the most senior registered nurse (RN) on duty. Seclusion was only initiated following as comprehensive an assessment of the person as practicable. This included a risk assessment; the outcome was recorded in the clinical file.

Dignity and Safety: The clothing worn in seclusion respected the right of the person to dignity, bodily integrity and privacy.

Monitoring of the Person: The person placed in seclusion was kept under direct observation by a RN for the first hour following the initiation of seclusion.

A written record of the person was made by a RN every 15 minutes. In one episode, the written record did not include: the person's level of awareness; the person's physical health, especially with regard to breathing, pallor or cyanosis; whether elimination/hygiene needs were met; and whether hydration/nutrition needs were met. In another episode, the written record did not include whether elimination/hygiene needs were met, and whether hydration/nutrition needs were met.

In two episodes, the Seclusion Care Plan did not include the meeting of the person's food/fluid needs; meeting of the person's needs in relation to personal hygiene, and meeting of the person's elimination needs.

Ending of Seclusion: Seclusion was ended by a RMP at any time following discussion with the person in seclusion and relevant nursing staff; or by the most senior RN in the unit/ward, in consultation with the person in seclusion and a RMP.

The person was informed of the ending of an episode of seclusion. An in-person debrief followed every episode of seclusion. 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

seclusion.

Clinical Governance: The episodes of seclusion were reviewed by members of the multi-disciplinary team (MDT) involved in the person's care and treatment, and were documented in the clinical file as soon as practicable and, in any event, no later than five working days after the episode of seclusion. The MDT review was documented and recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

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

a) **The registered proprietor did not ensure that a written record of the person was made by a registered nurse every 15 minutes which included the persons level of awareness, their physical health, especially with regard to breathing pallor or cyanosis, whether elimination and hygiene needs were met and whether hydration and nutrition needs were met, 5.3.**
b) **The seclusion room in Rowan Unit was not designed to withstand high levels of violence with potential to damage the physical environment as there was a large window on one wall of the room, 8.1(i).**
c) **Seclusion facilities were not furnished or maintained in such a way that ensured the person's inherent right to personal dignity and that the person's privacy was respected as the integrated blinds on doors and windows were not operational, 8.1.**
d) **The fittings in the seclusion room were not of such a design and quality as not to endanger the safety of the person in seclusion as there were hard and sharp edges observed, 8.3.**
e) **The seclusion room on Cedar Ward was on the corridor close to communal sitting rooms and sleeping accommodation, 8.1(ix).**
f) **There was a ligature point and electrical fixtures in seclusion rooms 8.1(ii).**
g) **The Seclusion Care Plan did not include the meeting of the person's food/fluid needs, the person's needs in relation to personal hygiene, and meeting of elimination needs 5.7.**

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 non-compliant on inspection. Please see ***Section 3.2: Non-compliant areas on this inspection****.*

Part 4 Consent to Treatment

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The clinical file of a patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined.

In this file, Form 17, "Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) - Unable to Consent", which was completed on behalf on the patient, did not contain the name of the medication(s) prescribed.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because in one clinical file, Form 17 did not contain the name of the medication(s) prescribed.

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

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 21: Privacy					
Reason ID : 10007634		**The registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times, as three bedrooms did not have locks on the inside of the door.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	As part of the APU's capital works, single bedroom doors to be replaced with anti-ligature, anti-barricade doors complete with locks with an over-ride function for safety.	Capital programme of works- regularly monitored through HSE estates engagement with Tallaght APU management and capital project team A quarterly Privacy Audit completed and an Action Plan developed for any issues.	The new doors will improve patient safety by reducing ligature risks, preventing effective barricading, and enabling staff to gain rapid access in an emergency while maintaining appropriate privacy	30/06/2027	Registered Proprietor nominee - APU Compliance GM, TUH Technical Services and HSE Estates
Preventative Action	As part of the APU's capitol works all single bedroom doors to be replaced with anti-ligature, anti-barricade doors complete with locks with an over-ride function for safety	A quarterly Privacy Audit completed and an Action Plan developed for any issues. Capital programme of works for Tallaght APU	The new doors will improve patient safety by reducing ligature risks, preventing effective barricading, and enabling staff to gain rapid access in an emergency while maintaining appropriate privacy	30/06/2026	Resitered proprietor nominee - APU Compliance GM, TUH Technical Services and HSE Estates

Regulation 22: Premises					
Reason ID : 10007635		**The registered proprietor did not ensure that the conditions of the physical structure and the overall approved centre environment was maintained with due regard to the specific needs of residents and the safety and wellbeing of residents as high risk ligature anchor points were not minimised to the lowest practicable level, based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A ligature audit was completed in September 2025 and June 2026 and a risk management plan to minimise high risk ligature points has been developed. A Capital Programme is underway which will address high risk ligature points, risks within the seclusion room and the replacement of fire doors. regard to ligature points and to oversee the reduction/management of same.	Ligature audit is completed annually or more frequently as required during the Capital Programme of works.	A Capital Programme is underway which will address high risk ligature points, risks within the seclusion room and the replacement of fire doors. regard to ligature points and to oversee the reduction/management of same.	30/06/2027	Clinical Director/ Registered Proprietor Nominee - Tallaght APU Compliance GM
Preventative Action	Daily and weekly environmental checks identify any new or previously unidentified ligatures within the unit. There is a process in place for staff to report maintenance issues relating to ligatures. A weekly	Ligature audit is completed annually	A Capital Programme is underway which will address high risk ligature points, risks within the seclusion room and the replacement of fire doors. regard to ligature points and to oversee the reduction/management of same.	30/06/2027	Clinical Director/ Registered Proprietor Nominee - APU Compliance GM

	Maintenance Tracker meeting is attended by the ADON, Facilities Manager, HSE Estates and admin. A ligature reduction committee sits regularly to assess the status of the Approved Centre with regard to ligature points and to oversee the reduction/management of same.				
Reason ID : 10007636		**The registered proprietor did not ensure hazards, including hard and sharp edges, were minimised as there were hard and sharp edges in the seclusion room in Cedar and Rowan, 22(3)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The seclusion room in Rowan and Cedar are part of the APU'S capital works programme and are due to be refurbished in Stages B & C of the capital programme, commencing May 2026. A new anti-vandal, anti-ligature window will be installed , ligature points will be removed. and hard and sharp edges will be removed.	Ligature audit was completed in September 2025 and June 2026 and a risk management plan to minimise high risk ligature points has been developed. A Capital Programme is underway which will address high risk ligature points	An ligature audit is completed annually or more frequently as required during the capital programme of works	31/12/2026	Clinical Director/ Registered Proprietor Nominee - APU Compliance GM
Preventative Action	Cedar seclusion will be decommissioned as a seclusion room in Q2 of 2027 and utilised as a	ligature audit is completed, and a risk management plan to minimise high risk	Daily and weekly environmental checks are conducted to identify any new or previously unidentified	31/12/2026	Clinical Director

	de-escalation room. Daily and weekly environmental checks identify any new or previously unidentified ligatures within the unit. There is a process in place for staff to report maintenance issues relating to ligatures	ligature points is developed.	ligature risks within the unit. A clear process is in place for staff to promptly report and address maintenance issues related to ligature risks.		
Reason ID : 10007637		**The registered proprietor did not ensure the approved centre was kept in a good state of repair externally and internally, as several fire doors were in need of replacement or repair, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Phase 2 of a programme of capital works is underway which will address the need to replace fire doors which are beyond repair. .	Full Phase will be complete by Q2 2027	Full Phase will be complete by Q2 2027	30/07/2027	Clinical Director, HSE Estates, Registered Proprietor Nominee - APU Compliance GM
Preventative Action	Daily and weekly environmental checks identify any issues of concern. There is a process in place for staff to report maintenance issues A weekly Maintenance Tracker meeting is attended by the ADON, Facilities Manager, HSE Estates and Admin. If items remain unresolved, they are escalated to the Integrated Facilities	Full Phase will be complete by Q2 2027	Daily and weekly environmental checks identify any issues of concern. There is a process in place for staff to report maintenance issues A weekly Maintenance Tracker meeting is attended by the ADON, Facilities Manager, HSE Estates and Admin. If items remain unresolved, they are escalated to the Integrated Facilities Management Committee. Fire door inspections take place bi-annually	30/06/2027	Clinical Director - HSE Estates- facilities manager

	Management Committee. Fire door inspections take place bi-annually				
Reason ID : 10007638		**The registered proprietor did not ensure current national infection control guidelines were followed as three clinical waste bins were located in general patient areas, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All clinical bins located in general patient areas were removed at the time of Inspection	This is now been incorporated into the weekly environmental checklist to support ongoing monitoring and ensure continue compliance	On inspection, all clinical bins located in general patient areas were removed	24/04/2026	ADON , CNM3- Nurse Manager
Preventative Action	All clinical bins located in general patient areas were removed	This is now been incorporated into the weekly environmental checklist to support ongoing monitoring and ensure continue compliance	On inspection, all clinical bins located in general patient areas were removed	24/04/2026	ADON - CNM3 - Nurse Manager

Regulation 27: Maintenance of Records					
Reason ID : 10007639		**The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness as they were not used in accordance with national guidelines and legislative requirements. Two resident identifiers were not on two residents' property lists, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Property lists reviewed to ensure compliance with national guidelines i.e that all documentation have two patient identifers	Weekly review of patient documentation i.e property list	Achievable and realistic	30/09/2026	Clinical Nurse Manager 2
Preventative Action	Ongoing, planned staff education on the admission and discharge process to ensure all standards are complied with e.g. patient identifiers are in place	Quarterly mantainence of records audits. Weekly review of patient property documentation by CNM2	Achievable and realistic	30/09/2026	Clinical Manager 2 & 3
Reason ID : 10007640		**The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness as they were not used in accordance with national guidelines and legislative requirements. In seven individual care plans the full name of each member of the multi-disciplinary team were not recorded, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure that all individual care plans record the full name and professional designation of every member of the multidisciplinary team involved in the resident's care, in accordance with regulation, national guidelines, and	An audit on ICP's are completed on a monthly basis, results are discussed at compliance and actions and recommendations are implemented.	Provide guidance to all relevant staff on the documentation requirements for multidisciplinary team records. Monitor compliance through monthly audits and provide feedback where improvements are required.	30/09/2026	Clinical Director/ ICP Committee/ Clinical Teams

	legislative requirements.				
Preventative Action	Since our 2025 inspection, significant work to improve the quality of Individual Care Plans has taken place. Under the governance of the ICP Committee, ICP Champions have been identified and ICP training has been rolled out. A checklist has been developed to assist teams in identifying issues to be included in the ICP. The ICP Audit tool has been revised, and monthly audits have been taking place.	Monthly ICP audits are carried out, with the findings discussed at compliance meetings. Appropriate actions are then taken, and recommendations are implemented to support ongoing compliance and continuous improvement.	Provide guidance to all relevant staff on the documentation requirements for multidisciplinary team records. Monitor compliance through monthly audits and provide feedback where improvements are required.	30/09/2026	Clinical Director/ ICP Committee/ Clinical Teams
Reason ID : 10007641		**The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness as they were not used in accordance with national guidelines and legislative requirements. Writing errors in 15 minutes observations for a resident who was in seclusion had been crossed out and had not been initialled by staff, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff have been made aware that if there is an error, records must be are in accordance with national guidelines and legislative requirements. Any errors made in handwritten records	Audit findings will be discussed, and any non-compliance will be addressed immediately through individual staff feedback and additional training where required.	All staff are required to complete documentation training on HSE land. Continuing Professional Development (CPD) sessions on documentation and record-keeping are provided to all staff to ensure accurate, consistent, and high-quality documentation practices.	30/09/2026	ADON /Nurse Managers

	will be corrected by drawing a single line through the error, entering the correct information, and initialing and dating the amendment.				
Preventative Action	All staff have been informed that all records must be completed in accordance with national guidelines and legislative requirements. If an error is made in a handwritten record, it must be corrected by drawing a single line through the incorrect entry, recording the correct information, and initialing and dating the amendment.	Audit findings will be discussed, and any non-compliance will be addressed immediately through individual staff feedback and additional training where required.	All staff are required to complete documentation training on HSE land. Continuing Professional Development (CPD) sessions on documentation and record-keeping are provided to all staff to ensure accurate, consistent, and high-quality documentation practices.	30/09/2026	ADON's/ Nurse Managers

Regulation 32: Risk Management Procedures					
Reason ID : 10007632		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre, as one serious incident was not reviewed in line with the approved centre policy, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following the inspection, the serious incident involving one resident was reported. The safeguarding policy has since been reviewed and updated, and a clear process for identifying Serious Reportable Events (SREs) has been implemented to support timely recognition and reporting	All Serious Reportable Events (SREs) are reported to the Mental Health Commission	A flowchart has been introduced to support the identification of Serious Reportable Events (SREs) and all staff have been made aware of the process and their responsibilities in relation to implementation	24/04/2026	Clinical Director- Director of Nursing- ADoN
Preventative Action	Following the inspection, the serious incident involving one resident was reported. The safeguarding policy has since been reviewed and updated, and a clear process for identifying Serious Reportable Events (SREs) has been implemented to support timely recognition and reporting	A flowchart has been introduced to support the identification of Serious Reportable Events (SREs) and all staff have been made aware of the process and their responsibilities in relation to implementation	The safeguarding policy has been updated, the SRE identification flowchart has been implemented, and all staff have been informed of the process. Compliance and governance will be monitored through routine governance and oversight.	24/04/2026	Clinical Director - Director of Nursing - ADoN

Reason ID : 10007633		The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre, as precautions were not in place to control all identified risks, 32(1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A Risk Management Process flow has been documented to support the notification and escalation of risks, risks identified are placed on the APU Risk Register in line with the HSE Enterprise Risk Management Policy.	Risk registers are reviewed and updated regularly.	Ongoing monitoring- Captured in minutes of QSSI meeting and Risk Registers.	30/09/2026	QPS Advisor/ Clinical Director/DON/ Head of Service/ Discipline Managers
Preventative Action	Risks are considered by the Department Manager for escalation in line with the Tallaght APU Risk Management Process If escalation is required, the risk assessment form and accompanying risk escalation form is sent to the Chair of the QSSI Committee meeting. The risk assessment is then considered as part of the QSSI Committee for inclusion in the Tallaght APU Risk Register.	Risk registers are reviewed and updated regularly.	Ongoing monitoring- Captured in minutes of QSSI meeting and Risk Registers.	30/09/2026	QPS Advisor/ Clinical Director/DON/ Head of Service/ Discipline Managers

Rules Governing the Use of Seclusion					
Reason ID : 10007625		**The registered proprietor did not ensure that a written record of the person was made by a registered nurse every 15 minutes which included the persons level of awareness, their physical health, especially with regard to breathing pallor or cyanosis, whether elimination and hygiene needs were met and whether hydration and nutrition needs were met, 5.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion documentation reviewed and edited see supporting evidence Seclusion pathway - 15 minute observations - now includes criteria for comments and completion i.e the persons level of awareness, their physical health, their pallor or cyanosis, whether elimination and hygiene needs were met and whether hydration and nutrition needs were met.	Each episode of seclusion is audited and reviewed at monthly review and oversight committee meetings	Realistic and achievable	31/07/2026	Clinical Nurse Manager 3
Preventative Action	Seclusion documentation reviewed and edited see supporting evidence Seclusion pathway - 15 minute observations - now includes criteria for comments and completion i.e the persons level of	Monthly audit and review at review and oversight committee meeting	Achievable	31/07/2027	Clinical Nurse Manager 3

	awareness, their physical health, their pallor or cyanosis, whether elimination and hygiene needs were met and whether hydration and nutrition needs were met.				
Reason ID : 10007626		**The seclusion room in Rowan Unit was not designed to withstand high levels of violence with potential to damage the physical environment as there was a large window on one wall of the room, 8.1(i).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Renovation of seclusion facilities in Rowan are part of Tallaght AC''s capital programme, Stage B commenced May 2026 and completed in July 2026 . As part of these works a new anti-vandal, anti-ligature window was installed .	Building works i.e anti vandal windows are compliant with relevant standards	Achieved	31/07/2026	Registered Proprietor nominee: APU GM for Compliance
Preventative Action	Renovation of seclusion facilities in Rowan are part of Tallaght AC''s capital programme, Stage B commenced May 2026 and completed in July 2026 . As part of these works a new anti-vandal, anti-ligature window was installed and ligature points will be removed. Cameras were upgraded and hard edges were removed	Building works i.e anti vandal windows are compliant with relevant standards	Achieved	31/07/2026	Registered Proprietor nominee: APU GM for Compliance

Reason ID : 10007627		Seclusion facilities were not furnished or maintained in such a way that ensured the person's inherent right to personal dignity and that the person's privacy was respected as the integrated blinds on doors and windows were not operational, 8.1.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Renovation of seclusion facilities in Rowan are part of Tallaght APU's capital programme, Stage B commenced May 2026 and completed in July 2026 . As part of these works a new anti-vandal, anti-ligature window with integrated blind was installed . This is controlled from the nurses station. Integrated blind on the door is mechanically controlled and was demonstrated as working at the time of inspection	Replacement of window and installation of new window and integrated blind outlined in capital works programme	Achieved	31/07/2026	Tallaght APU ADON
Preventative Action	Renovation of seclusion facilities in Rowan are part of Tallaght APU's capital programme, Stage B commenced May 2026 and completed in July 2026 . As part of these works a new anti-vandal, anti-ligature window with integrated blind was installed . This is controlled from the	Daily environmental check	realistic and achievable	31/07/2026	Clinical Manager 2

	nurses station. Integrated blind on the door is mechanically controlled and was demonstrated as working at the time of inspection. Ispection of seclusion facilities part of daily environmental check when not in use				
Reason ID : 10007628		**The fittings in the seclusion room were not of such a design and quality as not to endanger the safety of the person in seclusion as there were hard and sharp edges observed, 8.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Renovation of seclusion facilities in Rowan are part of Tallaght AC''s capital programme, Stage B commenced May 2026 and completed in July 2026 . As part of these works a new anti-vandal, anti-ligature window was installed and hard and sharp edges were removed	Inspected on completion of works by building contractors , HSE Estates and APU management .	Achieved	31/07/2026	Registered Proprietor Nominee - Tallaght APU, GM
Preventative Action	Renovation of seclusion facilities in Rowan are part of Tallaght APU's capital programme, Stage B commenced May 2026 and completed in July 2026 . As part of these works a new anti-vandal, anti-ligature window was installed and hard and	Daily environmental check	Achievable and realistic	31/07/2026	Registered Proprietor Nominee - Clinical Nurse Manager 2

	sharp edges were removed. Visually inspected during daily environmental check when not in use.				
Reason ID : 10007629		**The seclusion room on Cedar Ward was on the corridor close to communal sitting rooms and sleeping accommodation, 8.1(ix).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Renovation of seclusion facilities in Cedar are part of Tallaght APU's capital programme, Stage C which commenced July 2026 and is due to be completed in October 2026. This includes the replacement of the window. Seclusion facilities in Cedar will be de-commissioned when the capital works are completed in Q2 2027	Plan to de-commission Cedar seclusion set out in Capital Works Programme	Achievable and realistic	30/06/2027	Registered Proprietor Nominee - Tallaght APU GM & ADON
Preventative Action	Seclusion facilities in Cedar will be de-commissioned when the APU's capital works are completed in Q2 2027 and will be used as a de-escalation room.	Plan to de-commission Cedar seclusion set out in Capital Works Programme, regular engagement around project progress between Tallaght APU and HSE estates	Achievable and realistic	30/06/2027	Registered Proprietor Nominee - Tallaght APU GM & ADON
Reason ID : 10007630		**There was a ligature point and electrical fixtures in seclusion rooms 8.1(ii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Renovation of seclusion facilities in Rowan are part of Tallaght APU's	Seclusion facilities inspected by building contractors, HSE	Achieved	31/07/2026	Registered Proprietor Nominee - Tallaght APU GM

	capital programme, Stage B which commenced May 2026 and completed in July 2026 . As part of these upgrade works the intercom system was reviewed. Intercom system remains in place with anit-pick mastic now surrounding call button mechanism to prevent damage from tampering and to eliminate the ligature point	estates and APU management on completion of works			
Preventative Action	Renovation of seclusion facilities in Rowan are part of Tallaght APU's capital programme, Stage B which commenced May 2026 and completed in July 2026 . As part of these upgrade works, the intercom system was reviewed. Intercom system remains in place with anit-pick mastic now surrounding call button mechanism to prevent damage from tampering and to eliminate the ligature point. Seclusion facility visually inspected during every review	Capital Programme of works and daily environmental works	Achievable and realistic	31/07/2026	Registered Proprietor Nominee - Clinical Nurse Manager 2

	and during daily environmental inspections when not in use.				
Reason ID : 10007631		**The Seclusion Care Plan did not include the meeting of the person's food/fluid needs, the person's needs in relation to personal hygiene, and meeting of elimination needs 5.7.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion documentation reviewed and edited see supporting evidence Seclusion pathway - Care Plan - now includes instructions for facilitating a service user's elimination and personal hygiene needs being met	Each episode of seclusion is audited and reviewed on a monthly basis at the review and oversight committee meeting	Achievable and realistic	31/07/2026	Clinical Nurse Manager 3
Preventative Action	Seclusion documentaion reviewed and edited - see supporting evidence Seclusion pathway - Care Plan - now includes instructions for facilitatiing a serivce user's elimination and hygiene needs being met	Monthly review and audit	Achievable and realistic	31/07/2026	Clinical Nurse Manager 2& 3

Part 4 of the Mental Health Act 2001: Consent to Treatment					
Reason ID : 10007624		**In one clinical file, Form 17 did not contain the name of the medication(s) prescribed.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ensure that all Form 17s include the full name of all prescribed medication(s) before the form is finalised and filed.	An audit is completed, any omissions identified will be corrected immediately, and audit findings will be recorded and reviewed to ensure compliance.	Audits are conducted, findings are documented and reviewed, and corrective actions are implemented within agreed timeframes to support compliance.	30/09/2026	Clinical Director
Preventative Action	Ensure that all Form 17s include the full name of all prescribed medication(s) before the form is finalised and filed.	An audit is completed, any omissions identified will be corrected immediately, and audit findings will be recorded and reviewed to ensure 100% compliance by the end of the 4-week period.	Audits are conducted, findings are documented and reviewed, and corrective actions are implemented within agreed timeframes to support compliance.	30/09/2026	Clinical Director

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.

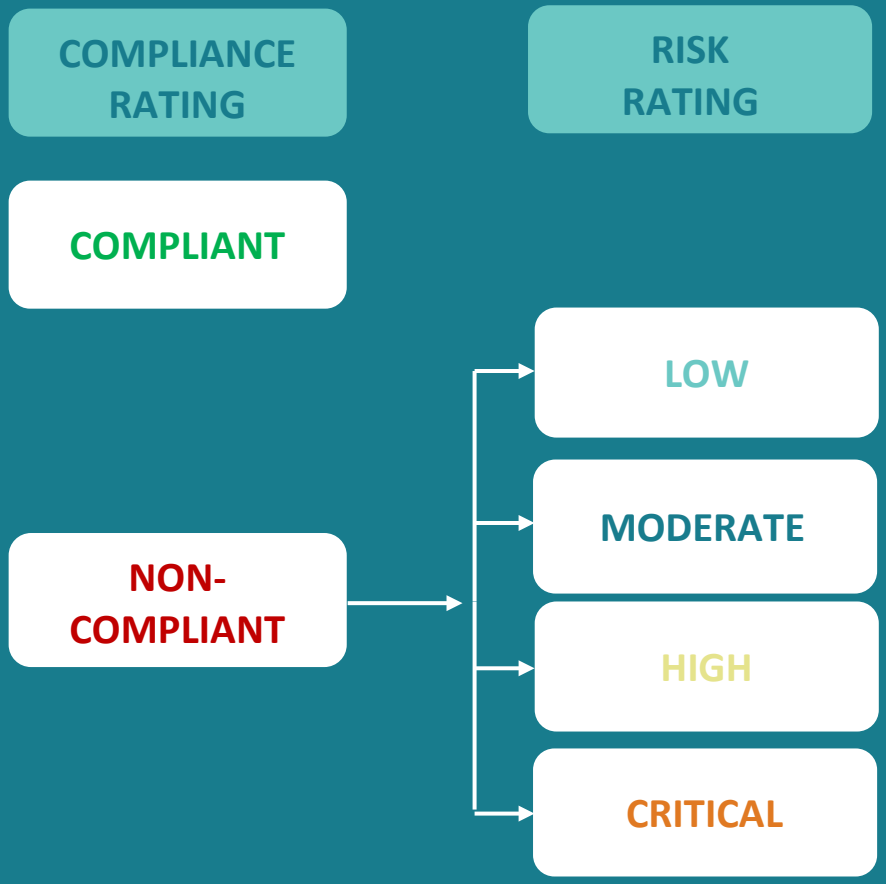
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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