Selskar House, Farnogue Residential Healthcare Unit

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

SELSKAR HOUSE, FARNOGUE RESIDENTIAL HEALTHCARE UNIT

Old Hospital Road, Wexford, Co. Wexford

Date of Publication:
31 August 2026

ID Number: AC0155

2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Psychiatry of Later Life

Conditions Attached:
None

Most Recent Registration Date:
01 May 2025

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mrs Anne Donaghey

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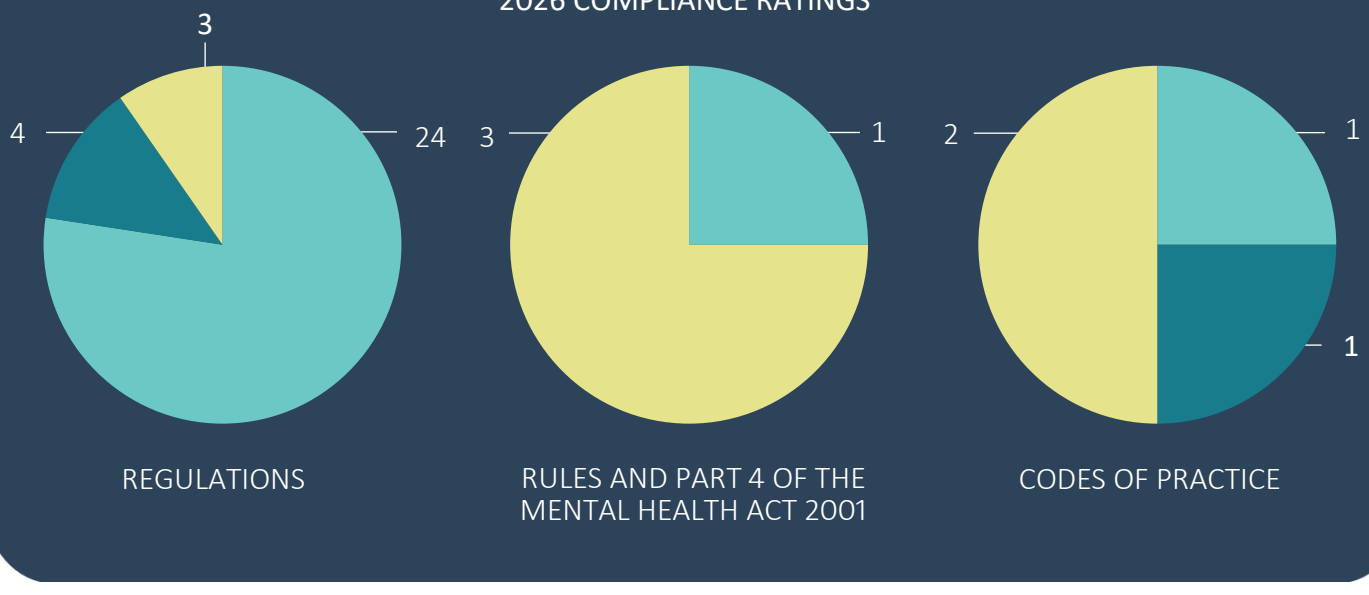
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
03 – 06 March 2026

Previous Inspection date:
11 – 14 February 2025

Inspection Type:
Unannounced Annual Inspection

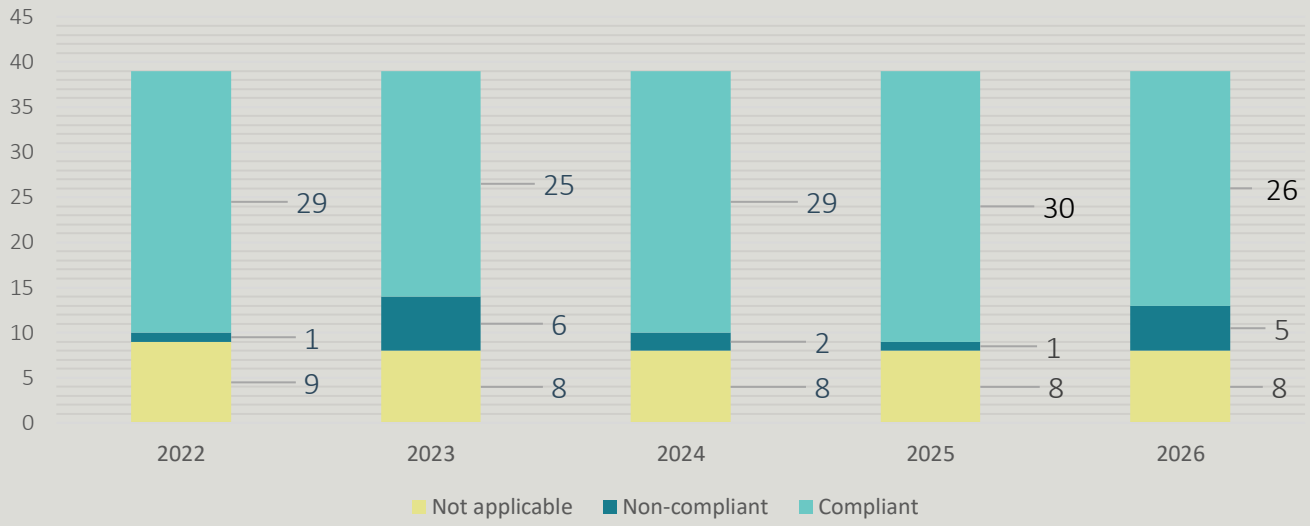
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

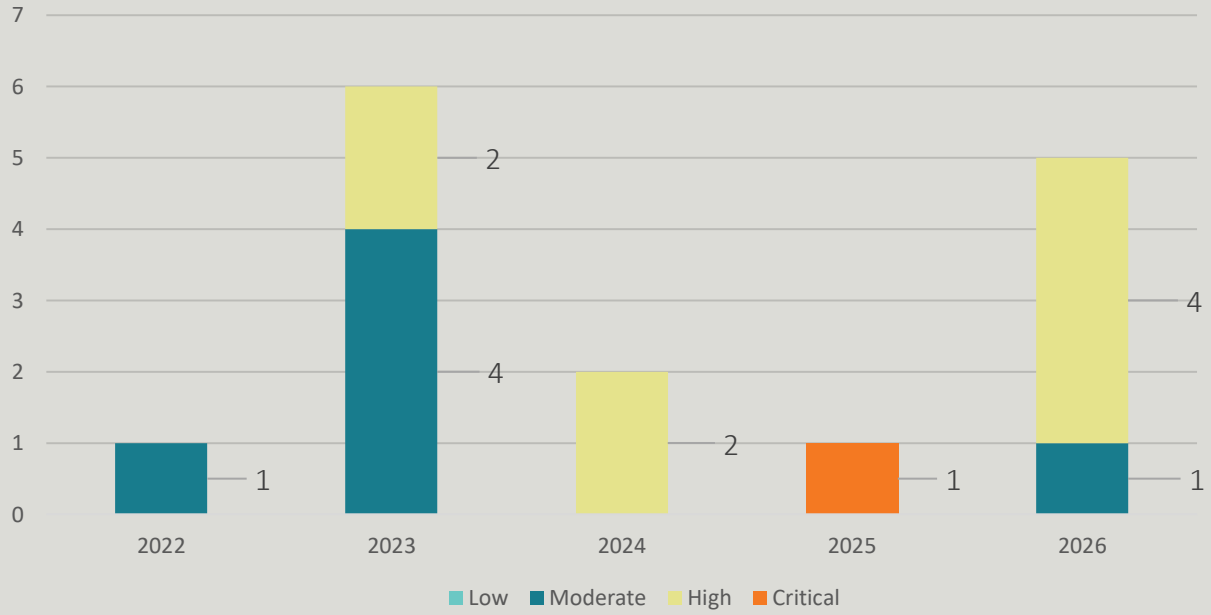
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Selskar House is situated on the ground level of Farnogue Residential Healthcare Unit, a modern, purpose-built facility, which also has a nursing home on the first floor. The approved centre accommodated residents under the care of the Psychiatry of Later Life (POLL) team. Residents were generally aged over sixty-five and had a diagnosis of dementia or serious and enduring mental illness.

Access to the approved centre was via a keypad secured entrance. There were two 10-bedded wards, and each ward included a day room/dining room, a nursing office, and a clinical room. All bedrooms were single, en suite, and situated around a central courtyard. Residents had access to the courtyard, an enclosed garden area and a sunroom, which was a multi-purpose space, used as a quiet space as well as a de-escalation area. An oratory was situated on the ground floor of Farnogue Residential Healthcare Unit, and this was accessible to residents of the approved centre.

1.2 Inspector of Mental Health Services Summary

The inspection of Selskar House was unannounced and occurred over four days from 3 March to 6 March 2026. This report reflects the findings at the time of inspection.

In 2025, the approved centre was non-compliant in one regulatory area. In 2026, this increased to five areas of non-compliance. The Code of Practice on the Use of Physical Restraint, Regulation 19: General Health, Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines and Regulation 32: Risk Management Procedures were all found non-compliant and risk rated high. Regulation 26: Staffing was also found non-compliant and risk rated moderate.

The inspection team were concerned in relation to resident access to appropriate services. Since July 2025, residents of the approved centre had no access to a psychologist, and since the last inspection the approved centre had no access to a pharmacist. The recruitment process for a psychologist was close to completion at the time of inspection, and while a pharmacist had recently been appointed to the service, involvement in the clinical care of residents had not commenced at the time of inspection. There was no access to specialist occupational therapy seating assessments, in line with residents' care plans. This risk had been escalated to area management; however, the residents’ assessed needs remained unaddressed.

Areas of good practice identified on this inspection included a varied programme of recreational and therapeutic activities. Staff and management demonstrated commitment to providing a quality service through the implementation of a regular audit schedule within the approved centre, and the development of quality initiatives. Throughout the inspection, care interactions between staff and residents were observed to be respectful, engaging and responsive to the needs of the residents.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**19**
Number of detained patients	0
Number of wards of court	1
Number of residents under the Assisted Decision Making Act	0
Number of children	0
Number of residents in the approved centre for more than 6 months	17
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	97%	81%	94%	97%	84%

1.5 Conditions of registration

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

1.6 Ongoing escalation and enforcement actions at time of inspection

None.

1.7 Escalation and enforcement actions commenced following this inspection

None.

2.0 Governance

Selskar House is located within the HSE Integrated Healthcare Area (IHA) of Waterford Wexford, which forms part of the HSE Dublin and South East Region. This new structure replaced former hospital groups and community healthcare organisations (CHOs) within the HSE. A meeting of the IHA Mental Health Services Executive Management Team (EMT) convened monthly, and separately there was a monthly meeting of the IHA Mental Health Services Quality and Safety Executive Committee (QSEC).

At a local level, the Quality and Patient Safety Committee (QPSC) met on a monthly basis. Representation from medical, nursing and health and social care professionals who worked directly in the approved centre, as well as the risk advisor, and health and safety advisor attended these meetings. Standing agenda items included: mental health engagement and recovery; regulation and compliance; staff training; risk management; and health and safety. Monthly QSEC meetings were attended by heads of discipline, the risk manager, health and safety representative, general manager, service manager and the area lead for mental health engagement. Escalation of matters from QPSC were discussed at these meetings. Further agenda items included: regulation and compliance; complaints and compliments; monitoring and audits; policies, procedures, protocols, and guidelines (PPPG); and health and safety. Incidents, risk assessments and the risk register were also reviewed in this forum. The Executive Management Team discussed matters escalated from QSEC meetings, and incorporated agenda items such as finance; capital projects; key performance indicators (KPI); human resources; strategy; workforce; and quality, safety and service improvement.

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, and risks were escalated, as necessary, to the Waterford Wexford Mental Health Service risk register. The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. A specific health and safety risk recorded on the approved centre risk register identified a number of control measures to mitigate the risk; however not all control measures were effectively implemented at the time of inspection. A staffing deficit identified on inspection was not risk assessed in relation to the clinical risk to residents, and this risk was not contained in the 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 incident relating to resident safety was not categorised as a serious reportable event (SRE). The incident was therefore not reported in line with the approved centre risk management policy and notified to the MHC in line with Mental Health Commission Guidance on Quality and Safety Notifications.

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 staff, a consultant psychiatrist, non-consultant hospital doctor, social work team leader, and senior grade occupational therapist. A psychology post was vacant since July 2025, with no arrangement in place to ensure the ongoing provision of psychological services to the residents of Selskar House during this time. At the time of inspection, the recruitment process for the appointment of a senior psychologist to the service was nearing completion. A staff training schedule was in place, and all staff had completed all required mandatory training.

The operational bed capacity of the approved centre was temporarily reduced from 20 beds to 19 beds at the time of inspection, due to a change in the designated use of one resident bedroom. The change in bed capacity was not notified to the Mental Health Commission (MHC) in line with the MHC Guidance on Quality and Safety Notifications.

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 were held monthly and since the last inspection, family members and supporters were invited to attend. 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 services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. The services and programmes were developed and coordinated by the occupational therapists, reviewed monthly, and were provided both in group and one-to-one sessions. Groups included art, baking, occupational therapy sensory group, and happy group which involved conversations, brain stimulation activities, and games. Imagination gym group involved sensory stimulation such as hand massages and music. External weekly facilitators provided gardening and woodwork groups, yoga and movement, dog therapy, and music therapy. Monthly equine therapy was also available to residents. Other services included group and individual community outings, and a drumming group. In October 2025, residents made a piece of art together and it was displayed at the Creativity Counts Art Exhibition in the Wexford Mental Health Association building as part of the Wexford Opera Festival. Residents also visited the art exhibition. In August 2025, a Fleadh Fringe event (Irish music and storytelling) took place in the approved centre.

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

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

3.3 Areas that were not applicable on this inspection

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

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.

No completed questionnaires were received, and one resident met with the inspection team. The feedback received was very positive in relation to the approved centre facilities and in relation to the resident's care and treatment. The resident stated the food was lovely, their room was very comfortable, and visits from family were facilitated. The resident reported that they were very happy with their treating team and staff were very friendly. One area of improvement was identified, suggesting an increase in the number of activities available to residents would be welcomed. Overall, the resident reported that they felt safe in Selskar House and there was nothing they would change.

4.2 Advocacy

The approved centre had access to an advocacy service, when required.

The inspectors did not receive a report from the Peer Advocacy in Mental Health representative, as no resident had availed of the advocacy service since the last inspection.

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 Nominee
- Clinical Director
- Executive Clinical Director
- Acting General Manager
- Acting Area Director of Nursing
- Occupational Therapy Manager
- Principal Psychologist
- Principal Social Worker
- Assistant Director of Nursing
- Assistant Director of Nursing Compliance
- Clinical Nurse Manager 2
- Administrator

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 19: General Health

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy. The policy was last reviewed in January 2024.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents' general health needs at admission, and as indicated by the residents' specific needs, but not less than every six months.

The clinical files of three residents who had been in the approved centre over six months were reviewed. The six-monthly health assessments documented a physical examination, family/personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and weight. For residents on antipsychotic medication, the six-monthly form documented that there had been an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG).

Residents had access to speech and language therapy, chiropody, and physiotherapy; and they had access to tissue viability via a private referral pathway.

Residents had no access to specialist occupational therapy (OT) seating assessments. There had been a referral pathway in place for seating assessments, however access to this service ceased in September 2025. At the time of inspection, there were four residents who were awaiting a seating assessment since December 2025. Funding had been secured and approved in January 2026 to source a private provider to complete the assessments, but the approved centre had been unsuccessful in sourcing an appropriate service.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that there were adequate arrangements in place for access to general health services and for referral to other health services as required, as there was no access to occupational therapy who specialised in seating assessments for residents, 19(1)(a).

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

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in July 2025.

The approved centre had access to a Drugs and Therapeutics Committee that met at least quarterly. Audits of the implementation of and adherence to medication policies were completed and were part of the regular audit schedule.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: 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, and a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident, and the signature of the medical practitioner for each entry. All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition.

Directions to crush medication were only accepted from the resident's medical practitioner with a documented reason as to why. The approved centre did not have appropriate and suitable practices relating to the ordering and prescribing of crushed medications. In the case of five MPAR's inspected, there was no evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed, as the approved centre had no access to a pharmacist. At the time of inspection, a pharmacist had been appointed to the approved centre on a 0.5 whole time equivalent basis and was in the process of completing an induction period. The pharmacist had not commenced involvement in the clinical care of residents.

Medication was stored in the appropriate environment as indicated on the label or packaging and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

The approved centre was non-compliant with this regulation because 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, as there was no access to a pharmacist in the approved centre, 23(1).

Regulation 26: Staffing

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had a staffing policy with a last-reviewed date of July 2024 recorded. The registered proprietor ensured that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice. All healthcare staff had completed the mandatory training in Basic Life Support, Fire Safety, Management of Violence and Aggression, The Mental Health Act 2001, Children First, and Safeguarding.

However, the skill mix of staffing was not sufficient to meet resident needs, as a psychology post had been vacant since July 2025, with no arrangement in place to ensure the ongoing provision of psychological services to the residents of Selskar House during this time. At the time of inspection, the recruitment process for the appointment of a senior psychologist to the service was nearing completion.

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%
Medical (4)	4	100%	4	100%	4	100%	4	100%	4	100%	4	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Healthcare Assistant (16)	16	100%	16	100%	16	100%	16	100%	16	100%	16	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the skill mix of staff was appropriate to the assessed needs of residents, the size and layout of the approved centre, 26(2).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

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

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

The risk management procedures did not reduce all risks to the lowest possible level of risk.

A specific health and safety risk recorded on the approved centre risk register identified a number of control measures to mitigate the risk; however, not all control measures were effectively implemented at the time of inspection.

Not all clinical risks were identified and treated, as a psychology post had been vacant since July 2025, with no arrangement in place to ensure the ongoing provision of psychological services to the residents of Selskar House during this time. No risk assessment had been completed in relation to the clinical risk to residents, and this risk was not contained in the risk register.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and at resident transfer and resident discharge, and prior to and during physical restraint.

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

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any

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

Not all clinical risks were reported. One incident relating to resident safety was not categorised as a serious reportable event (SRE). The incident was therefore not reported in line with the approved centre risk management policy and notified to the MHC in line with Mental Health Commission Guidance on Quality and Safety Notifications.

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

a) **The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as not all health and safety risks were treated and effectively mitigated, 32(1).**
b) **The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as one serious reportable event had not been notified to the Mental Health Commission, 32(1).**
c) **The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as not all clinical risks were 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 HIGH

INSPECTION FINDINGS

Processes:
The approved centre had a written policy on the use of physical restraint (PR). The policy was reviewed annually and was last reviewed in October 2025. It addressed the following:

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

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

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

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.

A multi-disciplinary review and oversight committee met at least quarterly and produced a report following each meeting, which was available to the Mental Health Commission on request.

Evidence of implementation: Two episodes of physical restraint were inspected. Physical restraint was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy. The consultant psychiatrist (CP) or the duty CP was notified as soon as was practicable. The episode of physical restraint was recorded in the person's clinical file. The dignity and safety of the person being restrained was respected. Staff involved in the use of physical restraint took into account any relevant entries in the person's ICP pertaining to the person's specific requirements or needs in relation to the use of physical restraint.

A medical examination of the resident did not occur within two hours of the start of the restraint in line

with the Code of Practice and the approved centre's policy on the use of physical restraint.

The Mental Health Commission was notified of the start time and date and the end time and date of each episode of physical restraint in the format and timeframe specified by the Mental Health Commission.

The episodes of physical restraint were recorded in the clinical file and in the clinical practice form (CPF). A copy of the CPF was in the clinical file and available to the Mental Health Commission on request.

The episodes of physical restraint were reviewed by members of the multi-disciplinary team within five working days from the date of the restraint. The review included the identification of the trigger events which contributed to the restraint episode; a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support; the identification of alternative de-escalation strategies to be used in future; the duration of the restraint episode and whether this was for the shortest possible duration; and an assessment of the factors in the physical environment that may have contributed to the use of restraint.

The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

A named senior manager was responsible for the approved centre's reduction of physical restraint.

The approved centre was non-compliant with this code of practice because the registered proprietor did not ensure that the Registered Medical Practitioner completed a medical examination of the person no later than two hours after the start of the episode of Physical Restraint, as this occurred seven hours after the start of the restraint, 3.4.

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 19: General Health					
Reason ID : 10007485		**The registered proprietor did not ensure that there were adequate arrangements in place for access to general health services and for referral to other health services as required, as there was no access to occupational therapy who specialised in seating assessments for residents, 19(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Engage a suitably qualified Occupational Therapist with expertise in seating assessments and establish a referral pathway for all residents requiring assessment.	100% of residents identified as requiring a specialist seating assessment will be reviewed and documented.	An external Occupational Therapy provider will be sourced through existing healthcare networks. The approved centre can access specialist Occupational Therapy services through contracted arrangements. Achieved.	13/04/2026	Senior Management (budgetary approval).
Preventative Action	Implement a Service Level Agreement with a specialist Occupational Therapy provider and maintain a referral tracking system.	Quarterly review will demonstrate 100% access to specialist seating assessments when clinically required.	Monitoring will be incorporated into existing governance and oversight processes. External specialist services are available and can be accessed through approved procurement processes.	10/08/2026	Senior Management

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10007491		**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, as there was no access to a pharmacist in the approved centre, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Engage a pharmacist to support medication management, medication review and staff advice.	A contract or service agreement with a pharmacist will be in place and documented.	Pharmacy services can be sourced through HSE. Achieved	24/04/2026	Registered Proprietor and Senior Management (budgetary approval).
Preventative Action	Establish and maintain a Service Level Agreement with a pharmacist and schedule regular medication management reviews.	Quarterly Reg. 23 Audits will demonstrate 100% access to pharmacist support when required	The pharmacist will participate in medication governance and audit activities. Ongoing pharmacy input can be supported through contracted services. Achieved.	01/05/2026	Registered Proprietor and Senior Management (budgetary approval).

Regulation 26: Staffing					
Reason ID : 10007489		**The registered proprietor did not ensure that the skill mix of staff was appropriate to the assessed needs of residents, the size and layout of the approved centre, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The skill mix of staff was not appropriate to the assessed needs of residents- specific absence of psychologist.	Complete a staffing and skill review and address identified gaps through recruitment- psychologist post.	Existing workforce planning processes will be used. Achieved.	29/05/2026	Psychology Manager & Senior Management (budgetary approval and recruitment authorisation
Preventative Action	Implement six-monthly staffing and dependency reviews.	Staffing review reports will demonstrate compliance with approved staffing requirements.	Reviews will be undertaken using existing workforce planning tools. Regular reviews support proactive workforce management.	04/01/2027	Senior Management.

Regulation 32: Risk Management Procedures					
Reason ID : 10007486		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as not all health and safety risks were treated and effectively mitigated, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review all outstanding health and safety risks and implement appropriate control measures.	100% of identified risks will be recorded on the risk register and assigned corrective actions.	The review will be completed using existing risk management systems. Current governance structures support risk review and mitigation activities.	30/08/2026	Health and Safety Officer, Clinical Nurse Manager and Senior Management where funding is required.
Preventative Action	Introduce quarterly environmental and health and safety audits.	100% of audit actions will be tracked and completed within agreed timelines.	Audits will be completed by designated managers using internal audit tools. Quarterly audits are already aligned with existing governance requirements.	07/09/2026	Health and Safety Officer and Assistant Director of Nursing.
Reason ID : 10007487		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as one serious reportable event had not been notified to the Mental Health Commission, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review the incident and submit any outstanding notifications to the Mental Health Commission. Provide refresher training to relevant staff.	100% of relevant staff will complete training	Training will be delivered internally using existing resources. Notification requirements are already established within existing policies. Achieved.	20/05/2026	Registered Proprietor and Assistant Director of Nursing.
Preventative Action	Implement a reportable event and notification tracker.	100% of reportable events will be notified within required timeframes.	The tracking process will be integrated into incident management procedures. Existing incident reporting systems support compliance monitoring.	31/07/2026	Assistant Director of Nursing and Clinical Management Team.
Reason ID : 10007488		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as not all clinical risks were assessed, treated, reported and monitored, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Review all resident clinical risk assessments and update any incomplete assessments and management plans.	100% of resident clinical risk assessments will be reviewed and updated where required.	The review will be completed through the multidisciplinary team process. Clinical staff currently undertake risk assessments and can complete the review within existing structures.	31/08/2026	Consultant Psychiatrist, Assistant Director of Nursing, Clinical Nurse Managers and Clinical Staff.
Preventative Action	Include clinical risk management as a standing agenda item at multidisciplinary and governance meetings.	Quarterly review will achieve at least 95% compliance with clinical risk assessment requirements.	Review and governance arrangements are already in place. The action can be incorporated into current multi disciplinary meeting schedules.	31/08/2026	Consultant Psychiatrist, Assistant Director of Nursing, Clinical Nurse Managers and Clinical Staff.

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10007490		**The registered proprietor did not ensure that the Registered Medical Practitioner completed a medical examination of the person no later than two hours after the start of the episode of Physical Restraint, as this occurred seven hours after the start of the restraint, 3.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Provide immediate refresher education to all relevant staff regarding the requirement for medical examination within two hours of restraint.	100% of relevant staff will attend refresher training.	Training will be delivered through existing clinical education structures. Achieved.	24/04/2026	Assistant Director of Nursing, Consultant Psychiatrist and Clinical Staff.
Preventative Action	A physical restraint checklist which includes medical review time-frames in place.	Post event will demonstrate 100% compliance with the two-hour medical review requirement.	Monitoring can be incorporated into current restraint review processes. Clinical staff already document restraint episodes and checklist.	31/07/2026	Assistant Director of Nursing and Clinical Nurse Managers

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.

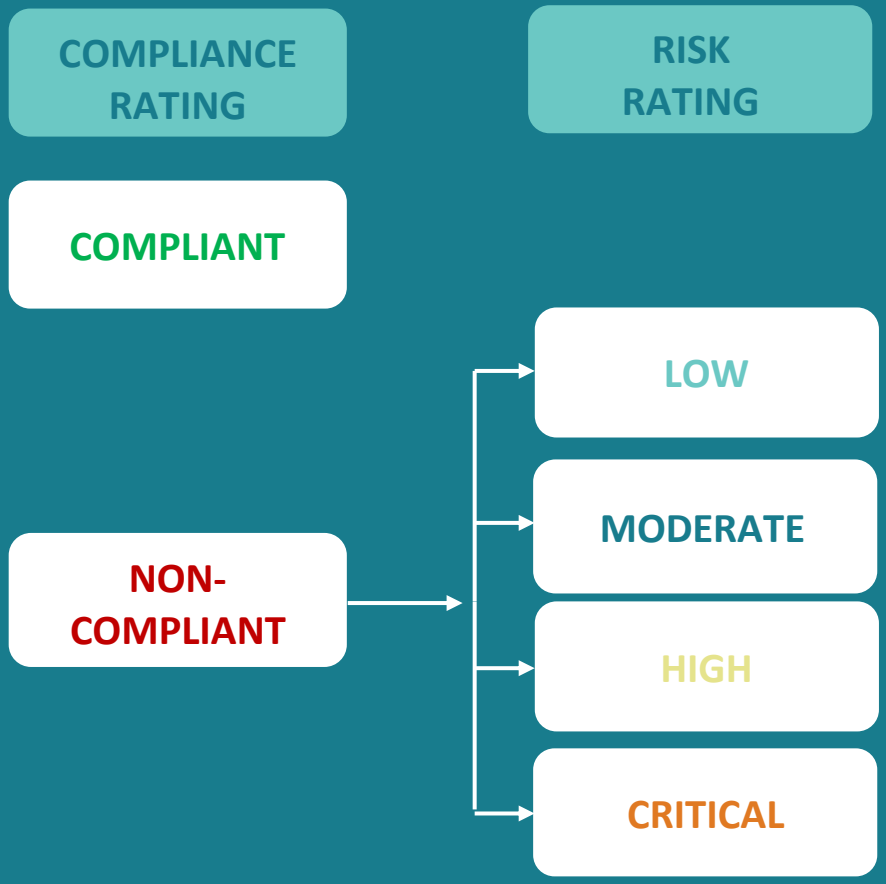
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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