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Acute Psychiatric Unit, Cavan General Hospital

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

ACUTE PSYCHIATRIC UNIT, CAVAN GENERAL HOSPITAL

Cavan General Hospital, Lisdarn, Cavan

Date of Publication:
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2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life
Mental health rehabilitation
Mental health are for people with intellectual disability

Conditions Attached:
None

Most Recent Registration Date:
01 March 2026

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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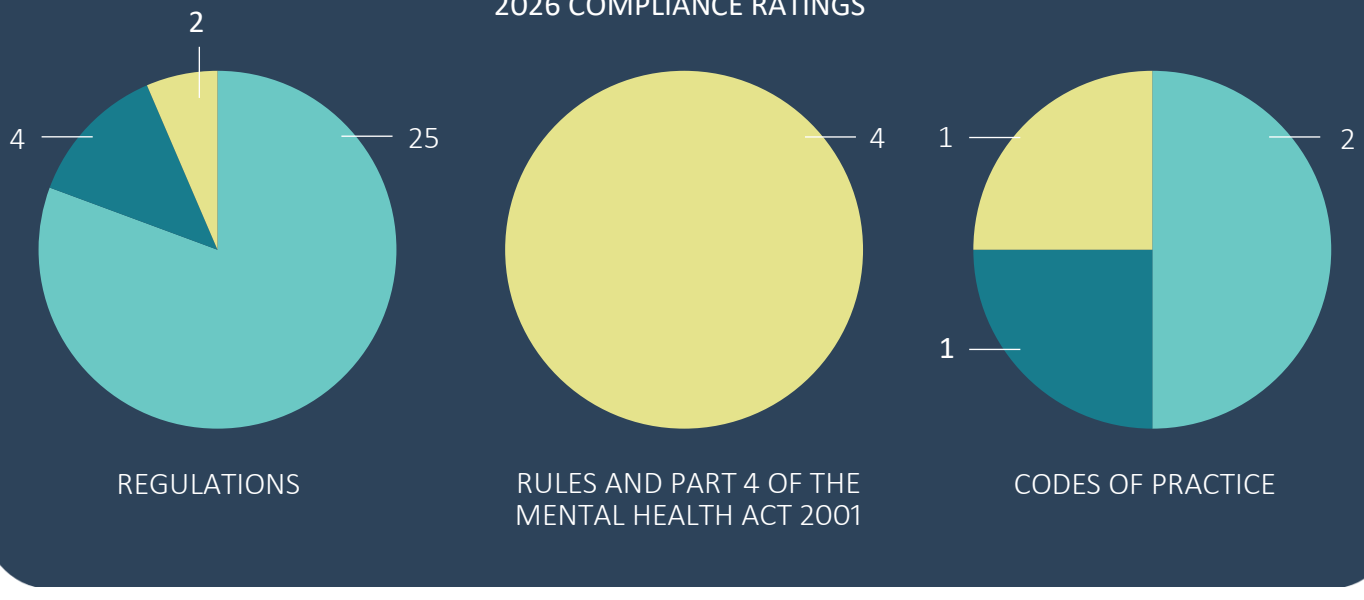
Inspection Date:
03 – 06 March 2026

Previous Inspection date:
09 – 12 September 2025

Inspection Type:
Unannounced Annual Inspection

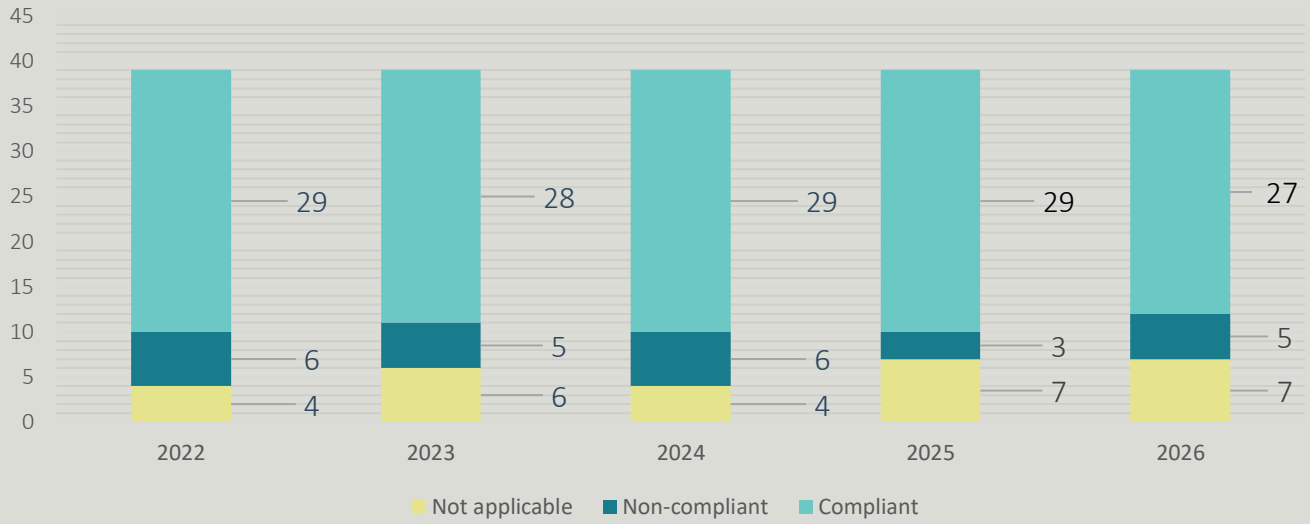
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

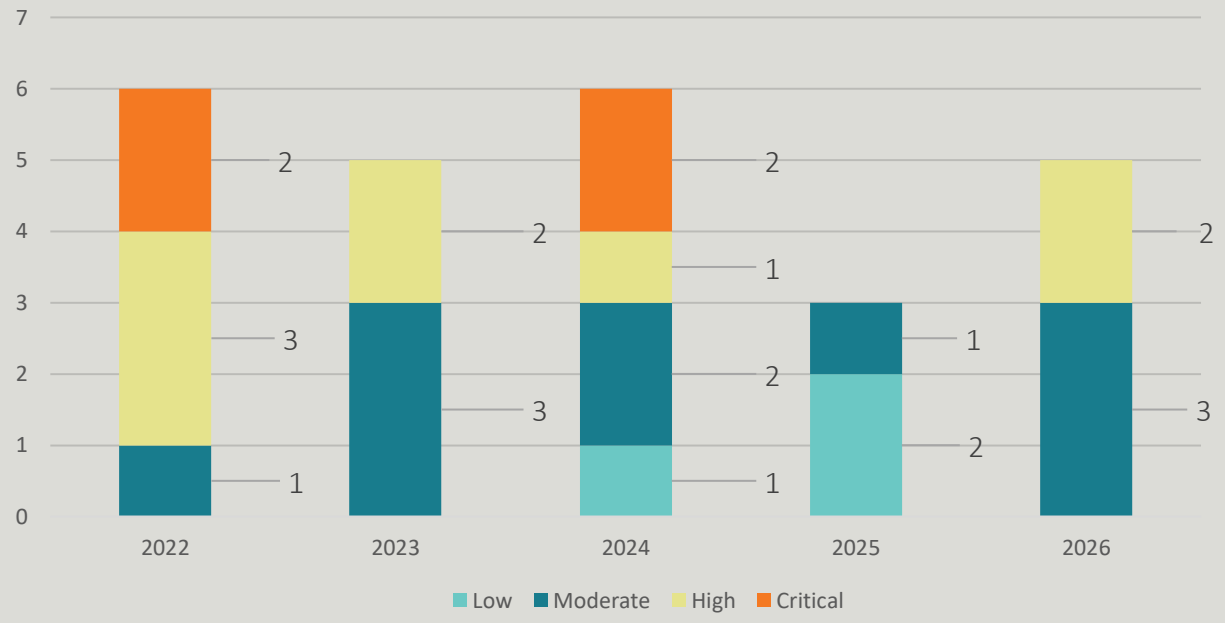
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

The Acute Psychiatric Unit (APU) is located on the lower ground floor of Cavan General Hospital. The approved centre provided 25 beds for mental health inpatient services for the population of Cavan and Monaghan.

The adult community mental health sector teams referred residents for inpatient care where they were managed by a dedicated inpatient treating team working in the approved centre. The community-based Psychiatry of Later Life (POLL) team also admitted to the approved centre and staff in the centre continued to manage the care and treatment of those residents.

Accommodation at the approved centre was comprised of three four-bed en suite bedrooms, one six-bed en suite bedroom and seven single en suite bedrooms. There was a large spacious dining room, two sitting rooms, a music room, a family room, a quiet room, and a well-equipped occupational therapy room and kitchen. There was a recreational room with exercise machines such as stationary bicycles, a football table and a boxing bag available to residents. The approved centre also had access to a central garden within the approved centre. This garden contained raised beds and seating for resident use.

1.2 Inspector of Mental Health Services Summary

The inspection of the APU Cavan was unannounced and occurred over four days from the 3rd to the 6th of March 2026. Overall, the inspection was very well co-ordinated by staff and management in the approved centre. This report reflects the findings at the time of inspection.

In 2025, three areas of non-compliance were identified at APU Cavan. In 2026, this increased to five areas of non-compliance. The non-compliant findings on this inspection included Regulation 8: Residents' Personal Property and Possessions; Regulation 13: Searches; and the Code of Practice on the Use of Physical Restraint, which were risk rated moderate. Regulation 19: General Health and Regulation 16: Therapeutic Services and Programmes were risk rated high.

There was evidence of good practice identified across several areas of the approved centre. For example, under Regulation 23: Medication, significant work had been completed in relation to policies, high dose antipsychotic treatment (HDAT), with significant input and oversight from the pharmacist who attended resident multi-disciplinary team (MDT) meetings.

Improvements in the physical environment were evident on this inspection with significant work undertaken to address ligature risks and refurbishment works to some bedrooms within the approved centre. The building work was aimed at improving the comfort, wellbeing and safety of residents. A Therapeutic Services Committee to enhance therapeutic services and programmes within the APU Cavan met regularly and was attended by a representation from all disciplines.

A regular audit schedule took place throughout the approved centre. There was a focus on continuous quality improvement with quality initiatives developed across some of the inspected regulations.

1.3 Resident Profile

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

Profile	
Number of registered beds	***25***
Total number of residents	**10**
Number of detained patients	3
Number of wards of court	0
Number of residents under the Assisted Decision-Making Act	0
Number of children resident	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	83%	85%	83%	91%	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

The Acute Psychiatric Unit (APU) Cavan is located within the HSE Integrated Health Area (IHA) of Cavan Monaghan, which forms part of the HSE Dublin and Northeast health region. There had been some changes to governance structure at the time of inspection. The Clinical Nurse Manager 3 post was newly created with the aim to further support staff in the delivery of high-quality care to the residents. The Assistant Director of Nursing (ADON) post had also been recently appointed, and the Head of Service was the new Registered Proprietor.

A meeting of the Cavan Monaghan Area Mental Health Management Team (AMHMT) took place monthly and was chaired by the Executive Clinical Director. Agenda items included compliance; human resources; quality; safety and risk; incident management; performance monitoring; finance; service user engagement; and comments, compliments and complaints.

The Cavan Monaghan Quality and Patient Safety committee met monthly and recurring agenda items included compliance reports; incident reviews; the risk register; policies, procedures, protocols, guidelines (PPPG), Assisted Decision Making; audits, and health and safety. Established sub-committees included therapeutics; PPPG; ligature reduction, and restrictive practices. Local governance structures included a monthly business meeting and a monthly governance meeting which were represented by all disciplines of the approved centre. The Area Lead for Mental Health Engagement and Recovery attended the Governance group and brought the Service User Experience Feedback report from the Your Voice Matters group to the attention of the group and for review.

Heads of discipline had received training in risk management, incident management and health and safety. A Quality and Patient Safety (QPS) advisor was available to the approved centre and persons with responsibility for risk were known by staff. Risks were recorded on the APU Cavan risk register and there was a process of escalation of risk, as necessary, to the Cavan Monaghan risk register. Risks identified on the risk registers included clinical risks, health and safety risks and corporate risks. Risk registers contained existing control measures in place to mitigate the risks identified, along with further actions required.

Incidents were reported and risk assessed through the National Incident Management System (NIMS) and clinical incidents were reviewed by the multi-disciplinary team. The approved centre implemented the HSE Incident Management Framework as required. However, the Quality and Safety Notification for one episode of physical restraint did not contain the correct start time and end time in the format specified by the Mental Health Commission or 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, consultant psychiatrists, non-consultant hospital doctors, a social worker, an occupational therapist, a psychologist, and a pharmacist. Inspectors were informed that there were no nursing vacancies

at the time of inspection, and when gaps in nursing numbers occurred, this was managed through the use of overtime and regular agency staff, who were well known to the centre. Continuing since the last inspection, the approved centre had a part-time psychology service on an in-reach basis. Inspectors were informed that a full-time psychologist was due to start in the approved centre on the 12th of March 2026 and that they would be based solely in the approved centre. While the lack of a speech and language therapy resource had been identified on the approved centre's risk register, two residents did not have timely access to this therapy in line with their individual care plans in accordance with best practice. A senior social worker was due to commence working in the centre on the 23rd of March 2026, who would be replacing a staff grade social worker.

A staff training schedule was in place, and most of the staff had completed the required mandatory training in Safeguarding; Children First; the Mental Health Act 2001; and Basic Life Support. All medical, nursing and healthcare staff who had not completed training in the Management of Violence and Aggression, Fire Safety, and Basic Life support at the time of inspection, were booked into upcoming training courses which were due to commence soon after the inspection finished.

Resident engagement in governance and quality improvement processes was facilitated throughout the service. Resident community meetings and suggestions boxes provided residents with the forum to voice requests, suggestions and concerns. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service. Advocacy was provided weekly at the approved centre, either through face-to-face or remote meetings and individual or group meetings could be facilitated. The advocacy contact details were displayed. Feedback from advocacy meeting was communicated to the area management team for consideration and to explore service improvement.

A working relationship had been established with GROW, Mental Health Ireland, Shine, Employability, Aware, Teach Oscail and addictions services who facilitated face-to-face support groups on a quarterly basis. These support groups aimed to foster stronger links with community support and services for residents on discharge.

With respect to quality improvements in care planning, residents had an additional option to attend an in-person meeting and/or complete a pre-care plan check in form, and this was discussed in the residents' review meeting. This quality initiative reflected and upheld the principles of recovery orientated practice in mental health including uniqueness of the individual, real choices and partnership/communication while acknowledging that the resident was the expert in their own life. It also provided information and support as a partnership in recovery to help the person realise their own goals and aspirations.

"My Discharge Booklet" was a nursing-led quality initiative developed in partnership with the Recovery College. This booklet was provided on admission, to support residents to track their progress, record key information about diagnosis and medication, and access important contacts and recovery resources. During weekly discharge groups, residents collaboratively add to their sections on early warning signs, strengths, coping strategies and ongoing recovery in a compassionate peer space, with pharmacist input on medication management. A QR code enabled feedback following discharge. The initiative meaningfully combined lived and learned experience, strengthening engagement, discharge planning and continuity of care.

During the course of the inspection, staff were observed engaging with residents in a caring, respectful, supportive and dignified manner, demonstrating clear commitment to their care. Additionally, the service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

2.1 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 (29)	29	86%	29	62%	29	83%	29	100%	29	100%	29	100%
Medical (3)	3	100%	3	75%	3	75%	3	100%	3	100%	3	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian (1)	1	100%	1	100%	1	N/A	1	100%	1	100%	1	100%
Pharmacist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Healthcare Assistant (1)	1	0%	1	100%	1	100%	1	100%	1	100%	1	100%

Staff that were overdue training or were new to the service were scheduled to attend the following training in; basic life support, fire training and management of violence and aggression in the weeks following this inspection.

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 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 15: Individual Care Plan	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 22: Premises	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	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 32: Risk Management Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Code of Practice: Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

3.2 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2022 and 2026 and the relevant risk rating when the service was non-compliant:

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.

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2022		2023		2024		2025		2026	
Regulation 08: Residents' Personal Property and Possessions	✓		✓		✓		✓		✗	Moderate
Regulation 13: Searches	✓		✓		✓		✓		✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	Critical	✓		✗	High
Regulation 19: General Health	✓		✗	High	✗	Low	✓		✗	High
Code of Practice on the Use of Physical Restraint	✓		✗	Moderate	✓		✗	Low	✗	Moderate

3.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
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 no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
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 no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.

4.0 Service-user Experience

4.1 Service-user feedback

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, in paper or by QR code, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- The Peer Advocacy in Mental Health representative was contacted to obtain resident's 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 the residents' experience of the approved centre as outlined below.

Resident and family feedback is an essential component of the inspection process. The inspection team met with one resident who reported that they were happy overall with their placement. They stated that the staff were "approachable and helpful", bedrooms were very comfortable, and that they felt very safe in the centre. They said that they felt very well cared for by staff and met their doctors regularly.

There were two surveys completed by the residents. They commented that the doctors, nurses and all the staff were very friendly and helpful. With regard to areas for improvement, suggestions were to have radios in bedrooms and more clocks around the approved centre.

Overall, residents reported that they were satisfied with the service and information provided about medication and their diagnosis. One resident was aware of who their multi-disciplinary team (MDT) members were, and the other respondent did not respond. Both respondents knew who their key workers were and that they were able to talk about worries, concerns or complaints with staff. They were happy with the way staff spoke to them, and they indicated that there was enough talking therapies available, if needed.

While one respondent stated that there were enough activities during the day, the other respondent indicated there was not. They both replied that their privacy and dignity was respected, and they were able to communicate freely with their family, friends and the Advocate.

With a rating of 1 being poor and 10 being excellent regarding their overall experience in the centre; one resident rated the service at 6 out of 10 and the other respondent allocated 8 out of 10.

4.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from a representative from the Peer Advocacy in Mental Health. They reported that overall residents appeared to have a good experience in the APU Cavan. They stated that it was a quiet unit, and there appeared to be a caring environment between nursing and other staff, for example, catering staff. The residents attended many daily activities and one-to-one Occupational Therapy (OT) and so, appeared to have good therapeutic support.

Positive comments from residents included the following:

- The nursing staff and other staff were nice, helpful, approachable, easy to talk to and were readily available to them.
- Several residents stated that the Social Worker was great and helped them a lot with housing and other issues.
- Some residents liked to attend the OT groups such as the art class, and they also liked working individually with the OT. A choir group, which began before Christmas was very popular.
- Residents noted they could clearly see who their key nurse was as it was stated clearly on a whiteboard.
- A digital information board and phone charging unit was available.
- Some residents seemed aware of the multi-disciplinary team (MDT) meetings, and the option to attend if they chose.
- Mental Health Commission (MHC) letters, admission, renewal orders and information booklets were made available to involuntary patients.
- One resident noted that they preferred being in a dormitory room rather than a private bedroom. They enjoyed the company of other residents as they preferred to not be alone.
- One resident had been given a Wellness Booklet to complete, to help them during their admission and after their discharge.
- Residents were aware that there was a lot of information on notice boards pertaining to the unit and activities and information on outside recovery supports, programmes and peer group meetings. They were also aware of translator services if needed.
- One resident mentioned that they were able to go out on leave, to shop or a coffee shop and during visits with family. Another resident enjoyed the use of a gym on the premises. Others stated that they liked the garden area and the freedom to go in and out of it as they pleased.
- Some residents stated they felt that they have enough space on the unit, with varying day rooms such as the library area, dining room and an outdoor garden space.
- One resident commented that they liked the unit, it was quiet and had various day areas to sit in and the unit appeared to be a clean and safe environment.
- One resident stated that the mobile shop that came to the unit was very good, especially if they were unable to leave the centre.
- Residents seemed generally happy with the food provided with some stating it was “very good” and “fabulous”.
- Peer Advocacy was available to all residents and the unit supported this.

Areas requiring improvement included the following:

- One resident mentioned that they did not like being in a dormitory ward as they hadn't enough privacy and were concerned for the safety of their belongings.
- One resident stated that, occasionally, they did not like the food offered on the unit but overall, it was ok.
- A resident remarked that they had not been given a copy of their care plan. They did not know what this was. This was resolved on speaking with the key nurse, and a care plan copy was given to the resident and explained.
- One resident stated they found it a little overwhelming on the unit, finding it hard to adjust to the unit as opposed to being at home.

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:

- Executive Clinical Director
- Registered Proprietor - Head of Service Mental Health
- Clinical Director
- Area Director of Nursing
- Business Manager
- Assistant Director of Nursing
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 2
- Practice Development Lead
- Principal Psychologist
- Pharmacist
- Occupational Therapist Manager
- Occupational Therapist
- Area Lead for Mental Health Engagement

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 8: Residents' Personal Property and Possessions

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to residents' personal property and possessions. The policy was last reviewed in June 2025.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan and in accordance with the approved centre's policy.

The registered proprietor had ensured that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

A resident's personal property and possessions were not safeguarded when the approved centre assumed responsibility for them. Specifically, several items belonging to residents in a safe had no resident identifier or label attached.

In addition, the correct identification and labelling of items was not in place for resident possessions stored in property rooms, to ensure that approved centre staff were aware of the ownership of property. Instead, there was only a single identifier or no identifier on property stored in the property room.

The access to and use of resident monies was overseen by either two members of staff or the resident and two staff members.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that a record was maintained of each resident's personal property and possessions in accordance with the approved centre's written policy, 8(3).

Regulation 13: Searches

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated. The policy was last reviewed in April 2025.

The policies and procedures also included requirements related to the searching, carrying out searches with the consent of a resident and carrying out searches in the absence of consent, and to the finding of illicit substances. However, policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she was accommodated did not show guidance regarding residents being given the opportunity to feedback regarding their experience of the search in relation to their dignity and privacy.

Residents were not given the opportunity to feedback regarding their experience of the search in relation to their dignity and privacy, in all three search documents inspected.

Resident consent was sought prior to all searches. The request for consent and the received consent were documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. There was always a minimum of two appropriately qualified staff in attendance when searches had been conducted and a written record of every search made, which included the reason for the search.

Not all components of the approved centre's search policies and procedures were implemented in practice. Three resident searches were inspected. In two of out of the three documented searches inspected, a risk assessment was not completed on the resident before the resident was searched.

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

a) The registered proprietor did not ensure that the approved centre's 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 included guidance about residents being given the opportunity to feedback regarding their experience of the search in relation to their dignity and privacy. This resulted in three residents not being given the opportunity to feedback following a search, 13(1).

b) **The registered proprietor did not ensure that the approved centre followed procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated as risk assessments were not completed prior to two searches, 13(1).**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The therapeutic services provided by the approved centre were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

The multi-disciplinary therapeutic programme was provided in Cavan. It was co-ordinated by the occupational therapist (OT), and it ran over seven days. Therapeutic services and programmes included the following: music therapy, social and cognitive games. The occupational therapist (OT) facilitated groups consisting of mindfulness, walking groups, independent living skills, community meetings, art therapy and sensory modulation. Psychoeducation sessions were based on service users' needs and covered topics such as relapse prevention, coping skills and building resilience. The OT also facilitated a weekly designated group for older patients based on their needs.

Education on medication sessions were held once a week and were facilitated by nursing and the pharmacy department. There was one hour a week dedicated to psychology and another hour for social work input. If a resident required one to one time, they were also facilitated with that option.

There was a dedicated nurse assigned to therapeutic activity each day on the ward to provide cover if a group was cancelled or a staff member was unavailable. Nursing staff facilitated social and a cognitive games group in the evenings with more skills-based groups such as decider skills and a breakfast or brunch club during the weekends.

Drop-in sessions with external community support agencies included Grow, Shine, Mental Health Ireland, Aware and Teach Oscail. The recovery college attended for one hour a week and presented on a variety of mental health and recovery topics. The Recovery College and Community Rehabilitation Team organised various social and leisure groups including soul singers, kickstart to recovery soccer, tennis for wellness, woodlands walks and hand drumming. The activity nurse or the OT was available to escort service users to community groups.

The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of the residents, as documented in their individual care plans. Two residents with a documented identified need for speech and language therapy did not have access to the service in line with their individual care plan.

Where a resident required a therapeutic service that was not provided internally, the approved centre did not arrange for the service to be provided by an approved, qualified health professional in an appropriate location.

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

a) **The registered proprietor did not ensure that where a resident required a therapeutic service or programme that was not provided internally, arrangements for the service to be provided by an approved, qualified health professional in an appropriate location was not provided, 16(1).**
b) **The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of the residents, as documented in their individual care plans. Two residents had no access to Speech and Language Therapy, 16(2).**

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a general health policy which was last reviewed in February 2026, and a policy on responding to medical emergencies which was last reviewed in February 2026. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

No resident was in the approved centre for six months at the time of the inspection. No resident was on antipsychotic medication for a year at the time of the inspection.

Not all residents received appropriate general health care interventions in line with individual care plans. One resident with a documented identified need for speech and language therapy did not have access to the service in line with their individual care plan, and another experienced a significant delay in accessing this service.

Residents could access national screening programs that are available according to age and gender. These included, breast check, cervical screening, retina check (diabetics only), and bowel screening.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that adequate arrangements were in place for access by residents to general health services required. One resident with a documented identified need for speech and language therapy did not have access to the service in line with their individual care plan, and another resident experienced a significant delay in accessing this service, 19(a).

7.0 Inspection Findings – Rules

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

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

8.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was 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 MODERATE

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in January 2026 and addressed the following:

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

Training policies and procedures included all of the requirements for this code of practice. The approved centre had a reduction of physical restraint policy on the reduction of restrictive practices; the policy included the following:

- Clear documentation of how the approved centre aimed to reduce, or where possible eliminate, the use of physical restraint.
- The role of leadership and the use of data to inform practice, specific reduction tools in use, and the use of post incident reviews to inform practice.
- How the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint.

Training and Education: All staff had signed a written document to indicate that staff involved in the use of physical restraint had read and understood the policy. All staff who participated, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

Monitoring: The approved centre had established a multi-disciplinary review and oversight committee. They met at least quarterly and covered all of their responsibilities including the review of compliance with the code of practice on physical restraint, and compliance with the approved centre's own policies and procedures, specific to each episode reviewed. They produced a report following each meeting of the review and oversight committee.

Evidence of Implementation: Three episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there were no other less restrictive methods available to manage the residents' presentation. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the residents had been completed no later than two hours after the start of each episode of restraint.

For one episode of physical restraint the registered proprietor did not notify the Mental Health Commission of the correct start time and end time of the episode of physical restraint in the format specified by the Mental Health Commission. Information submitted which recorded the length of time on one notification was incorrect.

The orders for physical restraint did not exceed a duration of 10 minutes. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode, and signed by the CP, or duty CP, within 24 hours.

In one clinical file the person was not informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint, and a record explaining why it had not occurred was not entered in the person's clinical file as soon as was practicable.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the residents' individual care plans pertaining to their specific requirements or needs in relation to the use of physical restraint. There was documented evidence that the principles of trauma-informed care were used during the episodes of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy. The residents were continuously assessed throughout the uses of restraint to ensure their safety.

Ending of Physical Restraint: The physical restraint in each instance was ended by the person who had led it. The time, date and reason for ending the physical restraint were recorded in the clinical files on the date that each episode ended. The residents were given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. This occurred within two working days of each episode of physical restraint, unless it was the preference of the resident to have the debrief outside of this timeframe. There was a record of all attendees who were present at the debrief and this was included in the clinical file. Appropriate emotional support was provided to the residents following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

Recording of the Use of Physical Restraint: The episodes of restraint were recorded in the clinical files. The episodes of restraint were clearly recorded in the clinical practice form. There was a copy of the clinical practice form in the clinical files, and it was available to the Mental Health Commission on request.

Clinical Governance: The episodes of physical restraint were reviewed by members of the multi-disciplinary team within five working days from the date of each episode. The multi-disciplinary team recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the residents. A named senior manager was responsible for the approved centre's reduction of physical restraint. An annual report on the use of physical restraint in the approved centre was completed.

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

a) **In one clinical file the person was not informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint. A record explaining why this communication had not occurred was not entered in the person's clinical file as soon as was practicable, 3.8.**
b) **For one episode of physical restraint, the registered proprietor did not notify the Mental Health Commission of the correct start time and the end time of the episode of physical restraint in the format specified by the Mental Health Commission, 3.10.**

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 08: Residents' Personal Property and Possessions					
Reason ID : 10007663		**The registered proprietor did not ensure that a record was maintained of each resident's personal property and possessions in accordance with the approved centre's written policy, 8(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The approved centre is maintaining a record of each resident's personal property and possessions and is ensuring that it is updated throughout the resident's admission.	Resident's property and possessions audit increased to bi-annual.	No barriers to implementation	03/03/2026	Approved Centre CNM2
Preventative Action	Increase to bi-annually the audit of residents' personal property and possessions and ensure inventories are completed on admission, transfer and discharge. Heads of Discipline ensure that all approved centre staff have read and understood the policy: Management of person's personal property and possessions.	Bi-annual audit CMMHS policy portal compliance.	No barriers to implementation	03/03/2026	Heads of Discipline Approved Centre CNM2

Regulation 13: Searches					
Reason ID : 10007664		**The registered proprietor did not ensure that the approved centre's 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 included guidance about residents being given the opportunity to feedback regarding their experience of the search in relation to their dignity and privacy. This resulted in three residents not being given the opportunity to feedback following a search, 13(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Operational policies and procedures have been amended to include resident feedback on dignity and privacy.	Bi-annual audit.	No barriers to implementation	22/07/2026	Approved Centre CNM3
Preventative Action	Heads of Discipline ensure that all approved centre staff have read and understood the CMMHS Search policy and implement the search policy authorisation form.	Bi-annual audit results CMMHS policy portal compliance.	No barriers to implementation	22/07/2026	Heads of Discipline
Reason ID : 10007665		**The registered proprietor did not ensure that the approved centre followed procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated as risk assessments were not completed prior to two searches, 13(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An action will not correct this non-compliance as a risk assessment must take place prior to the searches being completed. Staff education has been conducted since the occurrence with all	Bi-annual audit	No barriers to implementation	03/04/2026	Approved Centre CNM3

	approved centre staff to ensure future compliance.				
Preventative Action	Risk assessment has been added to search documentation. Heads of Discipline ensure that all approved centre staff have read and understood the CMMHS Search policy	Bi- annual audit CMMHS policy portal compliance.	No barriers to implementation	03/04/2026	Approved Centre CNM3. Heads of Discipline. Approved Centre CNM2.

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10007666		**The registered proprietor did not ensure that where a resident required a therapeutic service or programme that was not provided internally, arrangements for the service to be provided by an approved, qualified health professional in an appropriate location was not provided, 16(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The two residents who had been referred to Speech and Language Therapy (SLT) have received the service.	SLT have documented their assessments in the clinical files of both residents.	No barriers to implementation	06/03/2026	Nominee Registered Proprietor
Preventative Action	The approved centre will continue to use General Hospital services and if service for SLT is not provided within a timely manner based on resident need this will be escalated to the Nominee Registered Proprietor who will ensure SLT services are delivered. An SLT post is included as a development post for CMMHS in 2027.	General Health audit within the approved centre has been increased to bi-annually. Metrics are completed monthly. ICP audits are quarterly.	CMMHS is dependent on receiving approval and funding for the SLT development post.	03/03/2026	Nominee Registered Proprietor Responsible Consultant Psychiatrist
Reason ID : 10007667		**The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of the residents, as documented in their individual care plans. Two residents had no access to Speech and Language Therapy, 16(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The two residents who had been referred to Speech and Language Therapy (SLT) have received the service.	SLT have documented their assessments in the clinical files of both residents.	No barriers to implementation	06/03/2026	Nominee Registered Proprietor

Preventative Action	Speech and language service, through the acute hospital continue to provide SLT on referral to the APU, with escalation through registered proprietor.	General health audit within the approved centre has been increased to bi-annually. Metrics are completed monthly. ICP audits are quarterly.	CMMHS is dependent on receiving approval and funding for the SLT development post.	03/03/2026	Nominee Registered Proprietor Responsible Consultant Psychiatrist

Regulation 19: General Health					
Reason ID : 10007662		**The registered proprietor did not ensure that adequate arrangements were in place for access by residents to general health services required. One resident with a documented identified need for speech and language therapy did not have access to the service in line with their individual care plan, and another resident experienced a significant delay in accessing this service, 19(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The two residents who had been referred to Speech and Language Therapy (SLT) have received the service.	SLT have documented their assessments in the clinical files of both residents.	No barriers to implementation	06/03/2026	Nominee Registered Proprietor Speech and Language Therapist
Preventative Action	The approved centre will continue to use General Hospital services and if service for SLT is not provided within a timely manner based on resident need this will be escalated to the Nominee Registered Proprietor who will ensure SLT services are delivered. An SLT post is included as a development post for CMMHS in 2027.	The General Health audit within the approved centre has been increased to bi-annually. Metrics are completed monthly. ICP audits are quarterly.	CMMHS is dependent on receiving approval and funding for the SLT development post.	03/03/2026	Nominee Registered Proprietor Responsible Consultant Psychiatrist

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10007668		**In one clinical file the person was not informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint. A record explaining why this communication had not occurred was not entered in the person's clinical file as soon as was practicable, 3.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Approved centre CNM3 reviewed the physical restraint with the resident who acknowledged that the circumstances needed to discontinue the physical restraint was communicated to them by the restraint lead. The clinical file was updated accordingly.	All restraints in the approved centre are audited and the audits are reviewed at the CMMHS Restraint Reduction Group.	No barriers to implementation.	03/03/2026	Approved Centre CNM3
Preventative Action	Introduce physical restraint booklet for the approved centre which will include mandatory documentation. Heads of Discipline will ensure that all approved centre staff have read and understood the CMMHS policy on the use of physical restraint. All approved centre staff will be trained in PMCB which will include training in all aspects of physical restraint including documentation and	All restraints in the approved centre as of the 22nd of July will be audited no later than one week post restraint CMMHs policy portal compliance. Training records in PMCB.	No barriers to implementation.	27/07/2026	Approved Centre Clinical Director Heads of Discipline

	verbal requirements when utilising holding skills.				
Reason ID : 10007669		**For one episode of physical restraint, the registered proprietor did not notify the Mental Health Commission of the correct start time and the end time of the episode of physical restraint in the format specified by the Mental Health Commission, 3.10.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Correction of CIS notification has been completed.	Corrected on CIS.	No barriers to implementation	03/03/2026	Mental Health Act Administrator
Preventative Action	Introduce a second-person verification process before submission of all restraint notifications by CNM2 for approved centre. The new physical restraint booklet also ensures compliance with Mental Health Commission notification requirements.	All restraints in the approved centre as of the 22nd of July will be audited no later than one week post restraint Physical restraint audit tool updated as of 27th July 2026 to reflect the changes.	No barriers to implementation.	27/07/2026	Mental Health Act Administrator Approved Centre CNM2 CNM3 Compliance Officer. Approved Centre CNM3

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 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 resident'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 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 s to appropriate recreational activities.

Regulation 10: Religion

The registered proprietor shall ensure that resident s 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 s 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 . 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 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 resident'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 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 ;
(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) 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.

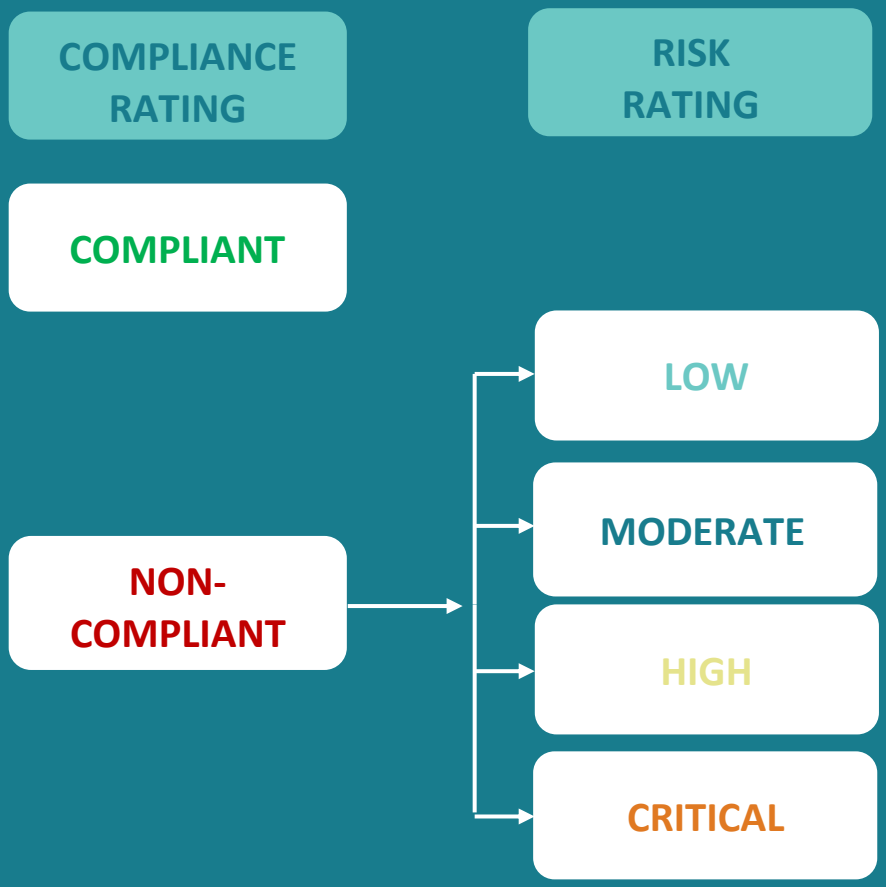
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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