Blackwater House

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

BLACKWATER HOUSE

St Davnet's Hospital Campus, Rooskey, Monaghan, Co Monaghan

Date of Publication:
31 August 2026

ID Number: AC0282

2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Continuing mental health care / long stay
Psychiatry of later life
Mental health rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
23 April 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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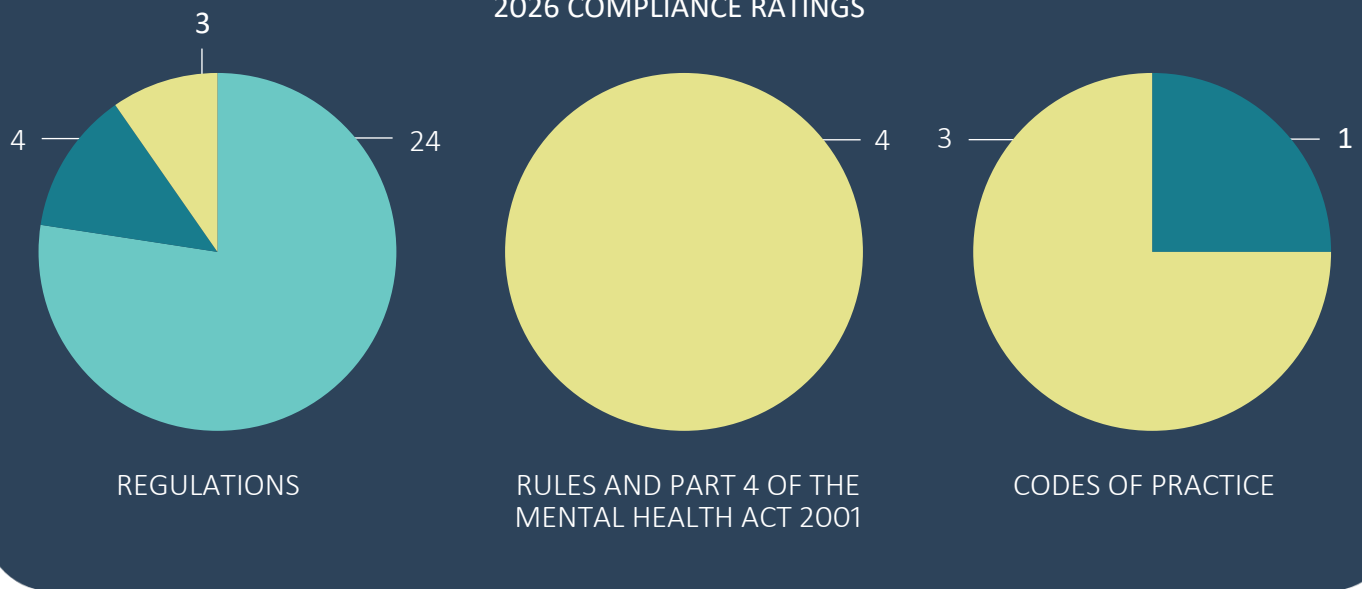
Inspection Date:
24 – 27 February 2026

Previous Inspection date:
15 – 18 July 2025

Inspection Type:
Unannounced Annual Inspection

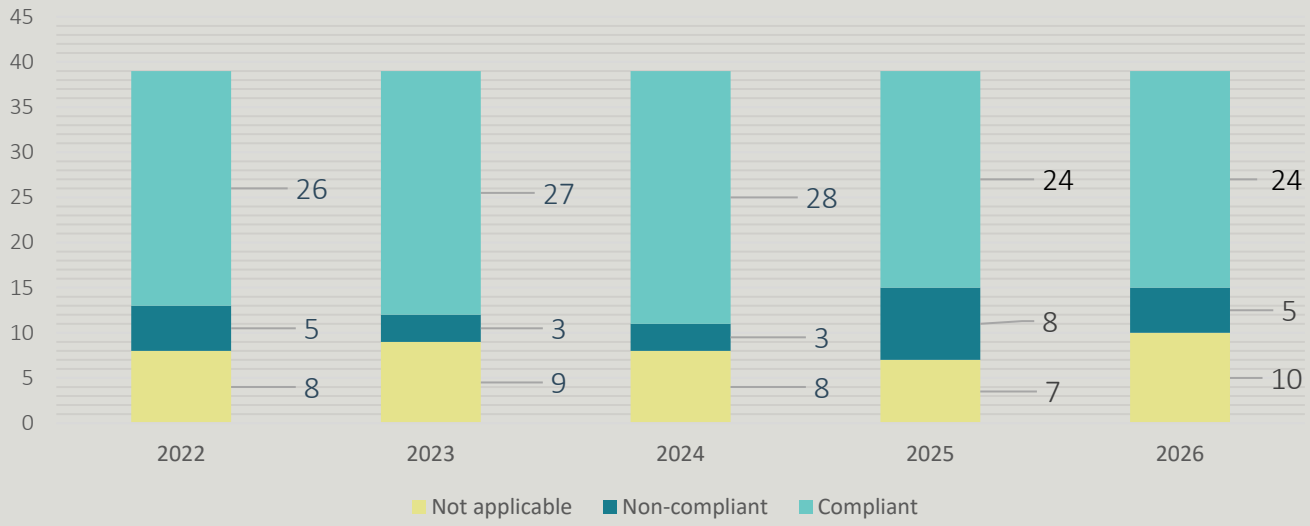
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

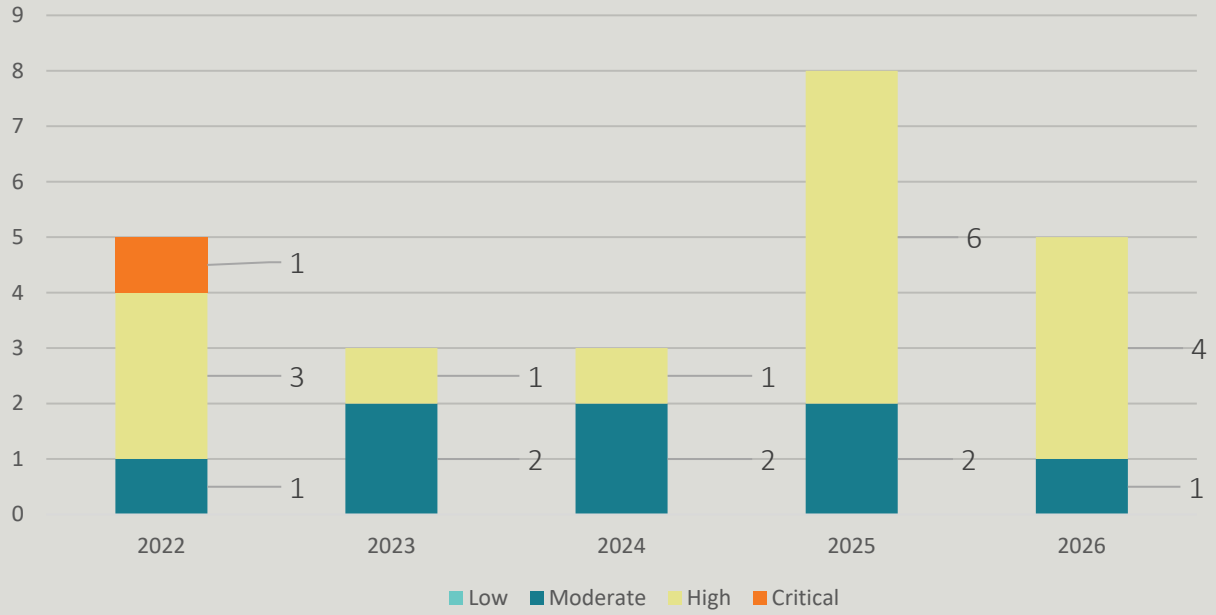
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2022 – 2026



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2022 – 2026



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Professor James V Lucey

1.1 Description of Approved Centre

Blackwater House is a purpose-built unit located on St Davnet's Campus, approximately two kilometres outside Monaghan town. It was managed by the Health Service Executive (HSE) and was still transitioning to the new HSE restructuring, which was due to be completed in March 2026. Previously under Community Healthcare Organisation Area 1 (CHO1), Blackwater House was in transition to Dublin and North East Integrated Health Area (IHA).

Blackwater House was registered to accommodate 16 residents. There were 14 residents at the time of the inspection. The approved centre was registered with the Mental Health Commission to provide acute adult mental health care, mental health rehabilitation, psychiatry of later life, and continuing/long stay mental health care. Three teams, the psychiatry of later life team, the mental health rehabilitation and recovery team, and the general adult mental health team had admission rights to the approved centre.

The approved centre was attached to a two-storey building. Located on the ground floor, the approved centre was comprised of two spacious bungalows connected by a shared corridor. The first floor of the approved centre contained offices, a tribunal room, and other non-clinical areas. Entrance doors to the building were secured with swipe access and secure airlock doors.

Each bungalow comprised of eight single en suite bedrooms, a quiet room, a sluice room and a sitting room with kitchenette facilities. The shared services corridor contained a clinical room, a consultation room, a visitors' room, a cleaning room, and a nursing station. Off the shared corridor, there was a kitchen, a dining room, an occupational therapy room and an activities room. Each bungalows had access to their own enclosed garden areas.

1.2 Inspector of Mental Health Services Summary

The inspection of Blackwater House was unannounced and occurred over a four-day period, from the 24 to the 27 of February 2026. This summary reflects the findings at the time of the inspection only. The inspection was well coordinated by the staff and management of the approved centre.

In 2025, the approved centre was found to be non-compliant in eight regulatory areas. There was an improvement in the 2026 inspection with the inspection finding six areas of non-compliances. While the

approved centre showed progress in 2026 by reducing the regulatory non-compliances, half of the 2026 findings were reoccurring issues from the previous year. A number of non-compliances were noted in relation to general health and risk management. There were clinical and health and safety risks identified during the inspection that had not been identified or assessed by the approved centre. Additionally, some risks had not been included on the risk register.

Clarity was found regarding the admission of high-acuity residents within the approved centre, clarifying previous concerns relating to ligatures within the premises. The inspection team were satisfied that the pre-admission process ensured potential incoming residents were correctly placed within the approved centre.

There had been improvements in the oversight regarding maintenance within the approved centre. Regular walkabouts were being completed by nursing management and maintenance staff, which identified concerns within the premises and allowed for repairs to be actioned in a timely manner. This management oversight was a contributing factor to the improvement in Regulation 22: Premises, resulting in full compliance during the 2026 inspection.

Additionally, there were areas where the approved centre exceeded the minimum standards set out in the Judgement Support Framework (JSF) 2026. Blackwater House was a homely, welcoming environment. Staff demonstrated a warm, respectful, and engaging approach to residents, contributing to a supportive and therapeutic environment. Namaste Care was regularly provided to residents with dementia, which is a concept focused on providing a holistic approach to residents' physical, sensory and emotional needs. Training had been completed by the occupational therapist and social workers with nursing staff. This supported an overall atmosphere of calm and person-centred care. It was evident that continuous efforts were made in improving the service.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**14**
Number of detained patients	1
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	13
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	84%	90%	90%	75%	83%

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

Blackwater House was previously part of the Health Service Executive's (HSE) Community Healthcare Organisation Area 1 (CHO1) and was still transitioning to the new HSE restructuring of Dublin and North East Integrated Health Area (IHA), which was due for completion in March 2026.

The governance processes comprised of three core meetings that met monthly; the Cavan Monaghan Mental Health Service Area Management Team (CMMHS) meeting, the Cavan Monaghan Mental Health Service Quality and Patient Safety (QPS) Committee meeting; the Leadership and Management Committee for Mental Health Services attended by senior managers. Agenda items included themes relating to service planning, key performance measures, capital works, recruitment, regulatory compliance, health and safety, risk and incident management, and finance.

Governance was further supported through the Blackwater House business meetings, which were held monthly. This forum reported into the QPS and CMMHS as appropriate. It was a comprehensive multi-disciplinary team meeting, with senior management representatives in attendance. Standing agenda items included policies, protocols, procedures, quality, safety and risk, health and safety, regulatory compliance and operational issues related to the approved centre. There were a number of working groups that supported continuous quality improvement and progress, including; the Ligature Reduction Group, Restraint Oversight Group, and the Policies, Protocols, Procedures and Guidelines (PPPG) Development Group.

Each head of discipline had regular input into the approved centre and met with their clinical staff regularly. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development. Each department had its own strategic goals and aims for staff and department development within the approved centre.

There were key personnel with responsibility for risk management in the approved centre. The person with overall responsibility for risk was identified and known by staff. The approved centre had a process in place for the management of risk. Incidents were recorded and risk-rated on the National Incident Management System (NIMS) using National Incident Report Forms (NIRF) and were reviewed by the Quality, Safety, and Service Improvement (QSSI) advisor and discussed during the CMMHS meetings, QPS meetings, and local business meetings as appropriate. Clinical risks were discussed by their treating teams as required. Incidents were reviewed at a local level at the Blackwater House Business meetings and by senior management at the QPS meetings to identify any trends or patterns occurring in the service. Serious Reportable Incidents (SREs) were discussed and investigated by the Serious Incident Management Team (SIMT).

The approved centre had a local risk register, and a corporate risk register with defined pathways for escalation and deescalation of risks to and from the QPS meeting, local business meeting, and CMMHS as appropriate. There was evidence of ongoing works to address risks within the approved centre. However, the risk management procedures were not adequate in identifying risks, reducing identified risks to the lowest practicable level, or appropriately identifying immediate control measures as significant health and safety risks were identified during the inspection, highlighting gaps in the centre's approach to risk

management procedures. The local risk register had not been reviewed within the timeframes set out by the approved centre, resulting in a clinical and health and safety risk remaining unidentified at the time of the inspection.

Nevertheless, both the local and corporate register contained risks relating to corporate, clinical and health and safety concerns, including remaining ligature anchor points, staffing vacancies in nursing and psychology, limited access to speech and language therapy and dietetic services. They also captured risks relating to infection prevention control (IPC) and safeguarding incidents. The approved centre maintained a robust safeguarding process that ensured incidents were managed effectively and their reoccurrence minimised. As part of the approved centre's registration, residents with acute mental health conditions could be admitted, however, there was a pre-admission suitability assessment in place, which determined the acuity of potential residents. Residents of high acuity were not accepted into the approved centre. In addition to the pre-admission suitability assessment, systems and processes were in place to regularly review resident's needs regarding the suitability of their placements, ensuring that care and treatment remained aligned with their individual clinical needs. There is a plan to remove Acute Adult Mental Health Care from their new registration commencing April 2026, which better reflects the current service being provided by the approved centre.

A scheduled audit programme was in place. Clinical audits were conducted at various intervals, monthly, quarterly, biannually, and annually by clinical nurse managers (CNM), non-consultant hospital doctors (NCHD) and the pharmacist. All audit results were discussed at the local business meetings, and information was provided to the CMMHS as appropriate.

Staff training compliance improved since last year's inspection, with all staff trained in fire safety and basic life support. This progress was sustained through regular oversight at the Blackwater House Business meeting. Although the levels of compliance with all mandatory trainings were not at 100% for nursing, this was explained due to leave. Staff returning from leave were scheduled to attend upcoming training in March and April 2026. The multi-disciplinary team comprised of nursing, medical, occupational therapy, psychology, and social work disciplines. While psychology and social work services met regulatory requirements through an in-reach model of care, the Heads of Disciplines noted that this arrangement was not optimal. They reported that the limited capacity hindered the delivery of comprehensive care across both community and inpatient settings. As a result, the psychology and social work managers have advocated for allocated posts specifically for the approved centre.

Resident input in governance and quality improvement processes was facilitated throughout the service. Weekly resident community meetings and suggestion boxes provided residents with a forum to voice requests, suggestions and concerns. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service. The advocacy contact details were displayed within the approved centre, and they attended the approved centre twice monthly in person and provided advocacy services twice a month in a remote capacity. The process of making complaints and the complaints officer contact details were displayed within the approved centre and in the resident information booklet. Complaints were dealt with by the staff in the approved centre and were documented with clear actions and outcomes detailed in a timely manner or in accordance with the approved centre's policy.

2.1 Therapeutic Services and Programmes

Therapeutic Services and Programmes
Each resident had access to an appropriate range of therapeutic services and programmes, in accordance with their individual care plan. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Therapeutic services were offered in a group setting and on an individual basis. Groups included Art Therapy, chair-based exercise, gardening facilitated by an Education and Training Board (ETB) tutor, flower arranging, bowling, indoor basketball, quiz, arts and crafts, baking, Relaxation Therapy, Music Therapy, Dog Therapy, cognitive stimulation (such as jigsaws, puzzles, word searches), and a Tovertafel interactive table (sensory games). An interactive TV screen was used for reminiscence groups and individual sessions (old newspapers and pictures relating to where residents lived). Residents were linked with community Occupational Therapy for therapeutic groups and sessions; residents joined local walking groups; two residents joined a choir, and the choir sang in the approved centre. One resident participated in Social Farming, a therapeutic practice involving engagement in daily agricultural activities. This initiative supported residents' overall wellbeing and fostered a meaningful connection with the local community. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

2.2 Staff Training Record

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (15)	13	87%	13	87%	15	100%	15	100%	15	100%	14	93%
Medical (6)	6	100%	6	100%	6	100%	6	100%	6	100%	6	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Dietitian (0)	N/A	%	N/A	%	N/A	%	N/A	%	N/A	%	N/A	%
Pharmacist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
[MTA] (18)	18	100%	15	83%	18	100%	N/A	%	18	100%	18	100%

3.0 Compliance

3.1 Compliant areas on this inspection

Please refer to **Appendix 2** for further guidance for compliance in relation to these regulations, rules and codes of practice.

Regulation/Rule/Act/Code		2026
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 16: Therapeutic Services and Programmes	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	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 31: Complaints Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	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 15: Individual Care Plan	✓		✓		✓		✓		✗	Moderate
Regulation 19: General Health	✓		✓		✓		✗	High	✗	High
Regulation 21: Privacy	✗	High	✗	Moderate	✓		✓		✗	High
Regulation 32: Risk Management Procedures	✗	High	✓		✓		✗	High	✗	High
Code of Practice on Admission, Transfer and Discharge	✓		✓		✓		✗	High	✗	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.
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 on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice 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 ECT	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:

- 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.
- 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.

Residents chose not to engage with the inspection team nor were any completed questionnaires received.

4.2 Advocacy

The approved centre had an advocacy service, and details were advertised throughout the approved centre. The Peer Advocate in Mental Health representative met with the inspection team during the inspection. The inspectors also received a report from the advocacy service, which was overall very positive.

Positive aspects identified in the report included that residents were well known by staff, had their own property and private bedrooms. Residents enjoyed participating in occupational therapies and recreational activities. There were activities to local beaches and areas of interest that residents enjoyed. Meals and snacks were enjoyed by residents.

5.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Registered Proprietor
- Executive Clinical Director
- Clinical Director
- Assistant Director of Nursing x2
- Business Manager
- Occupational Therapist Manager
- Principal Social Worker
- Clinical Nurse Manager 3
- Quality & Compliance Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Area Lead for Mental Health Engagement
- Nurse Practice Development Coordinator
- Blackwater House Administrator
- Consultant Psychiatrist Psychiatry of Later Life
- Consultant Psychiatrist Community Rehabilitation Service
- Consultant Psychiatrist General Adult
- Pharmacist
- Senior Occupational Therapist
- Quality and Patient Safety Advisor

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

6.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

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

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

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating **MODERATE**

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Five ICPs were inspected. The ICPs were a composite set of documents, which addressed the residents' goals, mental health care and treatment needs based on a multi-disciplinary team (MDT) assessment of the person. The documents within the ICPs were identifiable and uninterrupted and were not amalgamated with progress notes. The ICPs were discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

The ICPs identified appropriate goals for the residents. While the individual care plans identified the care and treatment required to meet goals for residents, not all individual care plans were updated contemporaneously in accordance with best practice to reflect changes to the required resources as per assessed needs. Two ICPs were not updated to reflect the required resources based on the residents' care and treatment.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all individual care plans were updated contemporaneously in accordance with best practice to reflect changes to the required resources as per assessed needs, as two individual care plans did not update the required resources.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had written operational policies and procedures for responding to medical emergencies. The policy was last reviewed in November 2023.

The approved centre had an emergency trolley and staff had access to an automated external defibrillator (AED) at all times. The clinical files of five residents who had been in the approved centre for more than six months were inspected. Residents received appropriate general health care interventions in line with their individual care plans. Three residents' general health needs were not assessed within six months.

Three six-monthly general health assessments were not completed properly as:

- Two six-monthly general health assessments did not document family or personal history.
- One six-monthly general health assessment was not completed in full as it did not contain the resident's family or personal history, smoking status, nutritional status (diet and physical activity, including sedentary lifestyle), dental health or a medication review.

Residents on anti-psychotic medication had an annual assessment that documented the following: glucose regulation, blood lipids levels, an electrocardiogram (ECG) and prolactin levels. Adequate arrangements were in place for residents to access general health services and for their referral to other health services if required.

Residents could access national screening programmes that were appropriate to their age and gender. These included breast checks, cervical screenings, retina checks and bowel screenings.

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

a) **Three residents' general health needs were not assessed within six months, 19(1)(b).**
b) **Two six-monthly general health assessments did not document family or personal history, 19(1)(b).**
c) **One six-monthly general health assessment was not completed in full and did not document family or personal history, nor was there an assessment of the resident's smoking status, nutritional status (diet and physical activity, including sedentary lifestyle), dental health or a medication review, 19(1)(b).**

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents were called by their preferred name based on their self-identification. Staff appeared and dressed professionally and interacted with residents in a professional, engaging and compassionate manner. Staff showed discretion when discussing the resident's condition or treatment needs. Permission was sought before entering a resident's room.

Residents' privacy and dignity were not maintained at all times. Two-bedroom doors were found to have non-functioning locks. Given that all en suite bathrooms lacked locks, the inability to secure the bedroom doors presented a significant concern regarding resident privacy and dignity. Additionally, the treatment room and the multi-disciplinary room did not have adequate screening, such as blinds, curtains or opaque glass. This resulted in a lack of privacy and confidentiality as other residents, staff members, visitors or members of the public were able to see into clinical areas.

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

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

a) **The registered proprietor had not ensured that all bathrooms, showers and toilets and single bedrooms had locks on the inside of the door as two bedrooms doors had non-functioning locks.**
b) **The registered proprietor had not ensured that all observation panels on doors of treatment rooms were fitted with blinds, curtains, or opaque glass, as the treatment and multi-disciplinary room had no blind, curtain or opaque glass.**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a series of written policies and procedures in relation to risk management. The risk management policy was last reviewed in August 2024, and outlined the roles and responsibilities for risk management, including:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The responsibilities of the multi-disciplinary team.
- The person responsible for the completion of six-monthly incident summary reports.
- A defined quality and safety oversight and review structure as part of the governance process for managing risk.

The policy also included:

- The process for identifying, assessing, treating, reporting and monitoring risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling specific risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register.
- The record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies, including the roles and responsibilities of key staff, the sequence of required actions, the process for communication and escalating emergencies to management.
- The process for the protection of children and vulnerable adults within the care of the approved centre.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. Corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate. Structural risks, including ligature points, were effectively mitigated through the pre-admission assessment process. By identifying the clinical acuity of residents prior to admission, the centre was able to proactively manage the environment and ensure that placement remained safe and appropriate.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Not all components of the risk management policy were implemented in practice; a significant clinical

risk was not assessed, treated, and monitored. Essential clinical equipment and cleaning supplies were left unsecured in residents' bedrooms, on public corridors and resident kitchen/sitting areas. The nursing management informed the inspection team that the clinical risk conflicted with the management of infection prevention control, resulting in the risk being overlooked. This was rectified by the end of the inspection and actions were taken to reduce the overall risk by removing these items to an appropriate locked area. As the local risk register had not been reviewed quarterly in accordance with their policy on risk management procedures, this specific clinical risk had not been documented on the risk register at the time of the inspection.

The approved centre failed to identify, assess, or monitor a significant health and safety risk relating to fire. Specifically, mandatory fire safety checks, including emergency lighting and fire alarm testing, were not conducted on the required weekly basis. While nursing management informed the inspection team that fire drills were simulated quarterly during training, there was no documented evidence to verify these exercises. This systemic oversight resulted in the risk remaining absent from the centre's risk register.

The approved centre had provided a six-monthly summary report of all incidents to the Mental Health Commission (MHC) in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting within the required timeframe. There was an emergency plan which specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

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

a) **The registered proprietor did not ensure that there were processes in place for managing fire safety risks, as fire weekly fire safety checks and quarterly fire drills were not being completed as required, 32(2).**
b) **The registered proprietor did not ensure that the risk register was maintained and reviewed in line with their policy, 32(2).**
c) **The registered proprietor did not ensure that all clinical risks were managed in line with their own policy, 32(2).**
d) **The registered proprietor did not ensure that all risks were assessed, treated, or monitored throughout the approved centre as a significant clinical risk was not documented on the risk register, 32(2)(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 3.2: 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.*

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in May 2024, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in May 2024, included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was inspected. The admission had been on the basis of a mental illness or disorder, and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family history, medical history, current and historic medications, current mental health state and risk assessment, and a physical examination. A key worker system was in place.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The discharge plan included the estimated date of discharge, a follow up arrangement and a reference to early warning signs of relapse and risks. The discharge meeting was not attended by all relevant members of the multi-disciplinary team, as there was only medical staff in attendance.

The discharge plan did not include documented evidence of communication with the relevant general practitioner.

The discharge assessment covered the following: psychiatric and psychological needs, current mental state examination, and a comprehensive risk assessment and risk management plan. The discharge was coordinated by a keyworker.

The discharge summary covered the following: diagnosis, prognosis, medication, follow-up arrangements, names and contact details of key people for follow-up, risk issues such as signs of relapse, and a family member was involved in discharge process.

A preliminary discharge summary was not sent to the general practitioner within three days.

A comprehensive discharge summary was not issued at all nor within the required 14 days following discharge.

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

a) **There was no documented evidence of communication with the relevant general practitioner, 34.2.**
b) **The discharge meeting was not attended by all relevant members of the multi-disciplinary team, as there was only medical staff in attendance, 34.4.**
c) **A preliminary discharge summary was not sent to the general practitioner within three days, 38.3.**
d) **A comprehensive discharge summary was not issued within 14 days, 38.3(b).**

Appendix 1: Corrective and Preventative Action Plan (CAPA)*

*CAPAs submitted by the registered proprietor nominee were requested and approved by the Mental Health Commission and incorporated in this inspection report. CAPAs are included in the report *verbatim* as received from the registered proprietor nominee.

Regulation 15: Individual Care Plan					
Reason ID : 10007504		**The registered proprietor did not ensure that all individual care plans were updated contemporaneously in accordance with best practice to reflect changes to the required resources as per assessed needs, as two individual care plans did not update the required resources.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Nurse management collaborated with key nurses of residents in the approved centre to review all individual Care Plans (ICPs) that were not updated contemporaneously in accordance with best practice. All changes and amendments were made to reflect changes as per residents assessed needs.	ICPs are audited monthly within metrics 3 monthly Care Plan audit 6 monthly peer review by CNM3 compliance	No barriers to implementation	03/03/2026	CNM3 Compliance Approved Centre CNM2s
Preventative Action	CMMHS are currently developing a new training programme in ICP's along with The Recovery College. CMMHS are revising the ICP audit tool to reflect a more person centred approach to	ICPs are audited monthly within metrics 3 monthly Care Plan audit 6 monthly peer review by CNM3 compliance	No barriers to implementation	30/09/2026	CNM3 Compliance Approved Centre CNM2s Heads of discipline.

	care plans. Heads of Discipline monitor the CMMHS Policy Portal to ensure 100% of staff have read and understand all policies including the Development, Management and updating of Individual Care Plans Policy.				

Regulation: 19: General Health					
Reason ID : 10007497		**Three residents' general health needs were not assessed within six months, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The three residents' general health needs were assessed subsequent to the inspection.	Complete	No barriers to implementation	03/03/2026	Approved centre NCHDs
Preventative Action	Residents' general health assessments will now be completed by the treating team's NCHD under the supervision of the treating consultant. New database developed with colour-coded alerts to ensure residents' general health needs are assessed within the correct timeframe. The General Health Audit is completed quarterly and the results of the audit are included as an agenda item at the approved centre's business meetings. All recommendations from the audits are implemented by Approved Centre management. All actions as a result of the audits are	Quarterly General health audit Frequency of audits monitored on Approved Centre audit planner	No barriers to implementation	03/03/2026	Approved centre CNM 3 Approved centre NCHDs and Consultants Heads of Discipline

	monitored by the CMMHS Quality Patient Safety Committee. In addition Quality care metrics monitor the general health assessments monthly Heads of Discipline monitor the CMMHS Policy Portal to ensure 100% of staff have read and understand all policies including the General Health Policy				
Reason ID : 10007498		**Two six-monthly general health assessments did not document family or personal history, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All relevant general health assessments were reviewed by nurse management and MDT members and all necessary sections, documentation and assessments were completed.	Complete	No barriers to implementation	03/03/2026	Approved Centre CMN3
Preventative Action	Residents' general health assessments will now be completed by the treating team's NCHD under the supervision of the treating consultant. New database developed with colour-coded alerts to ensure residents' general health needs are	Quarterly General health audit Frequency of audits monitored on Approved Centre audit planner	No barriers to implementation	03/03/2026	Approved centre CNM 3 Approved centre NCHDs and Consultants Heads of Discipline

	assessed within the correct timeframe. The General Health Audit is completed quarterly and the results of the audit are included as an agenda item at the approved centre's business meetings. All recommendations from the audits are implemented by Approved Centre management. All actions as a result of the audits are monitored by the CMMHS Quality Patient Safety Committee. In addition Quality care metrics monitor the general health assessments monthly Heads of Discipline monitor the CMMHS Policy Portal to ensure 100% of staff have read and understand all policies including the General Health Policy				
Reason ID : 10007499		**One six-monthly general health assessment was not completed in full and did not document family or personal history, nor was there an assessment of the resident's smoking status, nutritional status (diet and physical activity, including sedentary lifestyle), dental health or a medication review, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All relevant general health assessments were reviewed by	Complete	No barriers to implementation	03/03/2026	Approved Centre Clinical Nurse Manager 3

	nurse management and MDT members and all necessary sections, documentation and assessments were complete.				
Preventative Action	Residents' general health assessments will now be completed by the treating team's NCHD under the supervision of the treating consultant. New database developed with colour-coded alerts to ensure residents' general health needs are assessed within the correct timeframe. The General Health Audit is completed quarterly and the results of the audit are included as an agenda item at the approved centre's business meetings. All recommendations from the audits are implemented by Approved Centre management. All actions as a result of the audits are monitored by the CMMHS Quality Patient Safety Committee. In	Quarterly General health audit Frequency of audits monitored on Approved Centre audit planner	No barriers to implementation	03/03/2026	Approved centre CNM 3 Approved centre NCHDs and Consultants Heads of Discipline

	addition Quality care metrics monitor the general health assessments monthly Heads of Discipline monitor the CMMHS Policy Portal to ensure 100% of staff have read and understand all policies including the General Health Policy.				

Regulation 21: Privacy					
Reason ID : 10007505		**The registered proprietor had not ensured that all bathrooms, showers and toilets and single bedrooms had locks on the inside of the door as two bedrooms doors had non-functioning locks.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Maintenance Department fixed the locks of 2 bedrooms which were not functioning.	Locks inside bedroom doors, toilets, showers and bathrooms were functioning correctly after the corrective action and this was shown to the inspectors during the inspection.	No barriers to implementation	24/02/2026	Approved Centre CNM3
Preventative Action	Environmental checklist (including locks on doors) completed daily. Monthly maintenance log walk around in the approved centre records any issues which are communicated to The Maintenance Department.	By Environmental checklist Monthly maintenance log.	No barriers to implementation	27/02/2026	Approved Centre CNM2 and CNM3
Reason ID : 10007506		**The registered proprietor had not ensured that all observation panels on doors of treatment rooms were fitted with blinds, curtains, or opaque glass, as the treatment and multi-disciplinary room had no blind, curtain or opaque glass.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Opaque film was fitted to the observation panels on doors of treatment rooms to ensure the privacy of all residents.	Measurable by observation of the opaque films.	No barriers to implementation	24/03/2026	Approved Centre CNM3

Preventative Action	Environmental checklist implemented and completed daily Monthly maintenance log walk around in the approved centre records any issues which are communicated to The Maintenance Department.	By Environmental checklist Monthly maintenance log.	No barriers to implementation	27/02/2026	Approved Centre CNM2 and CNM3

Regulation 32: Risk Management Procedures					
Reason ID : 10007500		**The registered proprietor did not ensure that there were processes in place for managing fire safety risks, as fire weekly fire safety checks and quarterly fire drills were not being completed as required, 32(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire safety checks are being conducted on a weekly basis Fire evacuation drill was conducted on 22/03/2026 The approved centre requested review of the processes in place from the Fire Safety Officer and are complying with their recommendations.	Complete	No barriers to implementation	27/02/2026	Approved Centre CNM2 and CNM3
Preventative Action	CMMHS can assure the MHC that there are governance and management arrangements in place to monitor and oversee fire safety for the approved centre in the form of; A newly updated Fire Safety & Management Register which has been obtained from the Regional Fire Prevention Officer for HSE Dublin North & NE Region. This has been implemented since	The weekly fire checks & fire drills are documented.	No barriers to implementation.	02/03/2026	Approved Centre CNM3 and CNM2, HSE Fire Prevention officer for Dublin North & North East

	02.03.2026 and provides a structured approach to identify, monitor and mitigate fire safety risks in the approved centre. This is completed weekly by the CNM2 or designated nurse in charge of the approved centre.				
Reason ID : 10007501		**The registered proprietor did not ensure that the risk register was maintained and reviewed in line with their policy, 32(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The risk register for the approved centre has now been reviewed and updated.	The approved centre risk register is presented at QPS committee annually and reviewed by this committee for any errors or amendments Risk is a standard agenda item at monthly business meetings.	No barriers to implementation	22/03/2026	Approved Centre ADON and CNM3 Members of QPS committee
Preventative Action	The approved centre's risk register was reviewed by nurse management on 22nd March 2026. The risk register is a live document and is reviewed annually by the Quality & Patient Safety committee. The risk register is discussed under the standing agenda item	The approved centre risk register is presented at QPS committee annually and reviewed by this committee for any errors or amendments Risk is a standard agenda item at monthly business meetings.	No barriers to implementation	22/03/2026	Approved Centre ADON and CNM3 Members of the QPS committee.

	"Quality, Safety & Risk" at the approved centre's monthly business meetings. Any risks that cannot be managed by the approved centre are escalated to the Cavan Monaghan Area Management Team.				
Reason ID : 10007502		**The registered proprietor did not ensure that all clinical risks were managed in line with their own policy, 32(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All "dani centres" containing gloves and aprons have been removed from the approved centre. All bins and plastic bags have been removed from residents' bedrooms. The risk register for the approved centre has now been reviewed and updated.	The approved centre risk register is presented at QPS committee annually and reviewed by this committee for any errors or amendments Risk is a standard agenda item at monthly business meetings.	No barriers to implementation	22/03/2026	Approved Centre ADON and CNM3 Members of the QPS committee.
Preventative Action	The approved centre's risk register was reviewed by nurse management on 22nd March 2026. The risk register is a live document and is reviewed annually by the Quality & Patient Safety committee. The risk register is	The approved centre risk register is presented at QPS committee annually and reviewed by this committee for any errors or amendments Risk is a standard agenda item at monthly business meetings.	No barriers to implementation	22/03/2026	Approved Centre ADON and CNM3 Members of the QPS committee

	discussed under the standing agenda item "Quality, Safety & Risk" at the approved centre's monthly business meetings. Any risks that cannot be managed by the approved centre are escalated to the Cavan Monaghan Area Management Team. Environmental checklist implemented and completed daily.	Environmental checklist is documented.			
Reason ID : 10007503		**The registered proprietor did not ensure that all risks were assessed, treated, or monitored throughout the approved centre as a significant clinical risk was not documented on the risk register, 32(2)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Risk assessment was completed to capture all clinical risks identified within the approved centre and included on the updated risk register	The approved centre risk register is presented at QPS committee annually and reviewed by this committee for any errors or amendments Risk is a standard agenda item at monthly business meetings.	No barriers to implementation	22/03/2026	Approved Centre ADON and CNM3 Members of the QPS committee.
Preventative Action	The approved centre's risk register was reviewed by nurse management on 22nd March 2026. The risk register is a live document and is reviewed annually by	The approved centre risk register is presented at QPS committee annually and reviewed by this committee for any errors or amendments Risk is a standard	No barriers to implementation.	22/03/2026	Approved Centre ADON and CNM3 Members of the QPS committee.

	the Quality & Patient Safety committee. The risk register is discussed under the standing agenda item "Quality, Safety & Risk" at the approved centre's monthly business meetings. Any risks that cannot be managed by the approved centre are escalated to the Cavan Monaghan Area Management Team. Environmental checklist implemented and completed daily.	agenda item at monthly business meetings. Environmental checklist is documented.			

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10007493		**There was no documented evidence of communication with the relevant general practitioner, 34.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Consultant Psychiatrist responsible for the care of the resident completed the discharge summary and forwarded this to the relevant General Practitioner	Complete	No barriers to Implementation	19/03/2026	Approved Centre Consultant Psychiatrist
Preventative Action	A memo has been issued by the Clinical Director of the Approved Centre to all treating teams, reminding them of the need to communicate with relevant General Practitioners when discharging a resident and to document this in the clinical file when completed. The Approved Centre will audit all discharges when they occur to ensure future compliance with this code of practice. Heads of Discipline monitor the CMMHS Policy Portal to ensure 100% of staff have read and understand all policies including the Code of	The Approved Centre will audit all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centres monthly business meeting and also communicated to the Quality, Patient & Safety Committee's monthly meetings. The implementation of actions from the audits are overseen by the QPS committee.	No barriers to implementation	20/03/2026	Approved Centre Clinical Director Approved Centre CNM3 QPS committee members. Heads of Discipline

	Practice on Admission, Transfer and Discharge to and from an Approved Centre.				
Reason ID : 10007494		**The discharge meeting was not attended by all relevant members of the multi-disciplinary team, as there was only medical staff in attendance, 34.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident had been discharged prior to the inspection of the approved centre. Therefore it is not possible to correct this non compliance with an action. The preventative actions as detailed below prevent this non compliance from happening again.	The preventative actions are measured by auditing all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centre's monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. The implementation of actions from the audits is overseen by the QPS committee	No barriers to implementation of preventative actions	20/03/2026	An action to correct this non compliance is not possible however AMT have implemented preventative actions to ensure this does not happen again.
Preventative Action	A memo has been issued by the Clinical Director of the approved centre to all treating teams, reminding them to adhere to the Cavan Monaghan Policy on Admissions, Transfers & Discharges and the	The approved centre will audit all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centres monthly business	No barriers to implementation	20/03/2026	Approved Centre Clinical Director Approved Centre CNM3 QPS committee members. Heads of Discipline

	Mental Health Commission Code of Practice on Admission, Transfers & Discharges. The approved centre will audit all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centres monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. Heads of Discipline monitor the CMMHS Policy Portal to ensure 100% of staff have read and understand all policies including the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.	meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. The implementation of actions from the audits is overseen by the QPS committee			
Reason ID : 10007495		**A preliminary discharge summary was not sent to the general practitioner within three days, 38.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident had been discharged more than 3 days at the time of the inspection. Therefore it is not possible to	The preventative actions are measured by auditing all discharges when they occur to ensure future	No barriers to implementation of the preventative actions	20/03/2026	An action to correct this non compliance is not possible

	correct this non compliance with an action. Subsequently the Consultant Psychiatrist responsible for the care of the resident completed the comprehensive discharge summary and forwarded this to the relevant General Practitioner. The preventative actions as detailed below prevent this non compliance from happening again.	compliance with this code of practice. The audit results will be discussed at the approved centre's monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. The implementation of actions from the audits is overseen by the QPS committee			
Preventative Action	A memo has been issued by the Clinical Director of the approved centre to all treating teams, reminding them to adhere to the Cavan Monaghan Policy on Admissions, Transfers & Discharges and the Mental Health Commission Code of Practice on Admission, Transfers & Discharges. The approved centre will audit all discharges when they occur to ensure future compliance with this code of practice. The audit results will be	The approved centre will audit all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centres monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. The implementation of actions from the audits is overseen by the QPS committee	No barriers to implementation	20/03/2026	Approved Centre Clinical Director Approved Centre CNM3 QPS committee members. Heads of Discipline

	discussed at the approved centres monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. Heads of Discipline monitor the CMMHS Policy Portal to ensure 100% of staff have read and understand all policies including the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.				
Reason ID : 10007496		**A comprehensive discharge summary was not issued within 14 days, 38.3(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident had been discharged more than 14 days at the time of the inspection. Therefore it is not possible to correct this non compliance with an action. Subsequently the Consultant Psychiatrist responsible for the care of the resident completed the comprehensive discharge summary and forwarded this to the relevant General	The preventative actions are measured by auditing all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centre's monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. The	No barriers to implementation of the preventative actions	20/03/2026	An action to correct this non compliance is not possible

	Practitioner. The preventative actions as detailed below prevent this non compliance from happening again.	implementation of actions from the audits is overseen by the QPS committee			
Preventative Action	A memo has been issued by the Clinical Director of the approved centre to all treating teams, reminding them to adhere to the Cavan Monaghan Policy on Admissions, Transfers & Discharges and the Mental Health Commission Code of Practice on Admission, Transfers & Discharges. The approved centre will audit all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centres monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. Heads of Discipline monitor the CMMHS Policy Portal to ensure	The approved centre will audit all discharges when they occur to ensure future compliance with this code of practice. The audit results will be discussed at the approved centres monthly business meeting and communicated to the Quality, Patient & Safety committee's monthly meetings. The implementation of actions from the audits is overseen by the QPS committee	No barriers to implementation	20/03/2026	Approved Centre Clinical Director Approved Centre CNM3 QPS committee members. Heads of Discipline

	100% of staff have read and understand all policies including the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.				

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.

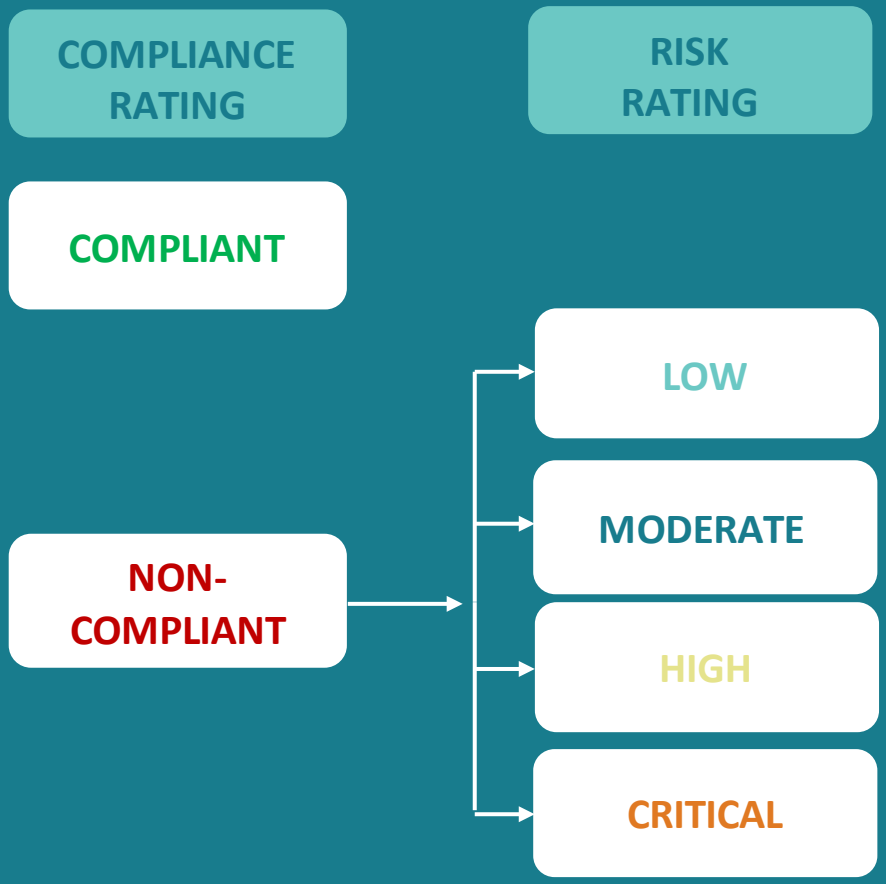
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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