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Maryborough Centre, St Fintan's Hospital

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

MARYBOROUGH CENTRE, ST FINTAN'S HOSPITAL

St Fintan's Hospital, Dublin Road, Portlaoise, Co. Laois

Date of Publication:
31 August 2026

ID Number: AC0338

2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Psychiatry of later life

Conditions Attached:
None

Most Recent Registration Date:
11 November 2025

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Marianne Tierney

Inspection Team:
Susan O'Neill, Lead Inspector
Aoife Gallaher
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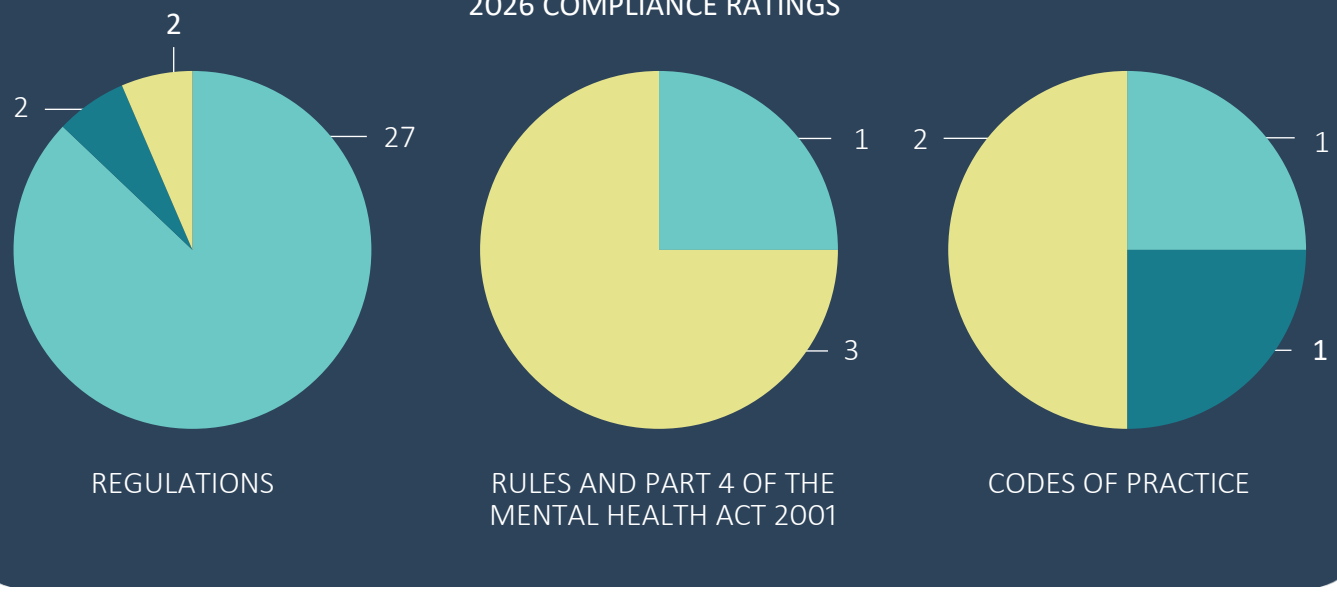
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
14 – 17 April 2026

Previous Inspection date:
01 – 04 July 2025

Inspection Type:
Unannounced Annual Inspection

2026 COMPLIANCE RATINGS

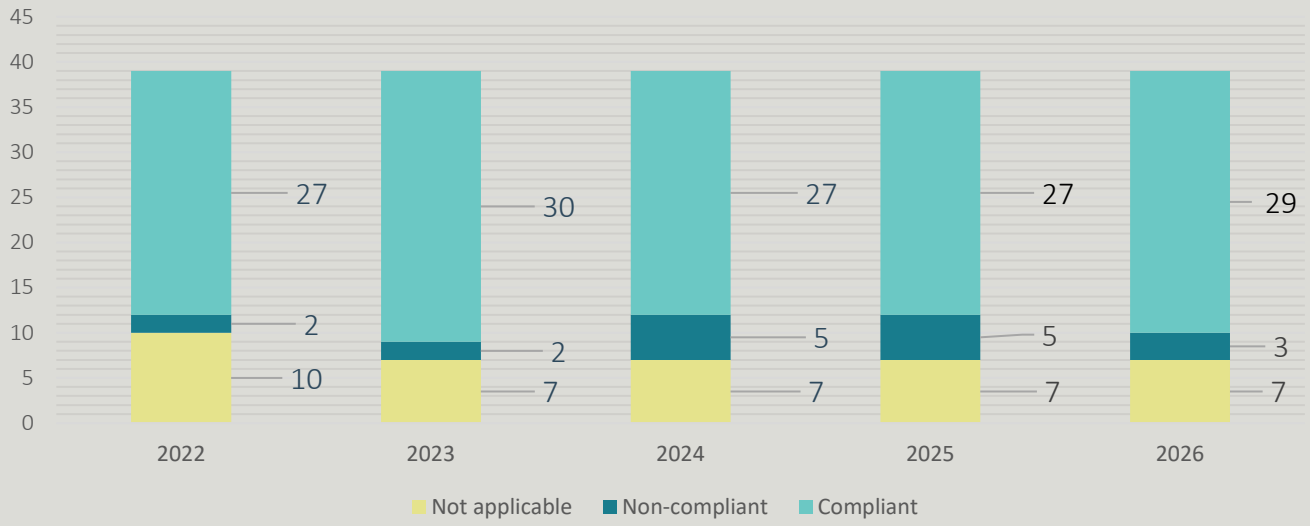


RATINGS SUMMARY 2022 – 2026

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

Please note: **The approved centre opened for the first time in 2022**

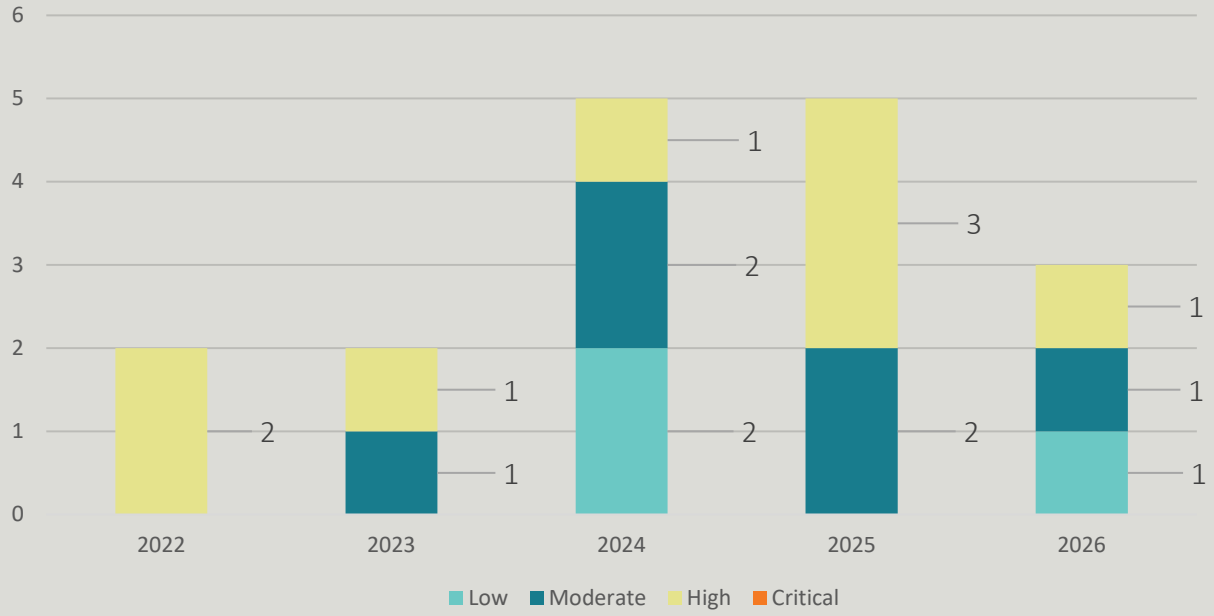
CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2022 – 2026



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.

Please note: **The approved centre opened for the first time in 2022**

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 Maryborough Centre is located within the grounds of St Fintan's Hospital, Portlaoise. The approved centre reopened in 2022 following extensive renovation works and provided accommodation for up to 16 residents. It comprised one twin en suite bedroom and 14 single bedrooms, of which 10 were en suite. The remaining four single bedrooms had direct access to shared bathroom and shower facilities. The centre included a high dependency unit, which accounted for three of the 16 beds. All bedrooms were decorated with residents' personal effects and were tailored to meet individual needs. The environment was bright, spacious, and well maintained.

Communal spaces available to residents included a large day room subdivided into different seating areas, a quiet space, and activities room. Additional shared facilities included a visitor's room, a sensory and relaxation space, a large internal sensory garden, developed with input from dementia care specialists to support sensory engagement and wellbeing.

Residents admitted to the approved centre were from across Laois and Offaly and included individuals under five general adult teams, one rehabilitation and recovery team, and one Psychiatry of Later Life (POLL) team. Upon admission, residents were cared for by the POLL team - a multi-disciplinary team which included medical, nursing and relevant health and social care professionals.

1.2 Inspector of Mental Health Services Summary

At the time of the inspection the approved centre was registered to provide Psychiatry of Later Life (POLL) services for the care and treatment of residents from counties Laois and Offaly. The approved centre was registered to accommodate 16 residents. The inspection of Maryborough Centre was unannounced and occurred over a four-day period. This report reflects the findings observed during that period only. Overall, the inspection teams findings were very positive. The inspection was well coordinated by the staff and management of the approved centre, and staff were highly responsive and cooperative throughout the process.

In 2025, the service was non-compliant with five regulations during the annual inspection. In the current inspection, the number of non-compliant regulations reduced to three. Service management demonstrated awareness and a proactive approach in relation to many of the compliance aspects raised. Issues concerning

the premises (Regulation 22) were focused on the presence of high-risk ligature anchor points and other specific hazards. However, the service was aware of these issues, was actively planning toward resolution and had implemented risk mitigations. Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines, was non-compliant as several new policy requirements were not accomplished, however, these policies had been drafted and were entering the final stages of review at the time of inspection.

Throughout the inspection, the team observed a strong commitment to person-centred care within the approved centre. Staff demonstrated a warm, respectful, and responsive approach to residents, contributing to a supportive and therapeutic environment. The overall atmosphere was calm and homely, and efforts toward continuous improvement were clear.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**15**
Number of detained patients	2
Number of wards of court	0
Number of residents under the Assisted Decision Making Act	1
Number of children	0
Number of residents in the approved centre for more than 6 months	7
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	93%	94%	84%	84%	91%

1.5 Conditions of registration

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

1.6 Ongoing escalation and enforcement actions at time of inspection

None.

1.7 Escalation and enforcement actions commenced following this inspection

None.

2.0 Governance

The Maryborough Centre was part of the HSE Midlands Integrated Health Area, which covers the counties of Laois, Offaly, Westmeath, and Longford. The approved centre operated under the governance of the Midlands Mental Health Service. Principal governance structures included the Area Catchment Management Team and a Quality and Patient Safety (QPS) Committee, both of which met on a monthly basis with membership including various heads of discipline and non-clinical senior managers. Locally, the 'Approved Centre Governance (ACG) Group and Oversight Committee' convened on a quarterly basis, providing a shared governance forum of both the Maryborough Centre and the Department of Psychiatry located in Portlaoise Hospital. Group membership included local managers and clinicians. Other established local governance forums included the Health and Safety Committee, the Drugs and Therapeutics Committee, the Policy Review Group, the Restrictive Practice Reduction Group, and the Audit Committee.

Risk responsibilities were allocated at both management and service levels throughout the approved centre. The multi-disciplinary team was engaged in developing, implementing, and reviewing individual risk management practices. The approved centre maintained a risk register which was reviewed quarterly at the ACG group Oversight Committee meetings and at the QPS committee meetings. Established referral pathways were in place for escalating and deescalating risks from the local risk register to the broader Mental Health Service risk register, where appropriate. The approved centre operated a standardised and structured system for incident management. All incidents were recorded using the National Incident Report Form (NIRF), risk rated appropriately and uploaded to the National Incident Management System (NIMS). A complete record of incidents was maintained on site, and the required six-monthly summary report was submitted to the Mental Health Commission in line with regulatory obligations.

An organisational chart defined key personnel and lines of responsibility and accountability. The Psychiatry of Later Life (POLL) team provided care and treatment for residents admitted to the approved centre. The team was adequately resourced with an appropriate skill mix of mental health professionals. General health disciplines were accessed by referral to primary care services, however, there were difficulties accessing Speech and Language Therapy and Dietetics services due to resource limitations. The mental health service was committed to accessing these specific services on a private basis if required.

The majority of staff were up to date with the required mandatory training. The training programme was appropriately resourced and there were systems in place to monitor training completion rates. Each mental health discipline had a process to undertake staff supervision or peer review, however, the majority of disciplines did not have a continuous system of staff performance appraisal.

Resident engagement in governance and quality improvement processes was facilitated throughout the service. Resident community meetings provided residents with the opportunity to voice requests, suggestions and concerns. The approved centre had access to advocacy services provided by Sage Advocacy – a national advocacy service for older people. Advocacy contact details were displayed within the approved centre. There was a mechanism to support the submission of compliments and complaints, which were reviewed at the ACG group Oversight Committee and at the QPS committee. The service also sought to

engage residents and families through the administration of service experience questionnaires. In the first quarter of 2026, a significant number of respondents provided very positive feedback on service quality which was reviewed locally. Service users, their family members and carers were actively involved in the inpatient multidisciplinary care planning process as appropriate.

There were multiple mechanisms in place to support service improvement and quality. The Quality and Patient Safety (QPS) Committee covered areas such as quality improvements initiatives, incident and risk reporting, audit results and regulatory compliance. The ACG Group reviewed matters specific to the approved centre, including mandatory training, restrictive practices, the risk register, Mental Health Commission inspection findings and actions required, complaints, admissions, delayed discharges, audits results, maintenance issues, and quality improvement activities. Outputs from this committee were reported to the Area Catchment Management Team. There was a system of continuous clinical audits in place for the approved centre which was coordinated through the Audit Committee. This new committee, established in January 2026, convened on a quarterly basis to plan, oversee audits, and address audit outcomes from both the Maryborough Centre and from the Department of Psychiatry. Audit results were also reviewed by the Approved Centre Governance Group and Oversight Committee and the QPS Committee.

2.1 Therapeutic Services and Programmes

Therapeutic Services and Programmes
The therapeutic services provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Therapeutic services and programmes included the following: There was a monthly psychology group which was based on themes such as mindfulness, cognitive flexibility, and problem solving. In addition, monthly social work groups took place and themes included reminiscence therapy through music and memories, Irish traditions, drama, outdoor fun and childhood memories. There were multiple weekly group programmes facilitated by the Clinical Nurse Specialist. Group programmes included reminiscence therapy, social dancing, art therapy, exercise, cognitive stimulation, and education. The occupational therapist cofacilitated weekly trips to a local farm with the aim of engaging residents in a social farming initiative. Social farming offered residents the opportunity to immerse themselves in a supportive and inclusive setting on a farm and supporting engagement in meaningful activities to build confidence and foster connection. Health and Social Care Professionals conducted assessment and treatment sessions on an individual basis with residents. The therapeutic services and programmes provided by the approved centre met the assessed needs of the residents, as documented in their individual care plans.

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

2.2 Staff Training Record

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (14)	12	86%	13	93%	12	86%	13	93%	13	93%	12	86%
Medical (3)	2	66%	3	100%	3	100%	3	100%	3	100%	3	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Pharmacist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

3.0 Compliance

3.1 Compliant areas on this inspection

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

Regulation/Rule/Act/Code		2026
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 15: Individual Care Plan	✓	Compliant
Regulation 16: Therapeutic Services and Programmes	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 26: Staffing	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 30: Mental Health Tribunals	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 32: Risk Management Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Rule on the Use of Mechanical Restraint	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

3.2 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2022		2023		2024		2025		2026	
Regulation 22: Premises	✓		✓		✗	Moderate	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✓		✗	Low
Code of Practice on the Use of Physical Restraint	N/A		✗	Moderate	✗	Low	✗	Moderate	✗	Moderate

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

3.3 Areas that were not applicable on this inspection

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

4.0 Service-user Experience

4.1 Service-user feedback

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, in paper or by 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.

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.

Five service user experience questionnaires were completed and returned to the inspection team:

- Three residents reported that staff members explained what was happening in a way they could understand upon arrival to the approved centre, while two residents indicated that this did not occur.
- All residents were satisfied with the information given about their diagnosis, care and treatment.
- Four residents reported that information on medications was explained in way that was understandable, while one resident indicated that this had not been explained.
- Three residents were familiar with their individual care plan while two were not familiar with it.
- Four residents were involved in the process of setting goals.
- All residents knew the members of their mental health team and who their keyworker was.
- Four residents indicated that they were always able to discuss worries or concerns with a member of staff, while one resident indicated that they could only do this sometimes.
- All residents reported that there were enough leisure activities during the day.
- All residents reported that there were enough talking therapies.
- All respondents were happy with how staff talked to them and felt that their privacy and dignity were respected.
- All residents were able to communicate freely with family, friends or advocates.
- All residents felt safe all the time.
- All residents reported that they felt able to give feedback to staff and to make complaints freely.
- Respondents reported on the most positive aspects of the service user experience. Comments included:
    - Very happy and content with care
    - The approved centre feels safe

    - Staff are nice
    - It’s a lovely ward
- Respondents also suggested improvements for the service. Comments included:
    - Medication could be changed to an earlier time.

4.2 Advocacy

The approved centre had an advocacy service. The inspectors did not receive a report from the advocacy representative.

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:

- Administrative support
- Assistant Director of Nursing
- Business Manager
- Clinical Nurse Manager 2 (two in attendance)
- Clinical Nurse Manager 3
- Consultant Psychiatrist
- Director of Nursing
- Executive Clinical Director
- General Manager
- Occupational Therapy Manager
- Pharmacist
- Registered Proprietor Nominee

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

6.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents in the approved centre had access to personal space, and all resident bedrooms and communal rooms were adequately sized. The approved centre was adequately lit, heated and ventilated. Signage and sensory aids supported resident orientation needs. Residents had space to move about, including outdoor spaces. The approved centre was clean, hygienic and free from offensive odours. Current national infection control guidelines were followed.

Hazards were not minimised, in that plastic refuse bags were used in bins in some areas of the approved centre. Ligature points were not reduced to the lowest practicable level. A ligature audit identified high risk ligature points within the approved centre which were not reduced to the lowest practicable level, based on risk assessment.

In general, the approved centre was kept in a good state of repair internally and externally, however, there were a number of fire door faults present. The maintenance department were in the process of carrying out repairs. Other fire doors in the approved centre did not have a suitable mechanism to hold the door in an open position. Due to the difficulty opening these doors, the ability of some residents to move independently and without assistance was impaired.

There were sufficient toilets and showers for residents in the approved centre, with at least one assisted toilet. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately furnished 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 all hazards were minimised as a fire door awaiting a magnetic lock system was observed to be difficult for a resident to open and move through without assistance from staff, 22(3).**
b) **The registered proprietor did not ensure that all hazards were minimised as plastic refuse bags were used in bins in some areas of the approved centre, 22(3).**
c) **The registered proprietor did not ensure that the physical structure and the overall environment was developed and maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, as not all ligature points were reduced to the lowest practicable level based on risk assessment, 22(3).**

d) **The registered proprietor did not ensure that the physical structure and the overall environment was developed and maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, due to fire door faults, 22(3).**

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

NON-COMPLIANT

Risk Rating LOW

INSPECTION FINDINGS

The approved centre had policies and procedures in relation to the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in February 2024. The policy and procedures in relation to the ordering, prescribing, storing and administration of medicines did not include the following:

- Rapid tranquilisation
- Clozapine management
- Lithium management
- Valproate in pregnancy and women of childbearing years
- Venous thromboembolism prevention and anticoagulation safety
- Antimicrobial stewardship
- Sepsis recognition and management

The registered proprietor ensured that the approved centre conducted audits on the implementation of, and adherence to the required medication policies.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident. The MPARs of five residents were inspected. The MPARs recorded allergies and sensitivities to any medication, or recorded that the resident had no allergies. The MPARs detailed medication administration routes, a record of all medications administered to the resident and a clear date of discontinuation for each medication. The Medical Council Registration Number (MCRN) and signature of every medical practitioner prescribing medication to the resident was recorded.

When a resident was identified as receiving high dose antipsychotic treatment (HDAT), an initial medical assessment and pharmacist review were completed, then repeated at a minimum, every six months. The assessment included a review of glucose regulation, blood lipid levels, prolactin level and heart function (electrocardiogram).

Medication was appropriately stored. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication was stored securely. Schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The registered proprietor did not ensure the approved centre had appropriate written operational policies relating to the prescribing and administration of medicines to residents, 23(1).

7.0 Inspection Findings – Rules

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

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

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

8.0 Inspection Findings – Mental Health Act 2001

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

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

9.0 Inspection Findings – Codes of Practice

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

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

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

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated March 2026. It addressed the following:

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

The policy did not include the identification of appropriately qualified persons to give the training.
The policy did not include the mandatory nature of training for those involved in physical restraint.

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

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed. The annual report was published on the approved centre's website. There was a multi-disciplinary review and oversight committee which met at least quarterly, and it met all of the approved centre's requirements.

Evidence of implementation: One episode of physical restraint was inspected. The order for physical restraint was appropriately initiated however, the person who led the physical restraint did not end it.

The person being restrained was informed of the reasons for the restraint and the circumstances which lead to its discontinuation. The person was assessed and monitored, and staff took into account any specific requirements or needs they had in relation to physical restraint, as indicated in their individual care plan (ICP). The person's representative was informed of the restraint or not, in accordance with the person's wishes, and an explanation was entered in their clinical file. The Mental Health Commission was informed of the start time and date, and the end time and date of each episode of seclusion.

An in-person debrief was offered to the person within two working days of the episode of physical restraint however, the person did not wish to participate in the debrief process. All episodes of physical restraint were appropriately recorded.

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

a) **The person who led the physical restraint did not end the restraint, 5.1.**
b) **The registered proprietor did not ensure that policies and procedures regarding staff training included the identification of appropriately qualified individuals to give the training, and the mandatory nature of training for those involved in physical restraint, 8.2(c), 8.2(d).**

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

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

Regulation 22: Premises				
Reason ID : 10007522		**The registered proprietor did not ensure that all hazards were minimised as a fire door awaiting a magnetic lock system was observed to be difficult for a resident to open and move through without assistance from staff, 22(3).**		
Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
(A) Risk Assessment completed immediately in respect of resident's ability to independently pass through door. (B) Maintenance will install a magnetic lock system (GF291) (GF280) to the door following Masterfile approval. Plan for 31st/08/2026. Interim control plan is in place including staff support for affected residents and daily checks of door function. (C) Estates/Maintenance will progress installation of suitable magnetic lock system with emergency release and fire alarm interface.	Risk Assessment and health and safety checks. Installation of Mag-Lock will be evidenced by work order, commissioning certificate and fire safety verification. Resident access/egress will be tested and documented following completion.	Yes	05/10/2026	CNM2, CNM3, ADON, Fire Officer, Maintenance Team

Fire Doors, access-control systems and emergency egress arrangements will be incorporated into approved centres planned preventative maintenance schedule and risk register. Any change to door hardware or access will require fire safety and resident risk assessment before implementation.	Audit of fire doors and emergency egress routes findings to be reported to ACG meetings quarterly.	Yes	31/12/2027	CNM2, CNM3, ADON, Fire Officer, Maintenance Team.
Reason ID : 10007523		**The registered proprietor did not ensure that all hazards were minimised as plastic refuse bags were used in bins in some areas of the approved centre, 22(3).**		
Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
(A) Risk Assessment of current bins in place. Environmental sweep completed. monthly walk around to check for plastic bags (B) Anti-Ligature bins sourced and ordered to replace current models (29/06/26).	Monthly walk about to check for plastic bags in Unit. Use of bags risk assessed and monitored/included in annual ligature audit Health and Safety walkthrough and audit with H&S Officer annually	Yes	31/12/2026	CNM2, CNM3, ADON, H&S Officer
(A) Bins with plastic bags are utilised in high traffic public areas of the ward only. All staff responsible for monitoring use of bags	Visible daily environmental sweep; ongoing agenda item at ward meetings	Yes	31/12/2026	MTAs, HCAs, Staff Nurses, CNM2s, CNM3, ADON.

and ensuring proper storage. (B) Small pedal bins removed from service users' rooms. There is ongoing market research into anti ligature bins for Approved Centres				
Reason ID : 10007524		**The registered proprietor did not ensure that the physical structure and the overall environment was developed and maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, as not all ligature points were reduced to the lowest practicable level based on risk assessment, 22(3).**		
Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
External contractor (Kellbuild) have developed ligature reduction handles and woodworks which remove previously highlighted ligature points. (See attached document for planned works). Funding currently being sought for same. High-risk (patient facing) areas will be prioritised for immediate action. Estates and clinical teams will agree a phased programme for works requiring capital approval.	Ongoing – Ligature Audits are completed annually and after any structural changes to the premises.	Yes	31/12/2026	Contractor Kellbuild, Maintenance Department. HSE Estates.
Plan shared with CMT for approval and	Ongoing – Ligature Audits are completed	Yes	31/12/2026	Registered Proprietor, HSE Estates, Maintenance Department, ADON & CNM3, H&S Officer, QPS Advisor.

commencement of works.	annually and after any structural changes to the premises. Health & Safety walkthrough and audit with H&S Officer completed annually.			
Reason ID : 10007525		**The registered proprietor did not ensure that the physical structure and the overall environment was developed and maintained with due regard to the specific needs of residents and the safety and wellbeing of residents, due to fire door faults, 22(3).**		
Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
MasterFire (Fire Specialists) have completed a full inspection of all fire doors throughout the Maryborough Centre in November 2025. (Date for 2026?) Report complete and Maintenance are working though the issues found in the inspection	Masterfire carry out fire audit of every six months Health and Safety walk about	Yes	31/12/2026	HSE Estates, Maintenance Dept, MasterFire (Fire Specialists)
ACG & Oversight Committee for Maryborough Centre will ensure an annual inspection of all Fire Doors is completed. Registered Proprietor will ensure any deficits identified are addressed in a costly/timely manner.	Masterfire carry out fire audit of every six months Health and Safety walk about	Yes	31/12/2026	HSE Estates, Maintenance Dept, MasterFire (Fire Specialists) ACG & Oversight Committee Members

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10007531		**The registered proprietor did not ensure the approved centre had appropriate written operational policies relating to the prescribing and administration of medicines to residents, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The approved centre will complete an urgent gap analysis of medication-management policies against Regulation 23, the current JSF and relevant organisational medicines-management requirements. Written operational policies will be developed or updated as per the gap analysis	Audit will be carried out by drugs and therapeutic committee on written operational policies included in Regulation 23 to include : 1.Ordering Medicines. 2.Prescribing of Medicines. 3.Storing of Medications. 4.Administration of Medicines. 5.High Dose of Anti-psychotic Treatment. 6.Rapid Tranquillisation. 7.Clozapine Management. 8.Lithium Management. 9.Valproate in Pregnancy/Childbearing Years. 10.Detoxification. 11.Anaphylaxis. 12.Venous Thromboembolism Prevention. 13.Antimicrobial Stewardship. 14.Sepsis Recognition & Management.	Yes	31/12/2026	CNM3, ADON, D&T Committee, Pharmacy Dept, NCHDs, Consultants.
Preventative Action	Medication-management compliance will be monitored through a structured audit programme, including prescribing and administration records, PRN use, controlled-drug checks, storage, omissions, medication incidents and	Yes	Medication management audits ongoing (Quarterly) . Findings, incident trends and improvement actions will be reviewed at the medicines-management/clinical-ACG meetings, with completion of actions tracked to closure.	01/12/2026	CNM3, ADON, D&T Committee, ACG Group, Pharmacy Dept, NCHDs, Consultants

	resident information. Policy review dates will be included in the policy register and reviewed at least every two years, or sooner where guidance, legislation, incidents or inspection findings require it.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10007528		**The person who led the physical restraint did not end the restraint, 5.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The incident was reviewed through the approved centre's incident-management and restrictive-practice governance process. A debrief was completed with the staff involved. The local physical restraint procedure was raised at the weekly staff education session on the ward and staff were reminded that the person leading the restraint retains responsibility for directing and ending the restraint, unless a clear clinical handover occurs and is documented.	Ongoing audits of Physical Restraint episodes as they occur. Education sessions with stakeholders All restraint episodes are brought to the restrictive practice oversight committee	Yes	31/12/2026	RPNs, CNM2s, CNM3, ADON, NCHDs & Clinical Director.
Preventative Action	Code of Practice governing the use of Physical Restraint to be discussed at ward meetings at regular intervals and education around COP to be maintained going forward.	Ongoing audits of Physical Restraint episodes as they occur. Education sessions with stakeholders.	Yes	31/12/2026	CNM2s, CNM3, ADON

Reason ID : 10007529		The registered proprietor did not ensure that policies and procedures regarding staff training included the identification of appropriately qualified individuals to give the training, and the mandatory nature of training for those involved in physical restraint, 8.2(c), 8.2(d).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Policy updated to ensure names of appropriately qualified individuals is clearly documented and the mandatory nature of training for those involved in Physical Restraint	Completed (21/5/26)	Yes	31/12/2026	CNM3, ADON.
Preventative Action	All staff who may participate in physical restraint will complete refresher education on the MHC Code of Practice, including leadership roles, continuous assessment, safe termination, monitoring, documentation, debriefing and least-restrictive alternatives.	Scheduled dates for training 2026 - October 6th & 13th - (Nursing Staff) Oct 23rd (Medical Staff) November 10th & 17th (Nursing Staff) Nov 27th (Medical Staff)	Yes	31/12/2026	CNM3, ADON, Clinical Director

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.

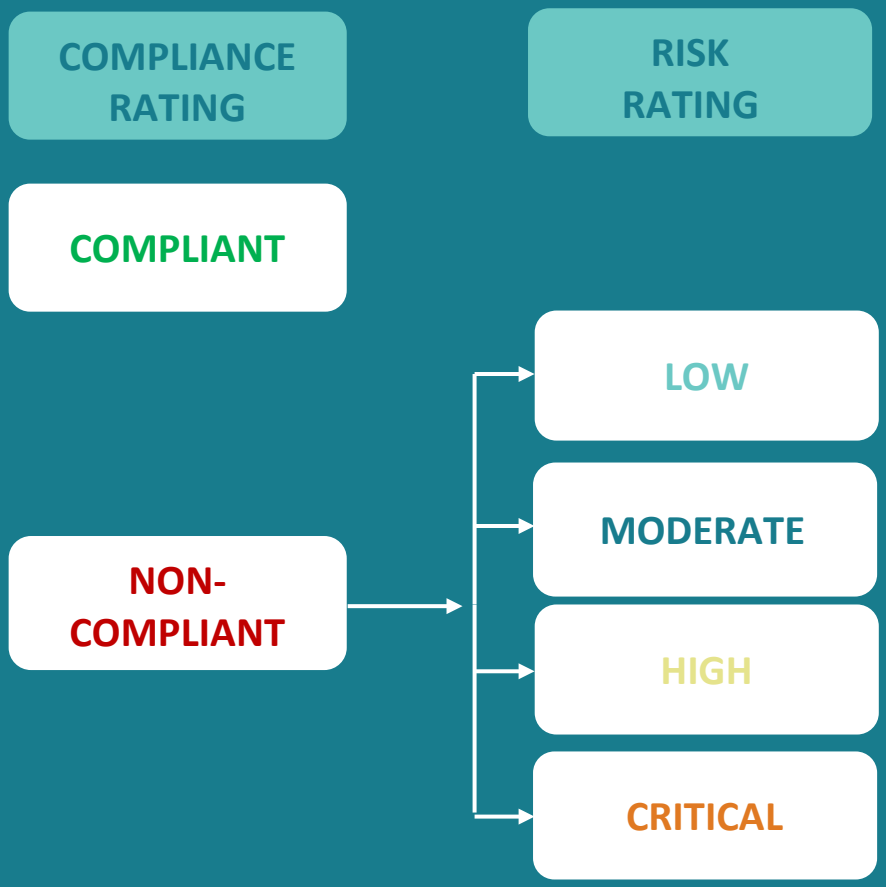
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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