Grangemore Ward, St Otteran's Hospital

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

GRANGEMORE WARD, ST OTTERAN'S HOSPITAL

John's Hill, Waterford

Date of Publication:
31 August 2026

ID Number: AC0153

2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health care / Long stay Mental Health Rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
1 March 2026

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mrs Anne Donaghey

Inspection Team:
Aoife Gallaher, Lead Inspector
Barbara Murphy
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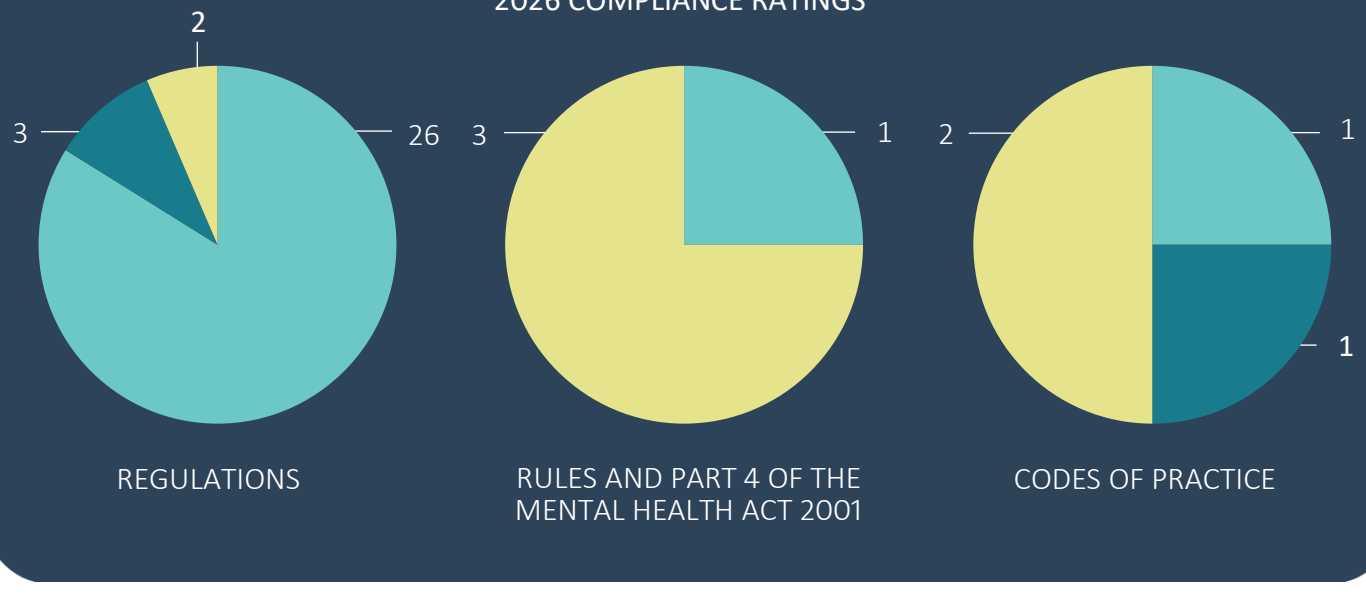
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
10 – 13 March 2026

Previous Inspection date:
22 – 25 July 2025

Inspection Type:
Unannounced Annual Inspection

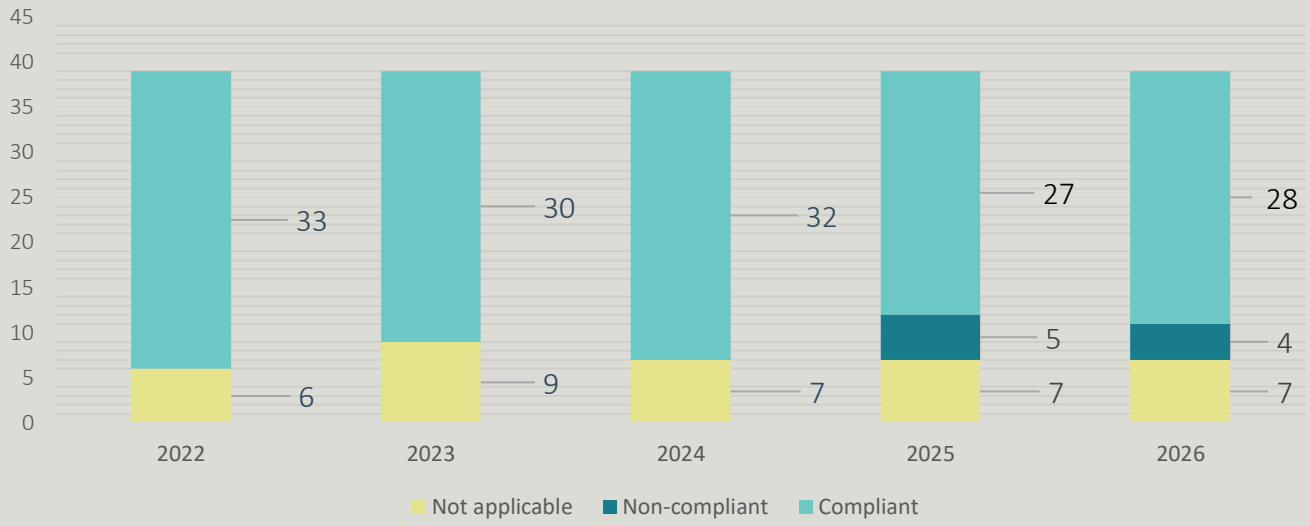
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

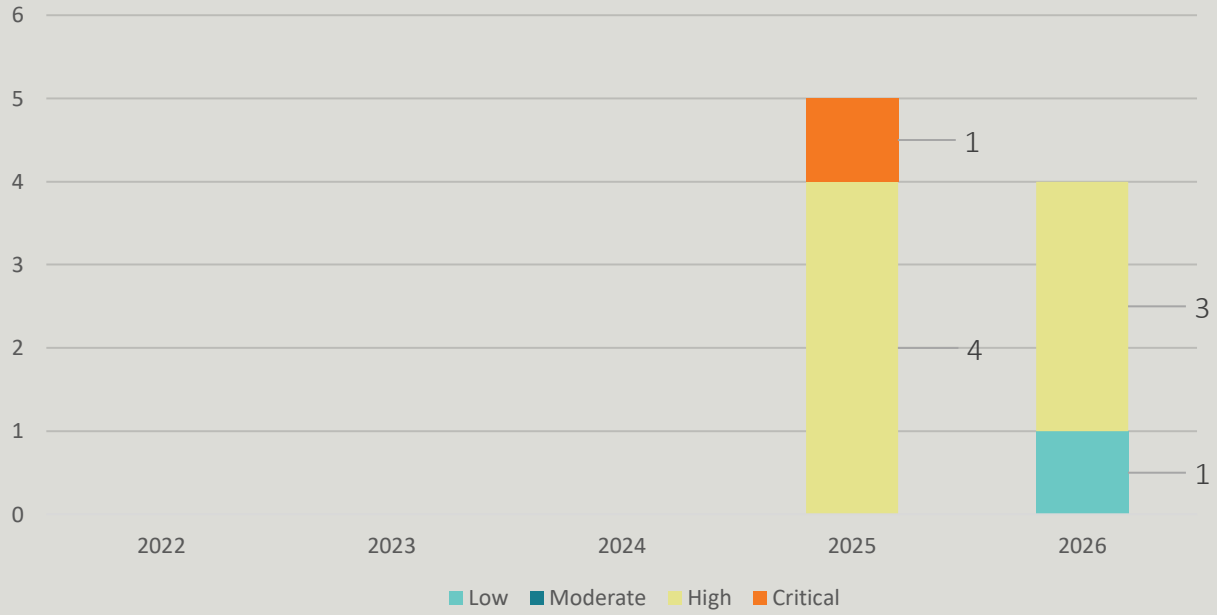
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



Contents

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

Grangemore Ward is a detached two-storey house located on the grounds of St. Otteran's Hospital in Waterford. It was registered with the Mental Health Commission with a bed capacity of 14, for continuing mental health care and mental health rehabilitation. There were 10 residents in the approved centre at the time of inspection, all were under the care of the mental health rehabilitation and recovery multi-disciplinary team.

Accommodation consisted of 14 single bedrooms. Five bedrooms were located on the first floor, with two shared bathrooms and shower facilities. A further nine bedrooms were on the ground floor, five of which were en suite. The remaining four bedrooms shared two bathrooms. Ground floor facilities also included a laundry room and sluice room, a dining room, a recreational room, and a large sitting room with an adjoining small sensory room. There was access to two well-maintained gardens. Residents in the approved centre could attend a unit within the grounds of St. Otteran's Hospital called the "Recovery Hub", which provided therapeutic programmes and activities.

1.2 Inspector of Mental Health Services Summary

The inspection of Grangemore Ward was unannounced and occurred over a four-day period, from the 10th to 13th of March 2026 inclusive. This summary reflects the findings at the time of the inspection only. The inspection was very well co-ordinated by staff and management in the approved centre. Many aspects of service provision exceeded the minimum standards set out in mental health legislation.

In 2025 the service was non-compliant with five areas of regulations which included four high non-compliance findings and one critical non-compliance finding related to Regulation 22: Premises. In 2026 there was a slight decrease in non-compliance with three reoccurring non-compliances, Regulation 23: Ordering, Prescribing, Storing and Administration of Medicine, Regulation 32: Risk Management Procedures and Regulation 22: Premises. Although the risk rating for Regulation 22: Premises had reduced from a critical non-compliance in 2025 to a high non-compliance, concern for safety in the approved centre in relation to faults in fire doors remained. Although some works had been carried out, all remedial fire works had not been completed as per time frame of February 2026 as agreed with Mental Health Commission. This was due to the external contractor not fulfilling its service level agreement. The repair and replacement of some fire doors remained outstanding.

At the time of inspection residents in the approved centre did not have access to a pharmacist. A business case was actively being perused to appoint a pharmacist to the service.

There was a varied programme of recreational and therapeutic activities available to the residents. A high standard of care was delivered by the multi-disciplinary team, with commitment of the staff demonstrated through respectful, engaging interactions with residents as well as quality patient centred care.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***14***
Total number of residents	**10**
Number of detained patients	0
Number of wards of court	0
Number of residents under the Assisted Decision-Making Act	1
Number of children	0
Number of residents in the approved centre for more than 6 months	10
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	100%	100%	100%	84%	88%

1.5 Conditions of registration

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

1.6 Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice 10000375	*31/07/2025*	• *Regulation 22: Premises, risk rated as critical.* • *Regulation 32: Risk Management Procedures, risk rated as high.*	*Three bedroom doors failed to close fully, work due to be completed Friday 1st May 2026*

1.7 Escalation and enforcement actions commenced following this inspection

None.

2.0 Governance

Grangemore Ward is located within the HSE Integrated Healthcare Area (IHA) of Waterford Wexford, which forms part of the HSE Dublin and South East Region. The IHA Mental Health Services Executive Management Team (EMT) convened monthly, as did the IHA Mental Health Services Quality and Safety Executive Committee (QSEC).

At local level, the monthly Grangemore Ward Compliance meeting was attended by senior clinical managers of various disciplines. Agenda items included regulatory, quality and operational issues. The Quality and Patient Safety Committee (QPSC) also met monthly with representation from medical, nursing and health and social care professionals who worked directly in the approved centre in attendance, as well as the risk manager. Escalated matters from the compliance meeting were discussed at QPSC as well as standing agenda items such as regulation and compliance; staff training; mental health engagement and recovery; health and safety and risk management. The QPSC reported to the Quality and Safety Executive Committee (QSEC). Escalation of matters from QPSC were discussed at these meetings as well as agenda items which included: health and safety, complaints and compliments; regulation and compliance; policies, procedures, protocols, and guidelines (PPPG); monitoring and audits; review of the risk register, incidents, and risk assessments. The Executive Management Team (EMT) discussed matters escalated from QSEC meetings, and agenda items such as human resources; strategy; safety and service improvement; finance; capital projects; and key performance indicators (KPI) were reviewed.

There were key personnel with responsibility for risk management. A risk manager was available to the approved centre. The person with overall responsibility for risk was identified and known by staff. The approved centre had a local risk register which contained health and safety risks, clinical risks and corporate risks. A clinical risk identified the risk of errors in the crushing of medications and lack of review by a registered pharmacist for residents on high dose antipsychotic treatment (HDAT) due to no direct input from a registered pharmacist in the approved centre. A business case to provide pharmacy input was under discussion. However, at the time of inspection residents did not have access to a pharmacist and there was insufficient pharmacy oversight of HDAT.

Health and safety risks identified incomplete fire door repair and replacement works. As the contractor did not complete works within the agreed timeframe, repair and replacement of some fire doors remained outstanding. It was reported by a member of the senior leadership team that the contractor would return to close out all remedial issues that were raised during the inspection. Due to prolonged lead time to receive new fire doors, works to replace remaining three fire doors were due to commence in April 2026.

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 residents in the approved centre were under the care of the rehabilitation team which included included nursing, medical, social work, occupational therapy and psychology disciplines. A staff training schedule was in place, and required staff had completed all required mandatory training.

Resident engagement in governance and quality improvement processes was facilitated throughout the service. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service. The peer advocate visited the approved centre bimonthly, and residents were also able to contact the advocate via phone or video link. Resident community meetings, suggestion boxes, and engagement with the complaints process were utilised to maximise resident feedback to management. The Area Lead for Mental Health Engagement was a member of the senior management meetings and provided feedback about resident experiences of mental services from across the region. The process for making complaints and the Complaints Officer contact details and were displayed within the approved centre and in the resident information booklet. Minor complaints were dealt with by the staff in the approved centre and were documented with clear actions and outcomes detailed.

2.1 Therapeutic Services and Programmes

Therapeutic Services and Programmes
The registered proprietor ensured that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan (ICP). The registered proprietor also ensured that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. One-to-one occupational therapy (OT) sessions were provided twice a week based on the identified need in the resident's ICP and were guided by the resident's preference and treating team. OT sessions included: Graded Exposure; Anxiety Management; Physical Activation; Mindfulness Through Arts and Craft; Cooking; Sensory; learning assessments; and seating assessments in conjunction with primary-care OT. Group OT sessions were provided four times a week in the following areas: Exercise; Cooking; Mindfulness Through Walking; Creativity; and Upcycling (creative reuse of old materials). The social worker provided one-to-one sessions twice a week and covered specialised areas including decision support arrangement queries, social welfare entitlement concerns, housing and accommodation, and family relationships. Psychology was available for specialised one-to-one sessions twice a week and included a drop-in clinic one afternoon a week from 2pm to 4pm. The services of a dietitian, speech and language therapist, and physiotherapist were provided externally and in accordance with the needs identified in the resident's ICP. These services were provided in the approved centre or where possible, residents were supported by staff to attend outside of the approved centre if physically able to do so.

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 (17)	17	100%	17	100%	17	100%	17	100%	17	100%	17	100%
Consultant (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
NCHD (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

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 21: Privacy	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 26: Staffing	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 30: Mental Health Tribunals	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Rule on the Use of Mechanical Restraint	✓	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 22: Premises	✓		✓		✓		✗	Critical	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✗	High	✗	High
Regulation 32: Risk Management Procedures	✓		✓		✓		✗	High	✗	High
Code of Practice on the Use of Physical Restraint	✓			N/A		N/A	✓		✗	Low

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

3.3 Areas that were not applicable on this inspection

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

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 quick-response code (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.

The inspection team met with one resident and six completed questionnaires were returned. A QR code was included on the questionnaire as another means for residents to complete questionnaires.

Some comments from residents included that the food was generally good, but that Saturday's menu always consisted of soup and sandwiches and that a change to that would be welcomed. This suggestion of a change to the menu had also been communicated within the community meeting minutes on several occasions, with some residents suggesting certain menu options.

Four out of six residents indicated they were familiar with their individual care plan, five out of six indicated there were enough talking therapies available. All residents knew who their mental health care team were, who their keyworker was, all residents felt safe, and all were able to talk about worries or concerns with staff as soon as they needed to, and all said they could communicate freely with family and friends. The most positive aspects of the residents' experience included the care provided by the staff, moments in the dining room and socialization, feeling safe, friendly staff, feeling like home, and going for a drive on the bus with the nurses.

On a scale of 1-10, with 1 being poor and 10 being excellent, the overall experience of care and treatment was rated 6,7,8, 9 and two 10's.

4.2 Advocacy

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

Positive Aspects of the Service included:

- Residents reported having autonomy in personal choices, including selecting and purchasing their own clothing.
- Residents spoke positively about activities available within the service, including the music group, iPad music sessions, up-cycling, cooking, flower arranging, and planting seeds and flowers.
- The return of the bus service was highlighted as a positive development, allowing residents to go on outings, including trips to Tramore and Dunmore East.
- Residents reported that opportunities to visit family members were facilitated and valued.
- Residents stated that their privacy was respected.
- Residents reported that the food provided was of good quality.
- Residents indicated that they could contribute during multi-disciplinary meetings and felt that their views were listened to.
- Engagement with psychology services was described as helpful.
- Residents commented that the environment was very clean and well maintained.
- Residents reported feeling well informed and comfortable approaching staff at times when they were unsure about something.
- Support from key nurses was described as positive.
- Staff were described as kind and helpful, and residents reported generally positive relationships with nursing staff.

Areas in Need of Improvement

- Some residents reported that the dining room environment can at times be noisy and uncomfortable.

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:

- Clinical Director
- General Manager
- Registered Proprietor Nominee
- Assistant Director of Nursing MHC Regulatory Compliance Support
- Occupational Therapy Manager
- Social Work Team Leader
- Senior Psychologist
- Consultant Psychiatrist x2
- Assistant Director of Nursing
- Acting Director of Nursing/Clinical Risk Manager

Apologies received from Consultant Psychiatrist, Principal Social Worker and Principal Psychologist.

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 22: Premises

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The registered proprietor ensured that the approved centre was adequately lit, heated and ventilated. Residents had access to personal space and appropriately sized communal rooms were provided.

The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition. There was cracked paint on bedroom walls, a hallway wall was stained, stair bannisters required painting, numerous skylights were dirty and had cobwebs, and the gutter pipes of the approved centre were rusting.

The inspection team noted that the door lock in a vacant single bedroom did not have a lock barrel, resulting in no override function being available in the case that the bedroom door was locked from the inside. This was rectified during the inspection.

The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs and the safety and wellbeing of the residents, staff and visitors. There were numerous issues which would affect fire door functionality in the event of a fire. With one bedroom fire door, there was there was a gap between the door and the door frame. Three sets of cross corridor fire doors failed to close fully, three bedroom doors failed to close fully, two doors were not fully sealed with brush/intumescent strips, one fire exit door did not remain closed when shut, three electromagnetic locks of one door were not secured to the wall, and two sets of electromagnetic locks would not connect in order to keep a fire door open when required.

A senior leadership team member reported that remedial work to repair the outstanding fire door issues on site was due to commence that month, March 2026, and that doors requiring replacement would be replaced in April 2026.

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

a) **The registered proprietor did not ensure that the premises were cleaned and maintained in good structural and decorative condition as a number of bedroom walls required painting, entrance hallway walls to the first-floor wall were marked, stair bannisters required painting, two upstairs Velux windows and the sitting room Velux window were dirty and had cobwebs, and the gutters of the approved centre were rusted, 22(1)(a).**

b) **The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs and the safety and wellbeing of the residents, staff and visitors as one single bedroom door lock did not have a lock barrel, which meant there was no override function for the lock, 22(3).**

c) **The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs and the safety and wellbeing of the residents, staff and visitors due to the fact that there was there was a gap between the doors and the door frame of one bedroom fire door, three sets of cross corridor fire doors failed to close fully, three bedroom doors failed to fully close, two doors were not fully sealed with brush/intumescent strips, one fire exit door would not remain in the closed position when shut, three electromagnetic locks were not secured to the wall, and two sets of electromagnetic locks would not connect in order to keep the fire door open, 22(3).**

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

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a Medication Management Policy available with a last-reviewed date of July 2025 recorded. The Medication Management Policy included the processes for ordering, prescribing, storing, and administering resident medication. The approved centre was in the process of developing their own policies relating to:

- High dose antipsychotic treatment (HDAT)
- Rapid tranquilisation
- Clozapine management
- Lithium management
- Valproate in pregnancy and women of childbearing years
- Detoxification
- Anaphylaxis
- Venous thromboembolism prevention and anticoagulation safety
- Antimicrobial stewardship
- Sepsis recognition and management

In the interim national policies, and National Institute for Health and Care Excellence (Nice) guidelines were utilised.

Five Medication Prescription and Administration Records (MPARs) were inspected and each MPAR contained the following: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident; a clear record of the date of discontinuation for each medication; and the Medical Council Registration Number of every medical practitioner prescribing medication to the resident.

The inspection team were informed that there was no access to a pharmacist on the approved centre's multi-disciplinary team, and a pharmacist was not consulted about the type of preparation to be used for medication. Residents receiving high-dose antipsychotic treatment were being assessed by a consultant with a repeat assessment every six months, but there were no pharmacy assessments or reviews in place.

The registered proprietor did not ensure that the approved centre had access to a Drugs and Therapeutics Oversight Committee that met at least quarterly. No timeframe could be given of when this committee could be established.

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

a) **There was no access to a pharmacist in the approved centre, 23(1).**
b) **The approved centre did not have access to a Drugs and Therapeutic Oversight Committee, 23(1).**
c) **When a resident was identified as receiving high-dose antipsychotic treatment, a pharmacist review was not completed, nor repeated at a minimum, every six months, 23(1).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The risk management policy was last reviewed in October 2025, and the Emergency Plan was last reviewed in November 2025; combined the following was covered:

- The process for the identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre.
- The person with overall responsibility for risk management.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register and the record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The registered proprietor did not ensure that the risk management policy was fully implemented throughout the approved centre.

The clinical risk in relation to insufficient pharmacy oversight of high-dose antipsychotic treatment was not identified, assessed, treated, and monitored. The approved centre had no pharmacy input into the multi-disciplinary team care plan or review of medications prescribed. As a result of this, a pharmacist was not consulted about the type of preparation to be used for medication. Residents receiving high-dose antipsychotic treatment were being assessed by a consultant with a repeat assessment every six months, but there were no pharmacy assessments or reviews in place.

The health and safety risks in relation to incomplete fire door repair and replacement works were not identified, assessed, treated, reported and monitored. Upon inspection, remaining issues were identified which would affect fire door functionality in the event of a fire. Repair and replacement of some fire doors was required.

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

a) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. Clinical risks in relation to insufficient pharmacy oversight of high-dose antipsychotic treatment were not identified, assessed, treated, and monitored, 32(1).**
b) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. Health and safety risks in relation to incomplete fire door repair and replacement works were not identified, assessed, treated, reported and monitored, 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 3.3: Areas that were not applicable on this inspection** for the list of rules that were not applicable on this inspection.*

8.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable on inspection. Please see ***Section 3.3: Areas that were not applicable on this inspection****.*

9.0 Inspection Findings – Codes of Practice

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

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

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

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating LOW

INSPECTION FINDINGS

Processes:

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

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

Training and Education:

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

Monitoring:

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

Evidence of Implementation:

There had been one episode of physical restraint in the approved centre since the last annual inspection. The order for physical restraint confirmed that there were no other less restrictive ways available to manage the person's presentation.

The use of physical restraint was not, however, ended by the staff member responsible for leading the physical restraint.

The consultant psychiatrist was notified about the episode as soon as was practicable, and this was recorded in the clinical file. The person who was restrained was given the opportunity to discuss the episode of physical restraint with members of the multi-disciplinary team involved in the person's care and treatment as part of a structured debrief process.

The approved centre was non-compliant with this code of practice because the use of physical restraint was not ended by the staff member responsible for leading the physical restraint, 5.1.

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 22: Premises					
Reason ID : 10007475		**The registered proprietor did not ensure that the premises were cleaned and maintained in good structural and decorative condition as a number of bedroom walls required painting, entrance hallway walls to the first-floor wall were marked, stair bannisters required painting, two upstairs Velux windows and the sitting room Velux window were dirty and had cobwebs, and the gutters of the approved centre were rusted, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Complete painting, cleaning of windows, and gutter repair.	All listed areas restored and signed off.	Use maintenance team and external contractors as required. These are routine maintenance works.	25/09/2026	Senior Management/ Budgetary Approval & Technical Services/ Approved Contractor
Preventative Action	Implement planned preventative maintenance schedule.	Bi-annual environmental/ Reg.22 Premsises audit scores ≥95%.	Yes	30/11/2026	Senior Management & Technical Services
Reason ID : 10007476		**The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs and the safety and wellbeing of the residents, staff and visitors as one single bedroom door lock did not have a lock barrel, which meant there was no override function for the lock, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Install compliant lock barrel with override function.	Lock replaced and tested.	Single-item repair. Minimal time and cost.	03/04/2026	Senior Management/ Budgetary Apporval
Preventative Action	Add door hardware checks to monthly maintenance/compliance walkround.	100% compliance checklist.	Integrated into existing checks. Simple visual inspection.	03/08/2026	Senior Management
Reason ID : 10007477		**The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs and the safety and wellbeing of the residents, staff and visitors due to the fact that there was there was a gap between the**			

		doors and the door frame of one bedroom fire door, three sets of cross corridor fire doors failed to close fully, three bedroom doors failed to fully close, two doors were not fully sealed with brush/intumescent strips, one fire exit door would not remain in the closed position when shut, three electromagnetic locks were not secured to the wall, and two sets of electromagnetic locks would not connect in order to keep the fire door open, 22(3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Repair/replace all faulty fire doors and electromagnetic locks.	All doors close fully and meet compliance standards.	Engage fire safety contractor. Clearly defined works list.	12/05/2026	Senior Management/Budgetary Approval & Technical Services/Approved Contractor
Preventative Action	Six monthly fire door compliance inspections by competent person.	100% inspection completion with documented outcomes.	Outsource if required. Standard compliance practice. Barrier may be budgetary approval	28/09/2026	Senior Management/Budgetary Approval & Technical Services/Approved Contractor

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10007482		**There was no access to a pharmacist in the approved centre, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Establish formal pharmacist service level agreement.	Pharmacist post documented and active.	Contract external provider if needed. Service Level Agreement. Barrier will be budgetary approval.	01/12/2026	Senior Management/ Budgetary Approval. Business case at IHA Level
Preventative Action	Schedule regular pharmacist input to MDT and medication reviews.	Monthly pharmacist involvement recorded.	Integrate into MDT schedule. Sustainable once contract established. Barrier will be budgetary approval.	04/01/2027	Senior Management
Reason ID : 10007483		**The approved centre did not have access to a Drugs and Therapeutic Oversight Committee, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Establish access to Drugs and Therapeutics Committee (internal or shared).	Committee terms of reference and meeting schedule in place.	Link with group or external provider. Can be shared across services. Barrier will be securing the pharmacist post/budgetary approval	01/12/2026	Senior Management
Preventative Action	Ensure quarterly committee meetings with medication governance oversight.	Minimum 4 meetings annually with recorded minutes.	Align with governance calendar. Routine governance practice. Barrier will be securing the pharmacist post/budgetary approval	04/01/2027	Senior Management
Reason ID : 10007484		**When a resident was identified as receiving high-dose antipsychotic treatment, a pharmacist review was not completed, nor repeated at a minimum, every six months, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Complete pharmacist reviews for all residents on high-dose antipsychotics.	100% reviews completed and documented.	Utilise newly established pharmacist access. Small cohort. Barriers will be budgetary approval for pharmacist post	01/12/2026	Senior Management. Pharmacist business case at IHA Level.
Preventative Action	Introduce 6 monthly automatic review schedule for high-dose cases.	Reg. 23 audit shows 100% adherence to review timelines.	Use digital audit system as tracker. Simple scheduling process. Barriers will be budgetary approval for pharmacist post	04/01/2027	Senior Management. Pharmacist business case at IHA Level.

Regulation 32: Risk Management Procedures					
Reason ID : 10007471		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. Clinical risks in relation to insufficient pharmacy oversight of high-dose antipsychotic treatment were not identified, assessed, treated, and monitored, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Introduce immediate pharmacy oversight for all residents on high-dose antipsychotics, by implementing a pharmacist post for the approved centre.	100% of identified residents reviewed by a pharmacist.	Business case and IHA Lead Level. Engage external pharmacist if internal resource unavailable. Barrier will be no pharmacist post approval.	01/12/2026	Senior Management-Pharmacist Executive Manager 3 has submitted an updated business case to IHA Lead
Preventative Action	Embed pharmacy review into risk management policy and MDT processes.	Quarterly audit demonstrating 100% compliance.	Yes -add review to existing care planning meetings. Requires minimal change to current workflows. Barrier will be no pharmacist post approval.	04/01/2027	Senior Management
Reason ID : 10007472		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. Health and safety risks in relation to incomplete fire door repair and replacement works were not identified, assessed, treated, reported and monitored, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Complete all outstanding fire door repair and replacement works. (Senior Management /Budgetary Approval)	100% of identified defects resolved and logged.	Achieved	12/05/2026	Senior Management /Budgetary Approval & Technical Services/ Approved Contractor
Preventative Action	Ensure 6 monthly (we were advised by inspector 6 monthly) environmental and fire door safety risk audits are carried out by approved contractor (it is recommended that a fire safety professional assesses all door sets to identify their likely fire performance). Grangemore is due a fire	Audit completion rate 100%; issues tracked on risk register.	Assign to maintenance lead. Fits within existing health & safety routines. Potential barriers are budgetary sign of on 6 monthly contract to inspect fire doors	28/08/2026	Senior Management/Budgetary Approval & Technical Services/ Approved Contractor

	door inspection in August 2026.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10007481		**The approved centre was non-compliant with this code of practice because the use of physical restraint was not ended by the staff member responsible for leading the physical restraint, 5.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Provide refresher training on safe termination of restraint.	100% staff trained and competency assessed on audit of Code of Practice Physical Restraint	Short training sessions required. Achieved.	11/03/2026	ADON - CNM2s
Preventative Action	Introduce post-incident review and discussion focus on physical restraint and its termination.	100% of incidents reviewed within 72 hours.	Use existing governance structures. Minimal additional workload.	16/03/2026	ADON -CNM2s

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.

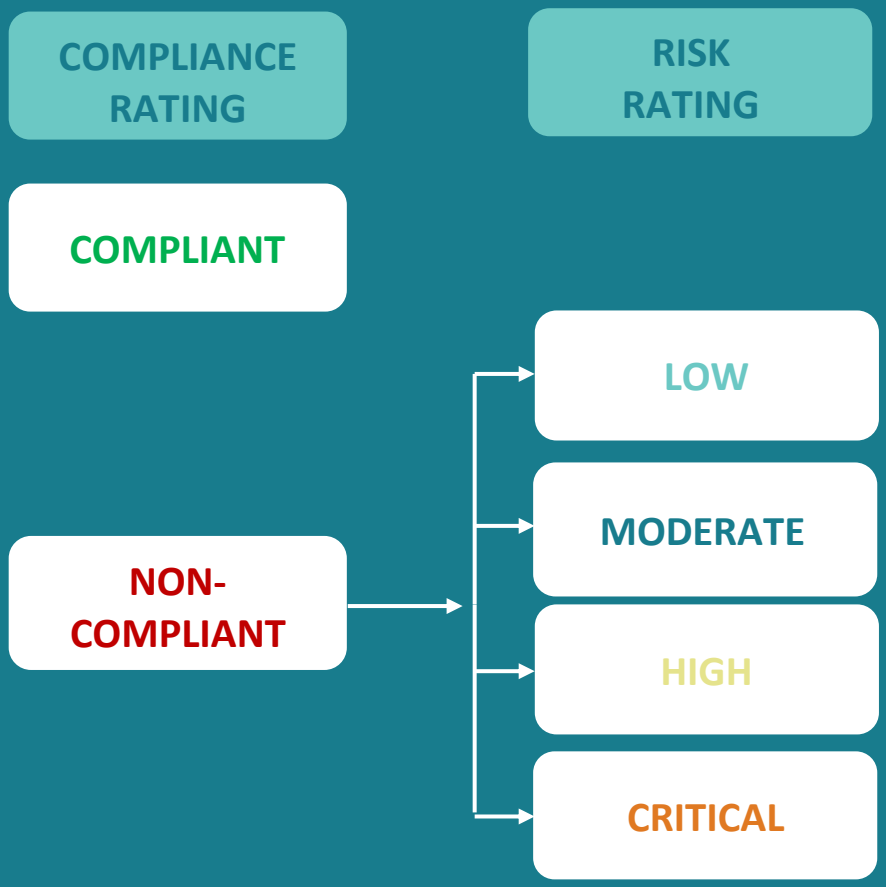
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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