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Adult Mental Health Unit, Sligo University Hospital

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

ADULT MENTAL HEALTH UNIT, SLIGO UNIVERSITY HOSPITAL

The Mall, Sligo, Co Sligo

Date of Publication:
31 August 2026

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2026 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
None

Most Recent Registration Date:
19 October 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Rosemary Hannigan

Inspection Team:
Aoife Mullaney, Lead Inspector
Barbara McGeough
Noeleen Burke
Noeleen Byrne

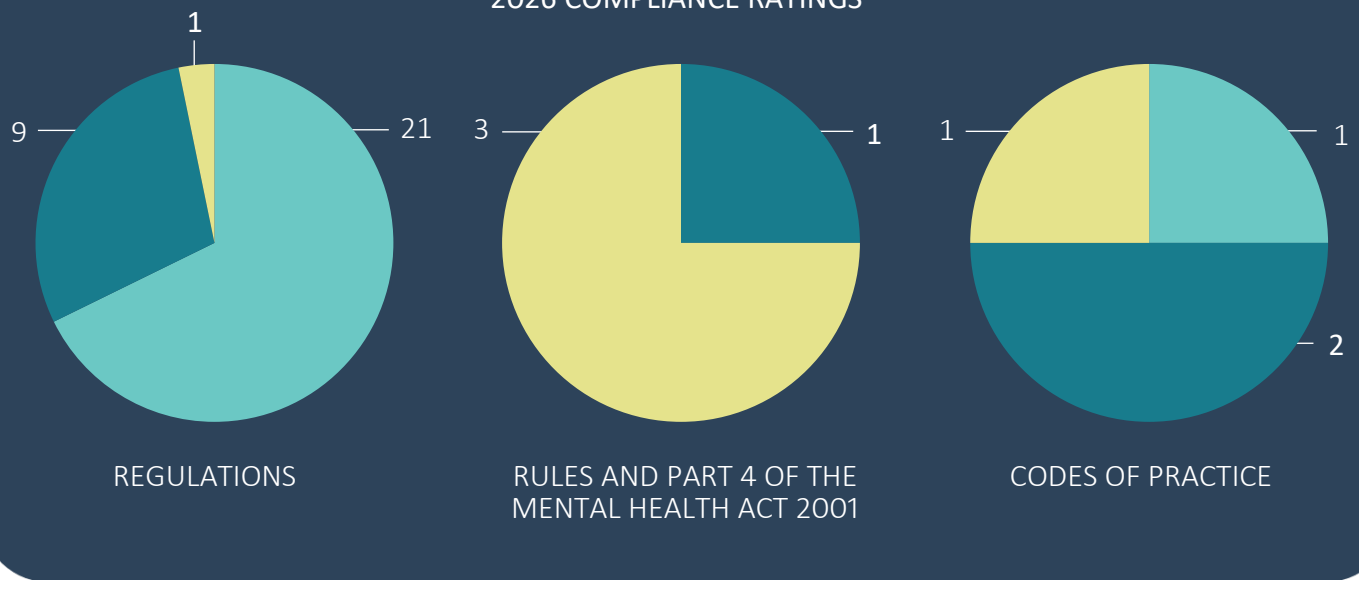
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
14 – 17 April 2026

Previous Inspection date:
19 – 22 August 2025

Inspection Type:
Unannounced Annual Inspection

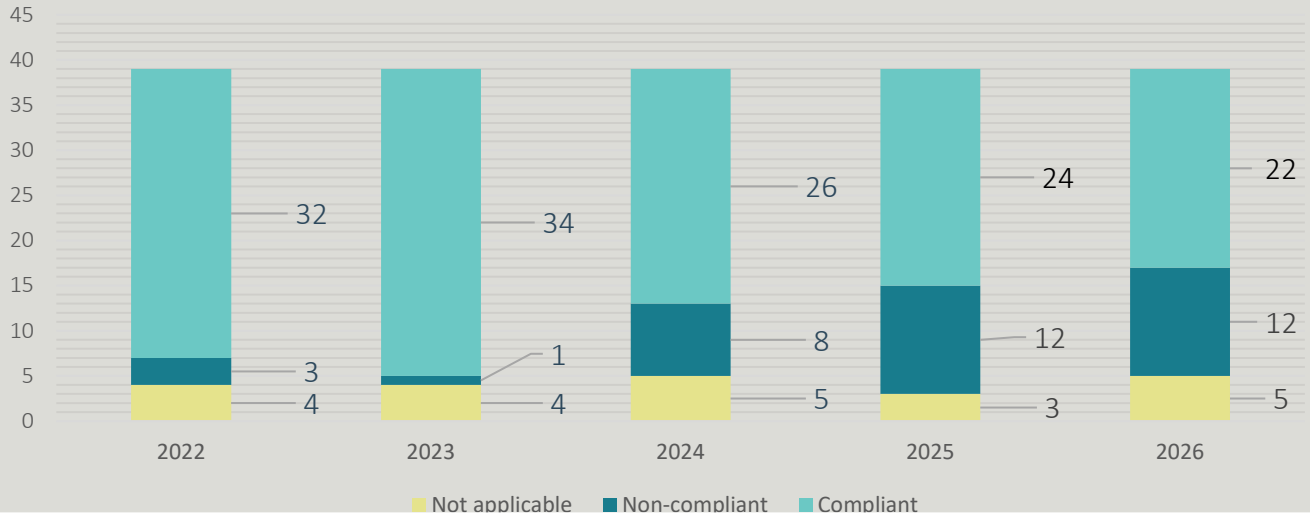
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

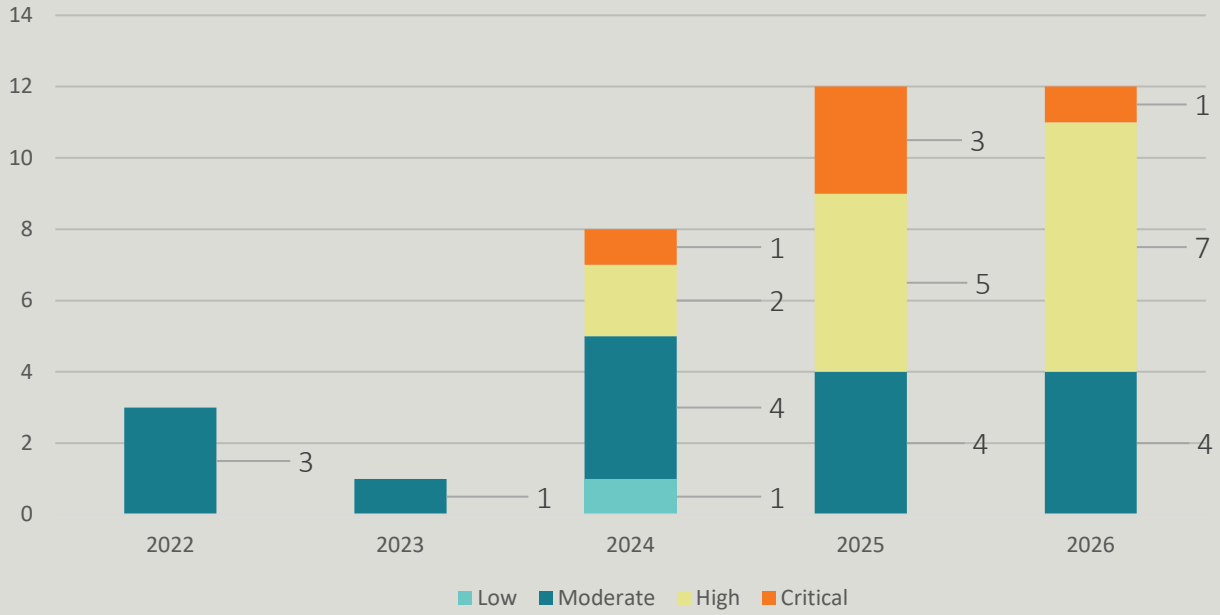
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2022 – 2026



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2022 – 2026



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

1.1 Description of Approved Centre

The Adult Mental Health Unit (AMHU) Sligo is a purpose-built, single-storey facility situated on the grounds of Sligo University Hospital (SUH) campus, offering scenic views of Benbulben mountain. The design of the building was both inviting and functional. The AMHU was physically integrated with SUH via a secure link corridor for clinical emergencies.

The entrance of the unit opened into an expansive, well-decorated lobby, containing a cafe-style seating area and a vending machine. The lobby was overlooked by the nursing station and administrative offices. Adjoining the reception area was a corridor containing offices for senior management and two dedicated visitors' rooms. Entry to both the corridor and the unit were restricted via an electronic swipe access system.

The unit's design prioritised safety and comfort, incorporating a high dependency unit (HDU) and a dedicated seclusion suite. The unit comprised of 25 spacious, single en suite bedrooms and was supported by a range of communal rooms, including several day rooms and quiet rooms, in addition to communal bathrooms, a dining room and a relaxation room. The layout was underpinned by dedicated therapeutic and rehabilitative spaces including an occupational activities room with a kitchen, a self-care room, and large internal garden equipped with exercise facilities. Further clinical areas included a treatment room, a multi-disciplinary treatment (MDT) room, and offices for allied health professionals.

Fourteen community mental health teams, including five general adult community mental health sector teams and seven specialist teams had admission rights to the approved centre. The general adult teams were assigned to the geographical areas covering North Sligo (and including Attention Deficit Hyperactive Disorder (ADHD) and Early Intervention in Psychosis (EIP)), South and West Sligo, Sligo Town, North Leitrim and South Leitrim. The specialist teams provided a service for specified population cohorts and included three Psychiatry of Old Age (POA) teams, the Rehabilitation and Recovery team, the Mental Health Intellectual Disability (MHID) team, the Crisis Resolution Team (CRT), and Liaison Inpatient Psychiatry Team from SUH. A new community mental health team, CAMHS Mental Health Intellectual Disability Team had recently been established but did not have admission rights.

The AMHU adopted an in-reach model of care, with medical staff and allied health professionals from the respective community teams attending the centre to provide treatment and support. Supported by SUH based Liaison Psychiatry Team and the Crisis Resolution Team (CRT), this collaborative approach balanced inpatient requirements with community-based support, providing continuity of care across transitions.

1.2 Inspector of Mental Health Services Summary

The inspection of the AMHU Sligo was unannounced and occurred over a four-day period, from 14 April to 17 April 2026. This summary reflects the findings of the service at the time of the inspection. In 2025, there were 12 areas of non-compliances. Similarly, in 2026 the number of non-compliances remained at 12 with a high number of reoccurrences from 2024 and 2025. Although the number of critical ratings reduced from three in 2025 to one in 2026, there was an increase in the number of high-risk ratings.

The critical rating in 2026 related to the Code of Practice on the Use of Electro-Convulsive Therapy (ECT). The findings highlighted critical documentation deficits with the prescribed documentation standards outlined in the Code of Practice. The seven regulations risk rated as high indicated deficits in the use of an evidenced-based nutritional assessment tool, individual care planning, management of general health intervention, medication management, risk management procedures, and the Rules Governing the Use of Seclusion. Four moderate risk ratings were evidenced, with respect to facilitating privacy during visitations, search procedures, maintenance management, and the Code of Practice on Physical Restraint.

Findings indicated improvements were required in clinical governance frameworks, defined lines of accountability and systematic auditing systems. As such, the Mental Health Commission (MHC) was not assured that minimum standards of safe, effective, high quality person-centred care and treatment was being provided in the approved centre for all regulatory areas. In response to the inspection findings, Sligo Leitrim Mental Health Services provided assurances to their commitment in addressing these areas of non-compliances.

Notwithstanding the identified areas of non-compliance, the service demonstrated a robust commitment to clinical research and professional education. A key highlight was the established Simulation in Psychiatry Programme, providing experiential learning in relation to emergency protocols and the use of restrictive practices. This initiative supported the approved centre's commitment to the reduction of restrictive practices. Furthermore, the Sligo/Leitrim Early Intervention in Psychosis (EIP) team continued to lead as one of three national demonstration sites for the HSE's National Clinical Programme. These initiatives, coupled with strengthened partnerships with Sligo University Hospital and community stakeholders, maintained a more integrated and cohesive model of care.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***25***
Total number of residents	**24**
Number of detained patients	4
Number of wards of court	0
Number of residents under the Assisted Decision Making Act	0
Number of children	0

Number of residents in the approved centre for more than 6 months	2
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	91%	97%	76%	67%	65%

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

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice 10000405	*30 April 2026*	*Following the annual regulatory inspection of 14 to 20 April 2026, the approved centre was found non-compliant with 12 regulations and 1 of these, the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, was risk rated as critical.*	*Approved centre submitted plans to address non-compliance, including with the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients in the approved centre. The MHC continues to engage with the HSE on this matter.*
Regulatory Compliance Meeting	*30 April 2026*	*In line with its regulatory enforcement process, the MHC determined that it was necessary to have a Regulatory Compliance Meeting with representatives of the approved centre.*	*At the Regulatory Compliance Meeting the approved centre provided the MHC with immediate assurances and the MHC continues to follow up on this matter through the immediate action notice 10000405.*

2.0 Governance

At the time of this inspection the Adult Mental Health Unit (AMHU) Sligo was in the final stages of transitioning from the Health Service Executive's (HSE) Community Healthcare Organisation Area 1 (CHO1) to the newly established Health Region Areas (RHA). Under this restructure, the AMHU was governed by the Sligo Leitrim Integrated Health Area (IHA) within the Health Region Area (RHA) West and North West. This structural transition was scheduled for completion by quarter three of 2026.

The Sligo Leitrim Mental Health Service met monthly at the Area Mental Health Management Team Meeting (AMHMT). Membership included the Head of Service, the Registered Proprietor, the Area Director of Nursing, the Executive Clinical Director, the Area Lead for Mental Health Engagement, Mental Health Act Administrator, and the heads of discipline for allied health professionals. Agenda items included themes relating to service planning and delivery, human resources, finance, training, quality, compliance, and risk.

There was a Quality and Risk Group (QRG) that convened monthly. Attendees included heads of disciplines, business manager, the Quality and Patient Safety (QPS) advisor, and a nursing representative from the approved centre. A number of subcommittees reported into the QRG, including the Drugs and Therapeutic committee, the Restrictive Practice Committee, and the Policy, Procedures and Guidance committee. Standing agenda items included a review of the risk register, overview of incidents and SIMTs, monitoring of restrictive practices, capital improvements, health and safety, and complaints and feedback.

A weekly multi-disciplinary compliance meeting subsumed the previous local business managers' meeting. Attended by clinical staff, maintenance staff, the business manager and the Mental Health Act Administrator. This meeting pertained specifically to the approved centre and centred on compliance with regulatory and legislative requirements and reported to the Quality and Risk Group. A primary focus was on restrictive practices, audits, risk and compliance, and resident feedback. Once a quarter, the compliance meeting conducted a review of the risk registers.

Management at the approved centre collaborated with the Garda Liaison Officer in quarterly meetings to improve admission processes and minimise unnecessary hospitalisations. These meetings were aimed at ensuring patients received targeted, appropriate care. The centre also convened quarterly health and safety meetings. Critical information was escalated to the compliance, QRG, and AMHMT meetings when necessary.

Key personnel responsible for risk management were clearly identified and recognised 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). Incidents reviewed locally, and trends analyses were presented at the weekly compliance meetings. Incidents were discussed at QRG and AMHMT meetings as appropriate. Serious Reportable Incidents (SREs) were discussed and investigated by the Serious Incident Management Team (SIMT). Clinical risks were discussed by their treating teams as required. While the approved centre maintained a structured risk management process, including a regularly reviewed health and safety statement and an escalation pathway to the Sligo Leitrim

Mental Health Service (SLMHS) risk register, considerable procedural gaps were identified. Existing procedures failed to adequately identify or manage a significant clinical risk. A safeguarding risk was noted, indicating that the centre's clinical risk management and safeguarding procedures were not consistently followed, particularly regarding mandated reporting requirements and discharge planning. Low compliance in safeguarding training was a contributing factor to these failures.

The organisational chart clearly outlined key roles and reporting structures. A notable improvement since last year's inspection was the enhanced access to core multi-disciplinary teams, including access to a dietician. While some resource deficits persist, particularly within the psychology teams, robust processes had been implemented to manage identified needs. The psychology referral pathway served as a model for resource-sharing and integrated working, effectively bridging service gaps across the approved centre, community teams and SUH teams. The Crisis Resolution Team (CRT) psychologist facilitated care for AMHU patients where community psychology vacancies existed. Despite these improvements to Regulation 26: Staffing, not all required staff had completed mandatory training, with numbers as low as 51% for safeguarding and fire safety, and 72% completing the Mental Health Act 2001 training.

Similarly to the 2025 inspection, the Code of Practice on the Use of Electro-Convulsive Therapy (ECT) remained at a critical level of non-compliance. Despite having a new Physical Health Clinical Nurse Specialist (CNS) and an ECT nurse within the approved centre in this year's inspection, deficits were found regarding the standards and safety requirements as per the Electroconvulsive Therapy Accreditation Service (ECTAS) of the Royal College of Psychiatrists and the Code of Practice on ECT.

There was a multi-disciplinary review and oversight committee for restrictive practice reduction that met quarterly and reported their findings to the QRG. There was an overarching reduction of restrictive practices policy, and individual policies and procedures had been updated accordingly. Although there had been a large reduction of restrictive practices within the approved centre since last year's inspection, non-compliances were found with the Rule on Seclusion and the Code of Practice on Physical Restraint.

Resident input in governance and quality improvement processes was facilitated throughout the service. Weekly resident community meetings and suggestion boxes provided residents with the forum to voice requests, suggestions and concerns. Residents attended the monthly AMHMT meetings, and feedback from the resident community meetings was discussed at the weekly compliance meeting. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service. Weekly meetings with the peer advocate occurred in person and virtually. The approved centre also utilised Care Opinion Ireland, which was an online platform where residents could share their experiences and feedback on the service.

2.1 Therapeutic Services and Programmes

Therapeutic Services and Programmes
The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. These interventions were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. A consistent therapeutic schedule was facilitated by two site-based occupational therapists (OT), consisting of two groups daily. At the time of the inspection, the allocated social worker was on leave. During periods of leave, social workers from Sligo University Hospital (SUH) teams provided an in-reach service to ensure continuity of social work input was maintained. These social workers attended care plan meetings and addressed the needs of residents as required. To mitigate vacancies in psychology staffing, the approved centre used a dual-pathway contingency model. A private company was in use for clinical assessments alongside an in-reach service from the community teams. Due to long-standing vacancies within the psychology community teams, a referral pathway had been developed by the principal psychologist and the Crisis Resolution Team (CRT) to ensure residents were provided with psychology provisions. Therapeutic services and programmes included: Independent Living Skills; Coping Through the Senses and Action Over Inertia. Recovery Through Activity groups included: gardening, creative group, relaxation, and bake to the beat. A focal point of the occupational therapy activities included the Cultural Celebration Group, which supported identity and belonging, reduced isolation and promoted recovery, in addition to encouraging cultural competence and inclusion. Coproduced groups included an outdoor gym group and yoga, both of which were facilitated by Sligo Sports Partnership and occupational therapy. Involvement from multidisciplinary teams were evident in the Lifestyle Balance Group, which consisted of pharmacy, nursing and non-consultant hospital doctors (NCHD) providing information relating to medication, blood pressure, sleep hygiene, healthy eating, and physical health. Nursing and occupational therapy led a Recovery Care Planning Group. In instances where a resident required a specialised therapeutic intervention 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.

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 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 12: Communication	✓	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 21: Privacy	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed Circuit Television	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 30: Mental Health Tribunals	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

3.2 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2022		2023		2024		2025		2026	
Regulation 05: Food and Nutrition	✓		✓		✗	Moderate	✗	Moderate	✗	High
Regulation 11: Visits	✓		✓		✓		✓		✗	Moderate
Regulation 13: Searches	✓		✓		✓		✗	Moderate	✗	Moderate
Regulation 15: Individual Care Plan	✗	Moderate	✓		✗	Moderate	✗	High	✗	High
Regulation 19: General Health	✓		✓		✓		✗	Critical	✗	High
Regulation 22: Premises	✓		✓		✓		✗	Moderate	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✓		✗	High
Regulation 26: Staffing	✗	Moderate	✓		✓		✗	High	✗	High
Regulation 32: Risk Management Procedures	✓		✓		✗	Low	✗	High	✗	High
Rule on the Use of Seclusion	✗	Moderate	✓		✗	Critical	✗	High	✗	High
Code of Practice on the Use of Physical Restraint	✓		✓		✗	Moderate	✗	Moderate	✗	Moderate
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	✓		✓		✓		✗	Critical	✗	Critical

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 had not admitted any children since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.

4.0 Service-user Experience

4.1 Service-user feedback

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

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

With the residents' permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

Seven residents met with the inspection team. Overall, feedback regarding staff, catering services, and the physical amenities of the centre were predominantly positive. Residents specifically commended the multidisciplinary team's involvement and the efficacy of external resources meeting personalised needs. Three residents advocated for increased access to structured activities, including psychological therapies, such as Cognitive Behavioural Therapy (CBT) or psychotherapy. One resident reported a functional deficiency in their bedroom door lock, impacting their sense of safety, however, acknowledged staff's responsiveness in managing same.

Two paper questionnaires were received. Feedback received was positive regarding staff and catering. Residents highly commended nursing, medical, and maintenance staff, categorising the care and professionalism as exemplary. The questionnaires revealed a variance in the clarity of communication, with two residents reporting staff did not give information to them regarding their diagnoses, care and treatment in a way they understood. One respondent reported they were involved in setting goals as part of their care planning. One person indicated they were happy with the information provided to them about their diagnosis, care and treatment.

Both residents reported they were unfamiliar with their individual care plan and did not know their multi-disciplinary team. One resident was not familiar with their keyworker and both respondents reported they were unable to talk about worries or concerns with staff when they need to. Both residents reported that they did not feel their privacy and dignity was respected. Similar to the verbal feedback, residents advocated for more leisure activities and psychological talk therapies.

Positive comments from the residents included:

- Staff - impeccable, kind, caring and helpful
- Staff are absolutely fab.
- Brilliant consultant and doctor.
- It's good here, really helpful. Try to get you on the right medication.
- Food is good.
- Exercise equipment is good.
- They are working to get it right for me.

Suggestions for improvements included:

- Therapy would be a good thing, like CBT or psychotherapy.
- Structured activities

4.2 Advocacy

The approved centre had an advocacy service, and details were advertised throughout the approved centre. The Peer Advocate representative spoke with the inspection team during the inspection. The inspectors also received a report from the Peer Advocacy in Mental Health service, which documented resident-led perspectives on positive care outcomes and identified areas for improvement, as detailed below:

Positive aspects included:

- Residents spoke positively about activities provided. Residents expressed that the activities helped alleviate anxiety.
- The facilitation of regular visits with family and friends was greatly appreciated by residents.
- Residents valued accompanied leave to spend time with family members.
- Residents felt supported and heard when they had raised concerns with nursing and medical staff.
- Residents appreciated the appropriately sized amenities, including outdoor amenities, and rooms facilitating safety, privacy, and comfort.
- Activities and support provided by occupational therapists (OT) and social workers.

Areas in need of improvement included:

- Limited availability of refreshments on the unit and the dependency on asking nursing staff.
- Laundry facilities outsourced to Dublin and the long timeframe.
- Processes for leave for voluntary patients.
- Residents would like more information and support relating to residents' mental health and physical health needs, care plans and more involvement in their care planning meetings.
- Noise levels of construction outside the approved centre.

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:

- Head of Service
- Registered Proprietor
- Executive Clinical Director
- Acting Area Director of Nursing
- Assistant Director of Nursing
- Business Manager
- Principal Psychologist
- Occupational Therapy Manager
- Area Lead for Mental Health Engagement
- Senior Social Worker Lead
- Senior Occupational Therapist
- Mental Health Act Administrator

Apologies: Clinical Director, Area Director of Nursing

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 5: Food and Nutrition

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents in the approved centre were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. A source of drinking water was available to residents at all times in easily accessible locations.

Nutritional and dietary needs were not assessed, with the use of an evidence-based nutrition assessment tool and addressed in the resident's individual care plan. A nutritional screening assessment was done on admission only and was not repeated at least monthly. In the six-monthly general health assessment, the approved centre recorded a significant weight gain for one resident. This weight gain trajectory had not been identified, and the resident's weight had not been monitored weekly which had been documented as a need in the admission assessment.

The needs of residents identified as having special nutritional requirements were not regularly reviewed by a dietitian. Dietetic input was not identified as a need or documented in the individual care plan of a resident who required it.

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

a) **The registered proprietor did not ensure that nutritional and dietary needs were assessed with the use of an evidenced-based nutrition assessment tool as key guidance within the tool was omitted and screening frequency did not align with the tool's intended use, 5(2).**
b) **The registered proprietor did not ensure that residents were provided with food and drink that took account of all special dietary requirements as the needs of one resident who required dietetic input had not been reviewed by a dietician, 5(2).**

Regulation 11: Visits

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had a written visitors policy, which was last reviewed in September 2024.

Visiting times were deemed to be appropriate and reasonable. A booking system was in place, however, visits could be facilitated outside of dedicated times, as required. Appropriate steps were taken to ensure the safety of residents and visitors during visits, as here were designated visiting facilities, comprising of two separate visitor's rooms that were located off the unit. One of the visitor rooms was specifically designated for visiting children.

The registered proprietor did not ensure that the privacy of residents during visits was fully respected. There were two visitor rooms which had glass observation panels on the doors, allowing for a full view into each room, with no blinds or opacity to facilitate a private visit. The window in one room did not have blinds, allowing for a view into the room from staff areas opposite the courtyard.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the privacy of a resident during visits was respected, 11(4).

Regulation 13: Searches

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had written operational policies and procedures on the searching of a resident, their belongings and their environment, carrying out searches with the consent of a resident, carrying out searches in the absence of consent, and the policy requirements relating to the finding of illicit substances. The policy was last reviewed in October 2025.

The clinical files of three residents were inspected in relation to search processes in the approved centre. In one clinical file inspected, the registered proprietor did not ensure that the consent of the resident was sought; that there was a minimum of two appropriately qualified staff in attendance when the search was being conducted; that the search was undertaken with due regard to the resident's dignity, privacy and gender; that the resident being searched was informed of what was happening and why; and that a written record of the search was made, which included the reason for the search.

Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. The resident search policy and procedure was communicated to all residents. Relevant staff could articulate the searching processes as set out in the policy.

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

a) **The registered proprietor did not ensure that consent of the resident was always sought as one clinical file did not have a record of consent recorded, 13(4).**
b) **The registered proprietor did not ensure that a minimum of two appropriately qualified staff were in attendance when searches were being conducted. Within one clinical file, there was no record of staff in attendance during a search, 13(6).**
c) **The registered proprietor did not ensure that all searches were undertaken with due regard to the resident's dignity, privacy and gender as there was no record of the search being conducted, 13(7).**
d) **The registered proprietor did not ensure that the resident being searched was informed of what was happening and why in one clinical file, 13(8).**
e) **The registered proprietor did not ensure that a written record of every search was made, including the reason for the search, 13(9).**

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The inspection team reviewed ten individual care plans (ICPs). The ICPs were a composite set of documents, were identifiable and uninterrupted, and were not amalgamated with progress notes.

The ICPs were developed by the multidisciplinary team (MDT) following a comprehensive assessment within seven days of the resident's admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, as appropriate.

Out of the ten ICPs inspected, three ICPS did not document appropriate goals for the resident or document the resources required to provide the care and treatment identified. One ICP was not reviewed by the MDT weekly, as is required in an acute setting; and three ICPs were not updated contemporaneously in accordance with best practice to reflect any changes to the goals, treatment, care, and required resources as per the assessed needs of the resident.

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

a) **Three individual care plans did not contain appropriate goals.**
b) **Three individual care plans did not contain resources.**
c) **Three individual care plans were not updated to reflect any changes to the goals and required resources as per the needs of the resident.**
d) **One individual care plan was not reviewed by the multidisciplinary team weekly.**

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 May 2025.

The approved centre had an emergency trolley and staff always had access to an automated external defibrillator (AED). Staff completed weekly checks of the AED and simulations of emergency events were held every month, facilitated by the Clinical Nurse Manager on duty.

Residents received appropriate general health care interventions in line with individual care plans. The approved centre conducted six-monthly general health assessments that documented the following at a minimum: a physical examination; family/personal history; weight; blood pressure; smoking status; nutritional status; medication review; and dental health.

In one clinical file, the resident's general health needs were not monitored and assessed as indicated by the resident's specific needs. One six-monthly general health assessment identified a concerning weight gain trajectory. Under the approved centre's food and nutrition policy, documented obesity requires a referral to an appropriate member of the multidisciplinary team or a dietician. As the nutritional screening assessment, completed upon admission was not repeated, this need was not identified, and a referral was not made. Consequently, adequate arrangements for general healthcare referrals were not in place.

For residents on antipsychotic medication, unless more regular review was indicated by physical examination, there were annual assessments of glucose regulation, blood lipids, prolactin, and electrocardiograms.

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

a) **The registered proprietor did not ensure adequate arrangements were in place for the referral to other health services as required for one resident, as a referral was not made to an appropriate member of the multi-disciplinary team with the consent of the resident/patient/service user, 19(1)(a).**
b) **In one clinical file, the registered proprietor did not ensure that the resident's general health needs were monitored and assessed as indicated by the resident's specific needs, in terms of weight management, 19(1)(b).**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Residents in the approved centre had access to personal space and appropriately sized communal rooms. Rooms were ventilated, and suitable and sufficient heating was provided. All resident bedrooms were appropriately sized to address the residents' needs. There was sufficient space for residents to move about, including outdoor spaces.

The approved centre was clean, hygienic, and free from offensive odours. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised.

The approved centre's physical structure was not maintained with due regard to the safety and well-being of residents, staff and visitors, as a number of fire doors were damaged and required replacement. The approved centre reported that works to replace the fire doors were due to complete on the 16 June 2026.

The premises were not maintained in good structural condition as the door lock in one bedroom was not functioning properly. It took numerous turns to unlock the door from inside the room. This was rectified at the time of inspection.

There was a sufficient number of toilets and showers for residents in the approved centre as each resident had an ensuite bedroom, and there was an assisted toilet and shower room available. There were suitable furnishings to support resident independence and comfort. Assisted devices and equipment were available to address resident needs.

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

a) **The registered proprietor did not ensure that the premises were maintained in good structural condition, as one bedroom door lock was not operating correctly, 22(1)(a).**
b) **The registered proprietor did not ensure that the condition of the physical structure was maintained with due regard to the safety and well-being of residents, staff and visitors, as a number of fire doors were damaged, 22(3).**

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

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written medication management and administration policy available in relation to the ordering, prescribing, storing and administration of medicines. The policy had a last-reviewed date of May 2025 recorded.

The policy also included processes and procedures relating to:

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

The registered proprietor ensured that the approved centre had access to a Drugs and Therapeutics Oversight Committee that met at least quarterly.

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

Ten Medication Prescription and Administration Records (MPARs) were inspected. Each MPAR recorded any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

Of the ten MPARs inspected, two residents were in receipt of HDAT. In the case of one resident, this was clearly documented on the MPAR and the clinical file. In the case of the other resident, neither the MPAR nor the clinical file documented that the resident was on HDAT. Although there was an allocated mental health pharmacist for the approved centre, there was no documented evidence of a pharmacy review of the HDAT treatment for the two residents.

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

a) **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents, as one resident was not identified as receiving high-dose antipsychotic treatment, 23(1).**
b) **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents, as in the case of two residents in receipt of high-dose antipsychotic treatment there was no pharmacist review documented, 23(1).**

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The numbers and skill mix of staffing in the approved centre were sufficient to meet resident needs, and an appropriately qualified staff member was on duty and in charge at all times, which was documented.

The registered proprietor ensured that staff had access to education and training through a coordinated and monitored annual training schedule and records. These were documented and up to date.

Not all healthcare staff were trained in Fire Safety, Basic Life Support, Management of Violence and Aggression, The Mental Health Act 2001, Safeguarding, and Children First.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Staff Training Record

Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (52)	50	96%	46	88%	51	98%	52	100%	52	100%	52	100%
Medical (39)	29	74%	20	51%	28	72%	28	72%	28	72%	20	51%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Pharmacist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all healthcare staff had completed education and training to enable them to provide care and treatment as not all staff were trained in Basic Life Support, Fire Safety, Management of Violence and Aggression, the Mental Health Act, Children First, and Safeguarding, 26(4).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

A comprehensive written policy was available in relation to risk management and incident management procedures. The policy was last reviewed in February 2025 and included requirements relating to the following:

- The person with overall responsibility for risk management
- The responsibilities of the registered proprietor.
- The responsibilities of the multi-disciplinary team (MDT).
- 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.

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. The risk management procedures actively reduced identified risks to the lowest practicable level of risk.

Not all clinical risks were identified, assessed, treated, reported, and monitored as a significant risk relating to one resident was not identified or recorded in their individual care plan (ICP). For this same resident, a risk assessment was not completed prior to discharge and the safeguarding requirements for the protection of vulnerable persons were not implemented as required.

MDTs were involved in the development, implementation, and review of individual risk management processes. Risks were reviewed in ICP MDT meetings, Quality and Risk group, compliance meetings, and Quality and Patient Safety meetings.

Residents and/or their representatives were involved in individual risk management processes.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT at their regular meeting. A record was maintained of this review and recommended actions.

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

a) **The registered proprietor did not ensure that all risks were identified or assessed throughout the approved centre as a significant clinical risk was not identified, 32(2)(a).**
b) **The registered proprietor did not ensure that appropriate actions were implemented relating to the protection of vulnerable adults within the approved centre, 32(2)(f).**

7.0 Inspection Findings – Rules

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

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

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

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

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

The approved centre had a written policy on the reduction of the use of seclusion which had been reviewed in October 2025. The policy addressed:

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

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

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

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policies. Not all staff who participated, or could participate, in the use of seclusion had completed the appropriate training, however, a record of attendance at training was maintained.

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

Evidence of Implementation:

Seclusion Facilities: The seclusion facilities were furnished, maintained and cleaned in such a way that ensured the person's inherent right to personal dignity and ensured that the person's privacy is respected. The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There were no ligature points, however, there was an

electrical fixture in the form of a clock encased on the wall of the seclusion room. As such, the fittings in the seclusion room were not of such a design and quality as not to endanger the safety of the person in seclusion. The electrical clock was at a height that was accessible to persons in the room and had visible damage marks on the plexiglass.

The seclusion room allowed staff to clearly observe the person within the seclusion room. Similarly to the rest of the approved centre, the seclusion room had underfloor heating but there were no external thermostat or controls in the seclusion suite to allow for appropriate temperature monitoring.

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

The consultant psychiatrist undertook a medical examination of the person and signed the seclusion register within 24 hours of the commencement of the seclusion episode. As soon as practicable, and if it was the person's wish in accordance with their individual care plan, the person's representative was informed of the person's seclusion, and a record of this communication was entered in the clinical file.

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

Monitoring of the Person: The person placed in seclusion was kept under direct observation by a RN for the first hour following the initiation of seclusion. A written record of the person was made by a RN every 15 minutes. In one episode, a Seclusion Care plan for the person was not developed by a RN.

Renewal of Seclusion Orders: In one episode the seclusion order was renewed. The order was renewed by an order made by a RMP under the supervision of the consultant psychiatrist (CP) or the duty CP following a medical examination, for a further period not exceeding four hours to a maximum of five renewals (24 hours) of continuous seclusion.

Ending of Seclusion: Seclusion was ended by a RMP following discussion with the person in seclusion and relevant nursing staff; or by the most senior RN in the unit, in consultation with the person in seclusion and a RMP. The person was informed of the ending of an episode of seclusion.

Following one episode of seclusion, an in-person debrief did not occur within two working days of the episode. No reason for this was documented.

Appropriate emotional support was provided to the person in the direct aftermath of the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion.

Clinical Governance: The episodes of seclusion were reviewed by members of the multi-disciplinary team (MDT) involved in the person's care and treatment, and were documented in the clinical file as soon as practicable and, in any event, no later than five working days after the episode of seclusion. The MDT

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

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

a) **Upon commencement of one episode of seclusion, a Seclusion Care Plan for the person was not developed by a registered nurse, 5.7.**
b) **The in-person debrief did not occur within two working days of one episode of seclusion, 7.6(ii).**
c) **The seclusion room did not have externally controlled heating and air conditioning, which enabled those observing the person to monitor the room temperature, 8.1(v).**
d) **Not all fittings in the seclusion room were of such a design and quality as not to endanger the safety of the person in seclusion, as there was an electrical fitting in the room, 8.1(ii), 8.3.**
e) **Not all staff who participated, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures, 11.1.**

8.0 Inspection Findings – Mental Health Act 2001

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

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

9.0 Inspection Findings – Codes of Practice

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

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

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

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint (PR). The policy had been reviewed annually and was dated August 2025.

It addressed the following:

- The provision of information to the person which should include information about the person's rights, presented in accessible language and format.
- Information regarding who can initiate and who may carry out the PR.
- Information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of PR.
- Who will receive training based on the identified needs of persons who are restrained and staff.
- The areas to be addressed within the training programme, which should include training in:
    - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
    - Alternatives to PR.
    - Trauma-informed care.
    - Cultural competence.
    - Human rights, including the legal principles of restrictive interventions.
    - Positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.
    - The monitoring of the safety of the person during and after the PR.
- The mandatory nature of training for those involved in PR.

It did not address the following:

- The identification of appropriately qualified person(s) to give the training.

The approved centre had a written policy on the reduction of physical restraint (PR). The policy was dated October 2025.

It addressed the following:

- How the approved centre aims to reduce, or where possible eliminate, the use of PR within the approved centre.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.

It did not address the following:

- How the approved centre will provide positive behaviour support as a means of reducing or, where

possible eliminating, the use of PR within the approved centre.

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

Monitoring: An annual report on the use of PR in the approved centre had been completed.

Evidence of Implementation: The documentation of two episodes of PR was inspected. In both episodes, PR was initiated by a registered medical practitioner (RMP) or registered nurse (RN) in accordance with the approved centre's policy on PR. The orders for PR confirmed that there were no other less restrictive ways available to manage the person's presentation.

The consultant psychiatrist (CP) or the duty CP was notified as soon as was practicable and this was recorded in the clinical files. The RMP completed a medical examination of the person no later than two hours after the start of the episode of PR.

In one episode, the person who was restrained had a history of trauma but there was no documented evidence that the principles of trauma-informed care were used during the episode when restraining the person.

Following each episode of PR, an in-person debrief was conducted with the person who was restrained, which gave the person the opportunity to discuss the PR with members of the MDT involved in the person's care and treatment. Appropriate emotional support was provided to the person following the episode of PR and support was offered to other persons who may have witnessed the restraint of the person.

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

a) **The registered proprietor did not ensure that if the person had a history of trauma and/or abuse there was documented evidence that the principles of trauma-informed care were used during the episode of restraining the person, 4.2.**
b) **The registered proprietor did not ensure that that the reduction of physical restraint policy clearly documented how the approved centre would provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint in the approved centre, 7.5(iii).**
c) **The registered proprietor did not ensure that the approved centre's policy on physical restraint included the identification of appropriately qualified person to give prevention and therapeutic management of violence and aggression training, 8.2(c).**

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated April 2025. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The ECT suite was not inspected as it was not located within the approved centre. Staff involved in ECT reported that ECT took place in Sligo University Hospital (SUH) and that the ECT suite had a private waiting area, adequately equipped treatment room, and an adequately equipped recovery room. High-risk residents were treated in a rapid-intervention area. There was a facility for monitoring electroencephalogram (EEG) on two channels. The staff reported that up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia were prominently displayed.

The ECT trolley containing required ECT equipment that was usually stored in SUH was brought to the approved centre for inspection. There was evidence that the ECT machines were regularly maintained including, a record of maintenance and confirmation of machine-servicing. Materials and equipment were in line with best international practice, and staff reported the same for emergency drugs, which were stored in SUH. Details of emergency drugs and equipment were included in the policy.

A named consultant psychiatrist (CP) had overall responsibility for ECT management, and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one resident who voluntarily underwent an ECT programme of 12 treatments was inspected. The CP gave appropriate information on ECT to the resident to enable them to make a decision on consent. Information was given on likely adverse effects of ECT. The information was given both verbally and in writing, in simple-to-understand language.

Subject to the urgency of clinical circumstances, the resident was given 24 hours to reflect on the

information as they wished. The resident was informed of their right to access an advocate of their choosing at any stage. All their questions were answered, and this was documented. ECT was only administered with the resident's consent and the CP assessed and was satisfied with the resident's capacity to consent before obtaining it.

A written record of the assessments of capacity to consent to ECT was kept in the resident's clinical file. Consent was also given by the resident before each ECT treatment session. All consent was obtained by a CP or a registered medical practitioner (RMP) under the supervision of a CP and recorded in the clinical file. The programme of ECT was only prescribed by the responsible CP and the prescription was recorded in the clinical file.

Anaesthesia for ECT was given by an anaesthetist who had experience in providing anaesthesia for ECT.

The following deficits were found in inspection:

- Out of the programme of twelve ECT treatments, the pre-anaesthetic assessment recorded in the clinical file:
    - Did not include a detailed full physical exam prior to seven treatments.
    - Did not record a detailed medication history prior to eight treatments.
    - Did not record the allergy status prior to one treatment.
    - Did not record the duration of fasting prior to six treatments.
- The monitor recordings before and immediately after treatment and recovery were not recorded and dated in every treatment. The record was not signed by the anaesthetist and filed on the voluntary patient's clinical file. Perioperative care was not recorded and signed in nine treatments and postoperative care was not recorded and signed in eight treatments by the anaesthetist and stored in the clinical file.
- The registered proprietor did not ensure that the approved centre's ECT policy was implemented throughout the duration of the ECT programme as the anaesthetist form was not completed after every treatment session and mental health staff did not ensure that all documentation was completed prior to every treatment.

The resident's clinical file and the forms that were required by this Code of Practice were made available to all involved in the administration of ECT. ECT was only administered by an RMP. Where the RMP was not a CP, he or she was under the supervision of a CP. ECT was administered by a constant current, brief pulse ECT machine capable of delivering a wide range of electrical dose, in line with best international practice.

There was a named CP with overall responsibility for the management of ECT. There was a named consultant anaesthetist with overall responsibility for anaesthesia. There was a minimum number of two registered nursing staff in the ECT suite at all times to safely meet the needs of patients, one of whom was designated as having overall responsibility for nursing care for patients receiving ECT. All staff involved in ECT were trained commensurate with their role, in line with best international practice.

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

a) **Out of a programme of twelve Electro-Convulsive Therapy treatments, the pre-anaesthetic assessment recorded in the clinical file did not include a detailed full physical exam prior to seven treatments, did not record a detailed medication history prior to eight treatments, did not record the allergy status prior to one treatment, and did not record the duration of fasting prior to six treatments, 8.3.**
b) **The monitor recordings before and immediately after treatment and recovery were not recorded and dated in every treatment. The record was not signed by the anaesthetist and filed on the voluntary patient's clinical file. Perioperative care was not recorded and signed in nine of the twelve treatments and post operative care was not recorded and signed in eight of the twelve treatments by the anaesthetist and stored in the clinical file, 8.8.**
c) **The registered proprietor did not ensure that the approved centre's Electro-Convulsive Therapy policy was implemented throughout the duration of Electro-Convulsive Therapy programme as the anaesthetist form was not completed after every treatment session and mental health staff did not ensure that all documentation was completed prior to every treatment, 13.1.**

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

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

Regulation 05: Food and Nutrition					
Reason ID : 10007620		**The registered proprietor did not ensure that nutritional and dietary needs were assessed with the use of an evidenced-based nutrition assessment tool as key guidance within the tool was omitted and screening frequency did not align with the tool's intended use, 5(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident's nutritional assessment file was reviewed in full. The SANSI nutritional screening tool was completed in accordance with the evidence-based guidance, ensuring all required sections were accurately documented and the resident's nutritional status was reassessed. Following the commencement of Dietitian involvement, the nutritional assessment was reviewed again and updated to reflect the Dietitian's recommendations and current nutritional needs.	Weekly audit of resident records will demonstrate compliance with completion of the SANSI nutritional assessment tool in line with guidance, appropriate reassessment at the required frequency, and documented review following Dietitian involvement. Audit results will be monitored by the Clinical Nurse Manager and reviewed at MDT and any non-compliance addressed promptly.	achievable and realistic with no barriers	13/04/2026	Clinical Nurse Managers, Dietician; Responsible Consultant Psychiatrist

Preventative Action	All residents will have their nutritional needs assessed using the approved evidence-based nutrition screening tool in line with the tool's guidance, including the recommended screening frequency. Dietitian involvement with the nutritional assessment will be reviewed and updated promptly to incorporate specialist recommendations. Nursing staff will be reminded of the correct completion and review requirements for the nutrition screening tool to ensure ongoing compliance with Regulation 5(2).	Weekly audit of resident records will demonstrate compliance with completion of the SANSI nutritional assessment tool in line with guidance, appropriate reassessment at the required frequency, and documented review following Dietitian involvement. Audit results will be monitored by the Person in Charge and any non-compliance addressed promptly.	achievable and realistic with no barriers	28/04/2026	Clinical Nurse Managers, Dietician; Responsible Consultant Psychiatrist
Reason ID : 10007621		**The registered proprietor did not ensure that residents were provided with food and drink that took account of all special dietary requirements as the needs of one resident who required dietetic input had not been reviewed by a dietician, 5(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident identified during the inspection was referred to and reviewed by the Dietitian. The resident's nutritional care plan and dietary requirements were	Weekly audit of ICP and Nutritional Tool, to ensure compliance with recommendations	Achievable and realistic with no barriers	28/04/2026	Nursing Staff, Clinical Nurse Manager; Dietician; Responsible consultant Psychiatrist

	updated to reflect the Dietitian's recommendations, and these recommendations have been implemented to ensure the resident's nutritional needs are met.				
Preventative Action	All residents' nutritional and dietary requirements will be regularly reviewed to ensure they continue to meet their individual needs. Residents identified as requiring specialist nutritional support will be referred promptly to the Dietitian, and all Dietitian recommendations will be incorporated into the resident's care plan and implemented without delay. The Clinical Nurse Manager will oversee referrals and weekly MDT reviews will ensure timely dietetic input and ongoing compliance with Regulation 5(2).	Weekly audit of ICP and Nutritional Tool, to ensure compliance of recommendations	Achievable and realistic with no barriers	28/04/2026	Nursing Staff, Clinical Nurse Manager; Dietician; Responsible consultant psychiatrist

Regulation 11: Visits					
Reason ID : 10007594		The registered proprietor did not ensure that the privacy of a resident during visits was respected, 11(4).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Privacy screening was actioned on the glass panel of the visiting room door during inspection to prevent visibility into the room while maintaining safety. The visiting room has been inspected to ensure it provides an appropriate level of privacy for residents during visits. Residents have been informed that the room is available for private visits.	Regular environmental audits	Achieved	10/04/2026	Clinical Nurse Managers Maintenance Foreman ADoN
Preventative Action	Regular inspection of privacy screening to ensure it remains intact and provides adequate privacy.	Regular audit of visitor rooms.	Achievable	13/04/2026	Maintenance Foreman Clinical Nurse Manager Household Support Staff

Regulation 13: Searches					
Reason ID : 10007595		**The registered proprietor did not ensure that consent of the resident was always sought as one clinical file did not have a record of consent recorded, 13(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified clinical file was immediately reviewed. Where consent had been obtained but not documented, the record was updated to accurately reflect the discussion.	Audit on consent and documentation standards Staff training on consent Discuss findings at staff meetings to reinforce compliance.	Achievable and realistic	13/04/2026	Clinical Nurse Manager (CNM)
Preventative Action	Training provided to all relevant staff on Regulation 13(4), informed consent, and documentation requirements. Monthly clinical documentation audits, including consent records, with findings reviewed by the Clinical Nurse Manager. Discuss audit findings and documentation standards at staff meetings and weekly compliance meeting to reinforce compliance.	Audit on consent and documentation standards Discuss findings at staff meetings to reinforce compliance.	Achievable and realistic	13/04/2026	Clinical Nurse Manager (CNM); ADoN; Clinical Director
Reason ID : 10007596		**The registered proprietor did not ensure that a minimum of two appropriately qualified staff was in attendance when searches were being conducted. Within one clinical file, there was no record of staff in attendance during a search, 13(6).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	t he identified clinical record was reviewed to determine whether the search had been conducted in accordance with Regulation 13(6). the record was updated to reflect the staff members who were present. All recent search documentation was audited to confirm that searches were conducted with two appropriately qualified staff members present and that this was clearly documented. Any gaps in documentation were addressed	audit of search documentation to monitor compliance.	Achievable and Realistic	13/04/2026	CNM1 and CNM2
Preventative Action	the search documentation template was revised to ensure compliance with the Regulation 13(6). and to include the patient's views, experience, and emotional response to the search, including any distress or concerns expressed.The finding has been discussed with the clinical team,	A monthly audit of search documentation will be completed f to monitor compliance.	Achievable and realistic	27/07/2026	Clinical Nurse Manager 1 Clinical Nurse Manager 2

	and staff have been reminded of their responsibility to ensure compliance with Regulation 13(6) and the approved Search Policy. Staff have been instructed that all searches must be conducted with a minimum of two appropriately qualified staff members present and that the names, roles, and signatures of staff in attendance must be clearly documented in the clinical record.				
Reason ID : 10007597		**The registered proprietor did not ensure that all searches were undertaken with due regard to the resident's dignity, privacy and gender as there was no record of the search being conducted, 13(7).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The search log was reviewed in conjunction with the clinical file. Guidance provided to staff to ensure all future searches are fully documented. All nursing and multidisciplinary staff were reminded of the requirements under Regulation 13(7) and the local policy for	Audit of searches	Achievable	13/04/2026	MDT members; Clinical Nurse Managers

	conducting and documenting searches.				
Preventative Action	Education will be provided to all clinical staff on the policy for resident searches, documentation standards, and the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006. The Clinical Nurse Manager will undertake audits of search documentation to monitor compliance with Regulation 13(7). Audit findings will be reviewed at the weekly compliance meeting if necessary with corrective actions implemented where deficits are identified.	Regular review of search documentation Audit	Achievable with no barriers to implementation	27/04/2026	MDT members; Clinical Nurse Managers
Reason ID : 10007598		**The registered proprietor did not ensure that the resident being searched was informed of what was happening and why in one clinical file, 13(8).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident's clinical record was reviewed to establish whether the resident was informed of the search and the reason for the search. All nursing and multidisciplinary staff were reminded of the requirements under	Review of all search documentation and regular audit.	Achievable with no barriers to implementation	27/04/2026	All MDT members; Clinical Nurse Managers

	Regulation 13(7) and the local policy for conducting and documenting searches.				
Preventative Action	Policy on searches reviewed. Search Log redesigned to include that information to resident regarding the search is recorded. All nursing and multidisciplinary staff were reminded of the requirements under Regulation 13(7) and the local policy for conducting and documenting searches.	Audit of searches	Achievable	31/07/2026	Clinical Nurse Managers; PPPG group
Reason ID : 10007599		**The registered proprietor did not ensure that a written record of every search was made, including the reason for the search, 13(9).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The search log was reviewed to establish whether any undocumented searches had occurred and to ensure all future searches are fully documented. All nursing and multidisciplinary staff were reminded of the requirements under Regulation 13(7) and the local policy for conducting and documenting searches.	Audit of searches conducted Findings discussed at staff meetings and weekly compliance meeting if deficits identified.	Achievable	13/04/2026	MDT members; Clinical Nurse Managers

Preventative Action	Guidance will be provided to all clinical staff on the policy for resident searches, documentation standards, and the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006. The Clinical Nurse Manager (CNM) will undertake audits of search documentation to monitor compliance with Regulation 13(7). Audit findings will be reviewed at the local weekly compliance meeting, with corrective actions implemented where deficits are identified.	Audit of searches	Achievable and realistic with no barriers to implementation	31/07/2026	Clinical Nurse Managers

Regulation 15: Individual Care Plan					
Reason ID : 10007602		**Three individual care plans did not contain appropriate goals.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified care plans were reviewed immediately and updated to clearly specify all goals. Residents' current needs were reassessed to ensure care plans reflected up to-date clinical requirements and supports.	Regular ICP audit every 6 months Staff training on a regular basis	Achievable and realistic	13/04/2026	Multidisciplinary team members
Preventative Action	Regular audits of care plans will be conducted to ensure completeness, quality, and compliance with regulatory standards. MDT reviews will include a specific check to ensure care plans clearly outline goals to deliver care.	Audit and review of ICP checklist Feedback of audits at regular weekly staff meetings Findings from ICP audits are reported at compliance and Quality and Risk meetings, with action plans implemented where deficits are identified.	Achievable and realistic	13/04/2026	Multidisciplinary team members Clinical Nurse Managers
Reason ID : 10007603		**Three individual care plans did not contain resources.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified care plans were reviewed immediately and updated to clearly specify all resources. Residents' current needs were reassessed to ensure care plans reflected up to-date	Regular ICP audit every 6 months Staff training on a regular basis	Achievable	13/04/2026	All MDT members

	clinical requirements and supports.				
Preventative Action	Regular audits of care plans will be conducted to ensure completeness, quality, and compliance with regulatory standards. MDT reviews will include a specific check to ensure care plans clearly outline resources needed to deliver care	Audit and review Feedback of audits at regular weekly staff meetings Findings from ICP audits are reported at compliance and Quality and Risk meetings, with action plans implemented where deficits are identified.	Achievable with no barriers to implementation	13/04/2026	MDT members Clinical Nurse ManagersAchievable with no barriers to implementation
Reason ID : 10007604		**Three individual care plans were not updated to reflect any changes to the goals and required resources as per the needs of the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The individual care plans were immediately reviewed and updated to clearly outline any changes to the goals and required resources. Regular audit and discussion of findings	Regular audit and discussion of findings	Achievable with no barriers to implementation	13/04/2026	All MDT members
Preventative Action	Ongoing ICP training is delivered to all relevant staff on developing comprehensive, person-centred care plans, and updating ICPs to reflect changing needs. Clearly assigning responsibility for each aspect of care All care plans will undergo	Regular audit of ICPs	Achievable and realistic	13/04/2026	Responsible Consultant Clinical Nurse Managers MDT members

	weekly MDT review, with formal sign-off to ensure clarity				
Reason ID : 10007605		**One individual care plan was not reviewed by the multidisciplinary team weekly.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The ICP was immediately reviewed and rectified by the MDT members.	Regular audit of ICPs and discussion of findings at Compliance and QRG meetings	Achievable	13/04/2026	All MDT members Clinical Nurse Managers
Preventative Action	Schedule to ensure ICPs are reviewed weekly.	Regular audit of ICPs Staff training on ICPs on a regular basis	Achievable with no barriers to implementation	13/04/2026	All MDT members Clinical Nurse Managers

Regulation 19: General Health					
Reason ID : 10007570		**The registered proprietor did not ensure adequate arrangements were in place for the referral to other health services as required for one resident, as a referral was not made to an appropriate member of the multi-disciplinary team with the consent of the resident/patient/service user, 19(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident's care plan and clinical needs were reviewed by the responsible consultant psychiatrist and multidisciplinary team.	Weekly review of care planand clinical needs by MDT Monthly review of evidence based nutritional assessment tool	Achieved	28/04/2026	Responsible Consultant Psychiatrist Dietitian MDT members
Preventative Action	A standardised referral pathway is now implemented to ensure all referrals are actioned. Referrals are documented in the clinical record and tracked until acknowledged and actioned.	Weekly MDT review Monthly review of evidence based nutritional tool	Achievable with no barriers to implementation	28/04/2026	Responsible Consultant Dietitian Nursing staff
Reason ID : 10007571		**In one clinical file, the registered proprietor did not ensure that the resident's general health needs were monitored and assessed as indicated by the resident's specific needs, in terms of weight management, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The clinical file was immediately reviewed by the treating team. A referral to the relevant clinical service was made.	Weekly MDT review Monthly review of nutritional evidence based tool	Achievable and realistic	28/04/2026	Responsible Consultant Psychiatrist Dietitian Nursing staff
Preventative Action	Weekly weight monitoring of residents Referral when clinically indicated following discussion at weekly	Weekly ICP review Monthly nutritional tool review	Achievable with no barriers to implementation	28/04/2026	Responsible Consultant Psychiatrist Dietitian Nursing staff

	MDT meeting Monthly monitoring of nutritional tool				

Regulation 22: Premises					
Reason ID : 10007608		**The registered proprietor did not ensure that the premises were maintained in good structural condition, as one bedroom door lock was not operating correctly, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Bedroom door lock was fixed during inspection and advised at feedback meeting. No corrective action required.	Environmental audits carried out regularly	No barriers to implementation Achievable	09/04/2026	Maintenance foreman; Clinical Nurse Managers
Preventative Action	Environmental audits carried out regularly. Maintenance request system in place.	Regular audit schedule Regular review at weekly compliance meeting of maintenance issues.	Achievable	09/04/2026	Maintenance foreman; Clinical Nurse Managers
Reason ID : 10007609		**The registered proprietor did not ensure that the condition of the physical structure was maintained with due regard to the safety and well-being of residents, staff and visitors, as a number of fire doors were damaged, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A comprehensive review of all fire doors throughout the AMHU was undertaken by an approved fire safety contractor to identify any damage, defects, or non-compliance with fire safety standards. All deficits identified during the review are currently being repaired or replaced as a priority. Any defects affecting fire compartmentation will be addressed	Regular review	External contractors not meeting deadlines are a barrier to implementation.	31/08/2026	ADON; Business Manager, Estates Manager, Registered Proprietor, Clinical Director

	immediately, with temporary risk control measures implemented where required until repairs are completed. A works schedule has been redevised, detailing the phased installation of new fire doors where replacement is required. The schedule includes defined timelines and oversight by the Business Manager, Estates Dept and Registered Proprietor to ensure completion. Additional fire drills will be conducted across all shifts to reinforce staff knowledge of emergency procedures, test evacuation arrangements, and identify any learning points. Outcomes from the drills will be documented, reviewed, and any identified improvements implemented.				
Preventative Action	A planned preventative maintenance programme for all fire doors is incorporated	Regular audit	Achievable	31/08/2026	ADON; Business Manager, Estates Manager, Registered Proprietor, Clinical Director

	into the AMHU's maintenance schedule. Routine inspections are completed at regular intervals (every 6 months) to ensure doors remain in good working order and compliant with fire safety regulations. Fire door inspections form part of the AMHU environmental and health and safety audit programme, with findings reported to the Compliance meeting. Fire drills continue to be scheduled (including random drills day and night) at regular intervals throughout the year, ensuring participation across day and night shifts, with records reviewed for trends and opportunities for continuous improvement. Progress against the fire door replacement works schedule will be monitored at weekly compliance and the monthly Quality and Risk meetings until all				

	works are completed. Evidence of completed repairs, replacements, and ongoing maintenance will be retained for audit and regulatory inspection.				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10007622		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents, as one resident was not identified as receiving high-dose antipsychotic treatment, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The resident's clinical file was reviewed, and the prescribing documentation and monitoring records were reviewed to ensure they accurately reflected the treatment regimen. Prescribing and documentation practices were communicated to the multidisciplinary team.	Weekly review of Drug Kardex Medication Audits Discussion at Drugs and Therapeutic Meetings	Achievable with no barriers to implementation	13/04/2026	Clinical Director; Responsible consultant psychiatrist, Pharmacist , CNM1, CNM2
Preventative Action	A review of prescribing practices has been undertaken to ensure all residents receiving high-dose antipsychotic treatment are appropriately identified, documented, monitored, and managed in line with the approved centre's medication prescribing policy and relevant clinical guidelines. All relevant Staff will be reminded of the requirement to clearly	Weekly review of Drug Kardex Medication Audits Discussion at drugs and Therapeutic Meetings	Achievable with no barriers to implementation	13/04/2026	Clinical Director Responsible Consultant psychiatrist , Pharmacist , CNM1, CNM 2

	identify and monitor residents prescribed high-dose antipsychotic therapy.				
Reason ID : 10007623		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents, as in the case of two residents in receipt of high-dose antipsychotic treatment there was no pharmacist review documented, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review of all residents prescribed high-dose antipsychotic therapy has been completed. The pharmacist reviewed the identified residents and documented these reviews in the clinical records.	Medication audits will include review of documentation of pharmacist assessments for all residents prescribed high-dose antipsychotic medication. Findings will be reported through the quarterly drugs and therapeutic group.	achievable with no barriers	13/04/2026	Clinical director, consultant psychiatrist ; pharmacist / nursing management
Preventative Action	The medication management process has been updated to ensure that all residents receiving high-dose antipsychotic treatment receive a documented pharmacist review in line with the Approved Centre's medication management procedures and MHC requirements. The pharmacist will now document all high-dose antipsychotic reviews	Medication audits will include review of documentation of pharmacist assessments for all residents prescribed high-dose antipsychotic medication. Findings will be reported through the quarterly drugs and therapeutic group meeting.	Achievable with no barriers	13/04/2026	Clinical director, Responsible consultant psychiatrist; pharmacist / nursing management

	in the resident's clinical record and communicate any recommendations to the multidisciplinary team. Staff have been informed of this requirement, and compliance will be monitored through regular medication audits and compliance meetings.				

Regulation 26: Staffing					
Reason ID : 10007611		**The registered proprietor did not ensure that all healthcare staff had completed education and training to enable them to provide care and treatment as not all staff were trained in Basic Life Support, Fire Safety, Management of Violence and Aggression, the Mental Health Act, Children First, and Safeguarding, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A comprehensive audit of all mandatory training records was completed to identify staff with outstanding training requirements. Staff who had not completed mandatory training were contacted directly and scheduled onto the next available training sessions. An email was issued to all staff outlining their mandatory training requirements, highlighting any outstanding modules, and reinforcing their responsibility to maintain compliance. The email also included completion deadlines and details of how to access training.	Ongoing monitoring and monthly audits to ensure sustained compliance with Regulation 26(4	Achievable and Realistic	13/04/2026	Clinical Director, ADON; CNM3, Clinical Tutor
Preventative Action	A centralised mandatory training matrix has been implemented to monitor compliance	Immediate implementation completed. Ongoing monitoring and monthly audits to	Achievable and realistic	04/05/2026	Clinical Director, ADON CNM3, Clinical tutor

	across all non compliant staff groups and provide a real-time overview of training status. Automated monthly reports are generated to identify training due for renewal within the following three months. Reminder emails are now issued to staff before training expiry dates. Training compliance report quarterly at AMHU Compliance meetings.	ensure sustained compliance with Regulation 26(4			

Regulation 32: Risk Management Procedures					
Reason ID : 10007591		**The registered proprietor did not ensure that all risks were identified or assessed throughout the approved centre as a significant clinical risk was not identified, 32(2)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Immediate review of the identified incident was undertaken on the day of inspection by the treating consultant and the multidisciplinary team. This included confirming the safety of the resident involved and ensuring no ongoing or unmitigated risk remained.	Ongoing review of identified incidents documented in clinical file. Audit of clinical risks	Achievable	26/05/2026	Responsible Consultant Psychiatrist MDT members
Preventative Action	The approved centre's risk management procedures were reviewed to strengthen the identification, assessment, escalation, and monitoring of clinical risks. All relevant staff will receive refresher training on risk assessment, reporting responsibilities, and the requirements of Regulation 32, with emphasis on the timely identification and escalation of clinical risks. A structured	•Audit programme - quarterly audits of referrals, screening quality, and timeliness of escalation. All identified clinical risk incidents are reviewed at the weekly MDT meeting and escalated as required.	Achievable with no barriers to implementation	30/04/2026	Principal Social Worker; MDT members; Responsible Consultant Psychiatrist

	review of the local risk register will be undertaken monthly by the multidisciplinary management team to ensure emerging safeguarding risks are identified, assessed, and appropriately managed. Quarterly audits of risk assessments to be conducted. Learning from audits, incidents, and reviews will be shared with staff to promote continuous improvement in risk identification and management. Education sessions for staff conducted by relevant trained professionals				
Reason ID : 10007592		**The registered proprietor did not ensure that appropriate actions were implemented relating to the protection of vulnerable adults within the approved centre, 32(2)(f).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified concern was reviewed immediately, and a comprehensive risk assessment was completed. A plan was developed in conjunction with the ICP for the resident concerned, with clearly	Quarterly audit of documentation Guidance for staff on identifying risk for vulnerable adults from relevant qualified personnel	Achievable with no barriers to implementation	09/04/2026	Responsible Consultant Psychiatrist MDT members

	defined control measures and review dates. Any immediate actions required to protect vulnerable adults were implemented without delay, including referral to the appropriate services where indicated, in line with national policy and local procedures.				
Preventative Action	The approved centre's procedures will be reviewed to ensure clear guidance on identifying, reporting, managing, and monitoring concerns for vulnerable adults. All clinical and relevant non-clinical staff will complete refresher training on safeguarding vulnerable adults, recognising abuse, reporting pathways, and their responsibilities under the approved centre's safeguarding policy. Quarterly audits of documentation, protection plans, referrals, and follow-up	Audit and ongoing review at weekly compliance meetings	Achievable with no barriers to implementation	02/06/2026	All MDT members

	actions will be undertaken to monitor compliance with Regulation 32(2)(f). Safeguarding will be a standing agenda item at weekly compliance meetings to review trends, audit findings, incidents, and opportunities for service improvement.				

Rules Governing the Use of Seclusion					
Reason ID : 10007573		**Upon commencement of one episode of seclusion, a Seclusion Care Plan for the person was not developed by a registered nurse, 5.7.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The clinical file of the identified patient was reviewed and a care plan with all requirements was identified erroneously written in the main ICP and the clinical notes. Staff were advised of this error and directed to the Seclusion Pack which includes a specific Seclusion Care Plan.	Audit of seclusion documentation and review at restrictive practices oversight committee quarterly.	Achievable	09/04/2026	ADON; CNM3; CNM1, CNM2
Preventative Action	All relevant staff to get refresher training on seclusion documentation.	Compliance with seclusion documentation to be discussed post episode Self auditing among nursing and medical staff post episode findings to be presented to restrictive practice committee.	Achievable and realistic	13/04/2026	ADON; CNM3; CNM1; CNM2
Reason ID : 10007574		**The in-person debrief did not occur within two working days of one episode of seclusion, 7.6(ii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The file of the patient was reviewed by nursing management and the treating consultant and MDT were reminded of the	Audits of episodes of seclusion Refresher training on MHC rules governing the use of seclusion	Achievable and Realistic	13/04/2026	Responsible consultant psychiatrist, ADON CNM3, CNM1 CNM2 MDT members

	requirements from the MHC in relation to Debriefs being carried out within two working days post episode of seclusion. The reason for the delay was then written into the clinical file.				
Preventative Action	Training on MHC rules governing the use of seclusion with emphasis on the requirements to document an in person debrief within two working days (or a date of the person's specified preference). Reminder system in place to ensure debrief is offered within the specified timeframe.	Audits of episodes of seclusion and refresher training on MHC rules governing the use of seclusion	Achievable and Realistic	27/04/2026	Responsible consultant psychiatrist , ADON CNM3, CNM1 CNM2 MDT members
Reason ID : 10007575		**The seclusion room did not have externally controlled heating and air conditioning, which enabled those observing the person to monitor the room temperature, 8.1(v).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The seclusion room process has been reviewed , room temperature can now be observed on newly installed clock to enable staff to monitor the ambient temperature during an episode of seclusion. Staff are now required	Temperature recorded on seclusion observation sheet and audit to to ensure ambient temperature 24hr on call maintenance team available to change temperature if required	Achievable and realistic	08/06/2026	Nursing Staff, CNM2,3 Maintenance foreman

	to record the room temperature hourly on the seclusion observation document throughout the duration of the episode.				
Preventative Action	Temperature checklist now incorporated as part of the seclusion observation checklist. Nursing staff to monitor temperature to ensure patients comfort and safety 24hr on call maintenance team to be called to adjust temperature if required.	Audits of temperature recording will be carried out by Nurse Manager.	Achievable and realistic	08/06/2026	Nursing Staff, CNM2,3 Maintenance foreman
Reason ID : 10007576		**Not all fittings in the seclusion room were of such a design and quality as not to endanger the safety of the person in seclusion, as there was an electrical fitting in the room, 8.1(ii), 8.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Anti-ligature non electric clock has been sourced and installed in the seclusion room.	Regular audit of premises and ongoing risk assessment of seclusion episodes	Achieved	08/06/2026	Maintenance Foreman Nurse Management
Preventative Action	Anti-ligature non electric clock has been installed.	Regular audit of premises and ongoing risk assessment of seclusion episodes	Achieved	08/06/2026	Maintenance Foreman Nurse Management
Reason ID : 10007577		**Not all staff who participated, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures, 11.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review of the staff training records was carried out and the	Clinical Director; Clinical tutor	Achievable and realistic	27/04/2026	Clinical Director; Clinical tutor

	relevant staff group were identified and scheduled to attend the next mandatory training and online training.				
Preventative Action	A centralised mandatory training matrix has been implemented to monitor compliance across all non compliant staff groups and provide a real-time overview of training status. Automated monthly reports are generated to identify training due for renewal within the following three months. Reminder emails are now issued to staff before training expiry dates. Training compliance report quarterly at AMHU Compliance meetings.	Automated monthly reports are generated to identify training due for renewal within the following three months. Reminder emails are now issued to staff before training expiry dates. Training compliance report quarterly at AMHU Compliance meetings.	Achievable and realistic	20/07/2026	Clinical Director Clinical tutor

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10007614		**The registered proprietor did not ensure that if the person had a history of trauma and/or abuse there was documented evidence that the principles of trauma-informed care were used during the episode of restraining the person, 4.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The restraint episode in question was reviewed to determine whether trauma-informed care principles were applied but not documented, and any available information retrospectively recorded where appropriate.	Regular audit of restraint episodes. Review at Restrictive Practices Oversight Committee.	Achievable and realistic	13/04/2026	Responsible Consultant
Preventative Action	Trauma informed practices guidance sessions to be arranged for relevant staff. Update restrictive practice documentation to include a mandatory section requiring staff to document: 1. Whether the person has a history of trauma and/or abuse. 2. The trauma-informed strategies used before, during, and after the restraint. 3. How re-traumatisation was minimised. Audit of	Regular audit of restraint episodes. Review at Restrictive Practices Oversight Committee.	Achievable with no barriers to implementation	01/09/2026	Clinical director; MDT members

	restraint episodes to verify that trauma-informed care has been appropriately documented for all relevant incidents.				
Reason ID : 10007615		**The registered proprietor did not ensure that if the person had a history of trauma and/or abuse there was documented evidence that the principles of trauma-informed care were used during the episode of restraining the person, 4.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The person's clinical file was reviewed to identify whether they had a documented history of trauma and/or abuse. A retrospective review of the restraint episode was completed, and documentation was updated where appropriate to reflect the consideration of trauma-informed care principles. The multidisciplinary team reviewed the individual's care plan to ensure trauma-informed approaches are clearly documented and readily accessible to staff.	audits and staff training	Achievable and realistic	20/04/2026	responsible treating consultant, CD ADON CNM3 safeguarding nominated person if applicable
Preventative Action	All clinical staff to receive refresher	audits and staff training	Achievable and realistic	30/06/2026	clinical director ADON CNM12,3 responsible consultant psychiatrist

	training on trauma-informed care, with particular emphasis on its application during restrictive interventions and documentation requirements. audits of restraint documentation will be done and discussed at quarterly restrictive practice committee meetings with corrective actions				
Reason ID : 10007616		**The registered proprietor did not ensure that the approved centre's policy on physical restraint included the identification of appropriately qualified person to give prevention and therapeutic management of violence and aggression training, 8.2(c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The relevant policy was immediately reviewed and updated to include the identification of appropriately qualified person to give prevention and therapeutic management of violence and aggression training, 8.2(c).	Annual review of restrictive practice policies	Achievable	31/07/2026	Clinical Director; Assistant Director of Nursing; PPPG group
Preventative Action	Annual review of policies relating to restrictive practices to ensure compliance	Audit of policies on an annual basis	Achievable with no barriers to implementation	31/07/2026	Clinical Director; Assistant Director of Nursing; PPPG group

	with MHC requirements.				

Code of Practice on the Use of ECT for Voluntary Patients					
Reason ID : 10007563		**Out of a programme of twelve Electro-Convulsive Therapy treatments, the pre-anaesthetic assessment recorded in the clinical file did not include a detailed full physical exam prior to seven treatments, did not record a detailed medication history prior to eight treatments, did not record the allergy status prior to one treatment, and did not record the duration of fasting prior to six treatments, 8.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A retrospective review of the relevant clinical files was completed. The review confirmed the documentation gaps identified. The findings were communicated to the relevant clinical team, and staff were reminded of the requirement to complete and document all components of the pre-anaesthetic assessment before each ECT treatment.	Audit and review of all ECT documentation Monthly meetings with Anaesthetist and Theatre staff to discuss all relevant documentation requirements.	Achievable with no barriers to implementation	03/07/2026	ECT Lead; Clinical Director; ECT Nurse
Preventative Action	A comprehensive review of ECT booklet and documentation was carried out with all relevant staff in AMHU and Theatre SUH. A process has been agreed to ensure full compliance with all ECT documentation each treatment.	Regular review of all documentation related to ECT 6 monthly audit of ECT process and documentation	Achievable with no barriers to implementation	31/07/2026	ECT Lead; Clinical Director; ECT Nurse; Anaesthetist and Theatre nursing team

Reason ID : 10007564		The monitor recordings before and immediately after treatment and recovery were not recorded and dated in every treatment. The record was not signed by the anaesthetist and filed on the voluntary patient's clinical file. Perioperative care was not recorded and signed in nine of the twelve treatments and post operative care was not recorded and signed in eight of the twelve treatments by the anaesthetist and stored in the clinical file, 8.8.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A retrospective review of all ECT clinical records was undertaken to identify any additional documentation deficiencies and address them where appropriate.	Review of documentation	Achievable	03/07/2026	ECT Lead; ECT Nurse; Clinical Director; Anaesthetist
Preventative Action	The ECT documentation pathway was reviewed and discussed to clearly define the responsibilities of the anaesthetist and clinical staff regarding documentation and filing requirements. Documentation requirements will be incorporated into the induction process for all anaesthetists providing ECT services. Two audits of ECT have been carried out to date and 6 monthly ECT audits are scheduled if required.	Review of documentation after each ECT treatment Regular audit	Achievable with no barriers to implementation	31/07/2026	ECT Lead; ECT Nurse; Clinical Director; Anaesthetist

Reason ID : 10007565		The registered proprietor did not ensure that the approved centre's Electro-Convulsive Therapy policy was implemented throughout the duration of Electro-Convulsive Therapy programme as the anaesthetist form was not completed after every treatment session and mental health staff did not ensure that all documentation was completed prior to every treatment, 13.1.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A retrospective review of all ECT clinical records was undertaken to identify any additional documentation deficiencies and same addressed where appropriate.	Regular audit of all ECT documentation after each treatment	Achievable and realistic	03/07/2026	ECT Lead; ECT nurse; Clinical Director; Anaesthetist
Preventative Action	The ECT documentation pathway was discussed and agreed to clearly define the responsibilities of the anaesthetist and clinical staff regarding documentation and filing requirements. Documentation requirements will be incorporated into the induction process for all anaesthetists providing ECT services	Regular audit of all ECT documentation after each treatment	Achievable with no barriers to implementation	31/07/2026	ECT Lead; ECT nurse; Clinical Director; Anaesthetist

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.

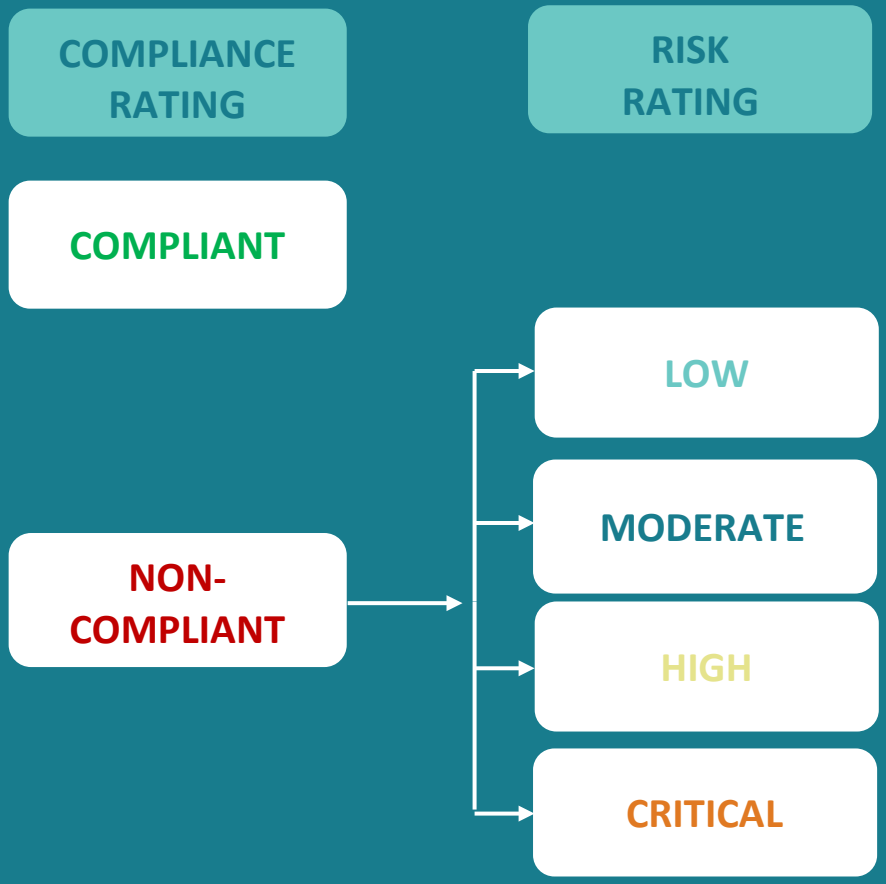
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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