Department of Psychiatry, Connolly Hospital

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, CONNOLLY HOSPITAL

Blanchardstown, Dublin 15

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2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care

Conditions Attached:
None

Most Recent Registration Date:
06 December 2024

Registered Proprietor:
HSE

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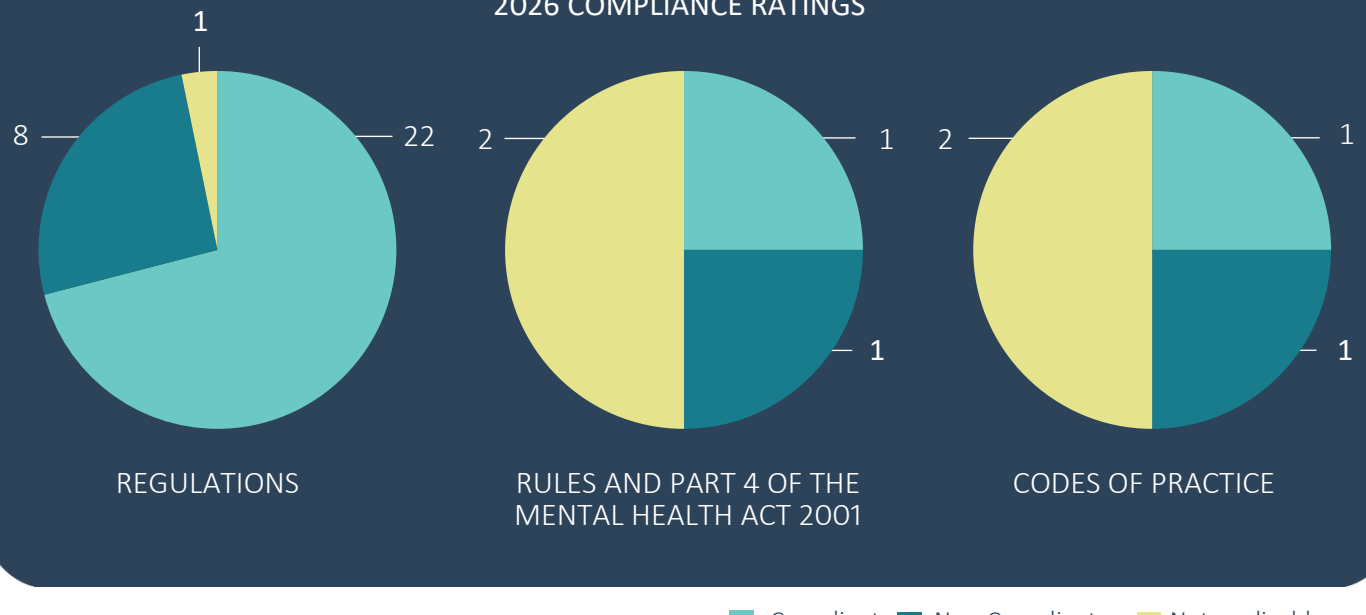
Inspection Date:
10 – 13 March 2026

Previous Inspection date:
10 – 13 June 2025

Inspection Type:
Unannounced Annual Inspection

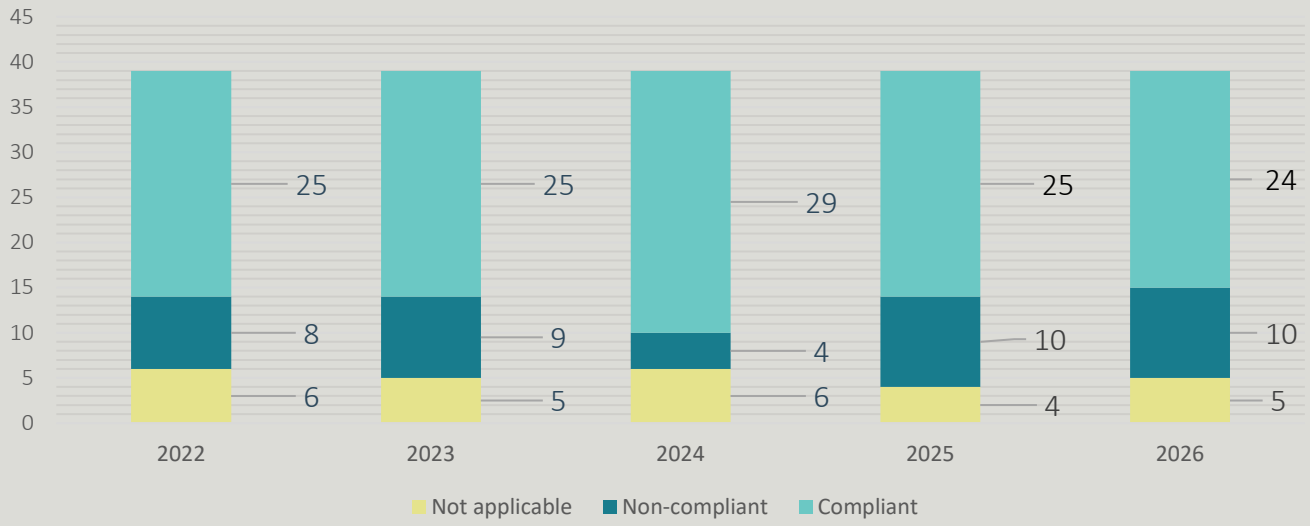
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

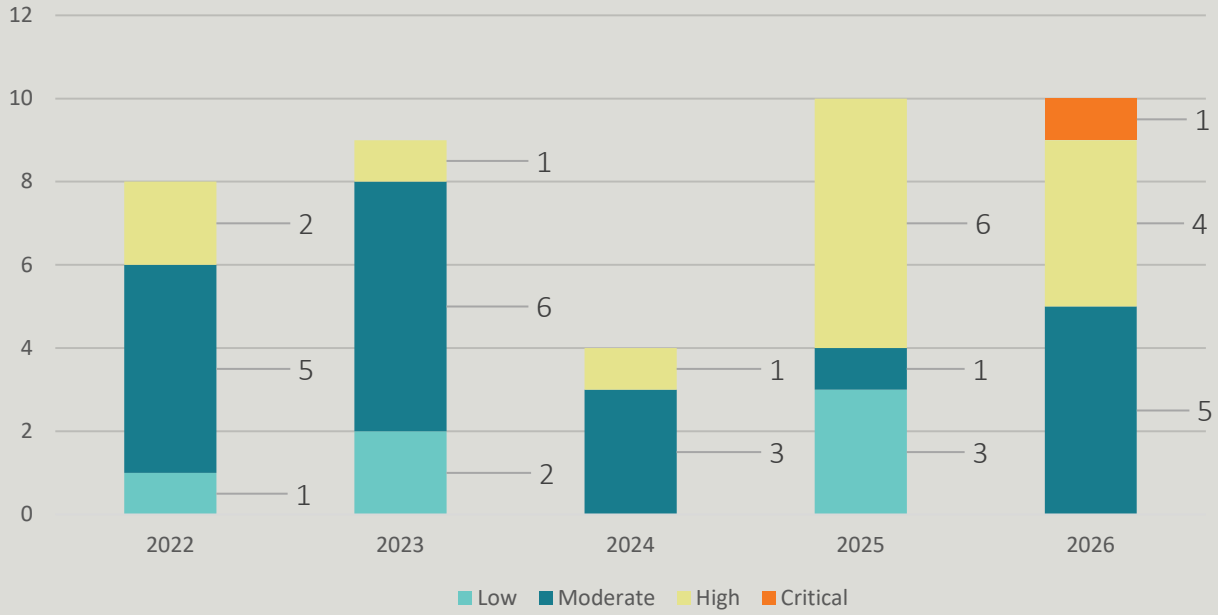
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 Department of Psychiatry (DOP) is located on the lower ground floor of Connolly Hospital, Blanchardstown. Access to the approved centre is by swipe card or by request, which is facilitated by security staff. A long corridor with staff offices, a tribunal room, and a family visiting room led to two wards, Ash Ward and Pine Ward and to a therapies department, at the end of the corridor. The therapies department included a recreational room, an arts and crafts room, a sensory room, an occupational therapy kitchen and a garden.

The approved centre is registered for 47 beds with the Mental Health Commission. Residents were accommodated within three wards. Both Ash and Pine Wards had accommodation for 21 residents each. A High Dependency Unit (HDU) was located between Pine and Ash wards and had accommodation for five residents, within five single bedrooms, and incorporated a seclusion room, a day room, dining room and an external courtyard.

Resident accommodation on both Ash and Pine Wards consisted of a mix of three single rooms, two with en suite bathrooms, three double rooms with en suite bathrooms, and three four-bedded rooms. Residents in Ash Ward and Pine ward had shared access to a large courtyard. Both wards had three small multi-purpose day rooms and a dining room. There was also access to a large outdoor space for residents.

1.2 Inspector of Mental Health Services Summary

The inspection of the Department of Psychiatry (DOP), Connolly Hospital was unannounced and occurred over a four-day period, from the 10th to 13th of March 2026 inclusive. This summary reflects the findings at the time of the inspection.

In 2025, the service was non-compliant with 10 areas of regulation. In 2026, while there was no change in the total number of areas non-compliance, there were areas of improvement since the last inspection in: Regulation 26: Staffing, Regulation 31: Complaints Procedures, and in Part 4 Consent to Treatment, which were found to be compliant on this inspection.

There were seven areas of recurring non-compliances in 2026 and in five of those regulatory areas, the risk rating increased. The most concerning of these related to Regulation 22: Premises which increased in terms of risk rating to a critical level, as known health and safety deficits in the approved centre were not addressed

since the last inspection. There were also three new regulatory areas found to be non-compliant during this inspection, namely: Regulation 05: Food and Nutrition, Regulation 09: Recreational Activities and Regulation 32 Risk Management Procedures.

The inspection was very well co-ordinated by staff and management in the approved centre. Many aspects of service provision exceeded the minimum standards set out in mental health legislation. The management and staff of the approved centre demonstrated a commitment and a focus on continuous quality improvement with quality initiatives in progress and a regular audit schedule taking place in the approved centre.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**39**
Number of detained patients	9
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	3
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	76%	74%	88%	71%	71%

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 10000399	18 March 2026	Non-compliance with a risk rating of critical identified on inspection: • Regulation 22: Premises Four non-compliances identified with a risk rating of high: • Rules Governing the Use of Seclusion • Regulation 32: Risk Management Procedures • Regulation 09: Recreation • Regulation 16: Therapeutic Services	Ongoing correspondence with the approved centre. The HSE is in the process of developing a Management of Actions and Reporting Template for the approved centre. The MHC has requested a copy and will monitor progress.

2.0 Governance

The Dublin North City Mental Health Services (DNCMHS) Management Team were responsible for the overall governance and operation of the approved centre, with the exception of estates and fire maintenance which was the responsibility of the Board of Connolly Hospital. There was regular engagement between the approved centre's management and the Connolly Hospital management. The DNCMHS Management Team meeting was conducted monthly and attended by the head of service, executive clinical director, service manager, area director of nursing, heads of disciplines, area lead for service user engagement and administrative staff. Standing agenda items included service planning, quality and patient safety, human resources, finance, communications, regulation and compliance. Feedback from committees such as Quality and Patient Safety committee, (QPSC) drugs and therapeutics committee, health and safety committee and research and ethics committee also formed part of the agenda.

The Quality and Patient Safety Committee (QPSC) met monthly. Agenda items included discussions in relation to, service user experience, quality indicators and outcome measures, quality improvement initiatives and plans, audit and report recommendations and planning. Other agenda items included meeting national standards, guidelines, policies, and risk management processes. All incidents, near misses, risk assessment and the risk register were also discussed and reviewed. Quality and safety reports from committees were reviewed, as were reports for mandatory education and training for staff.

The Compliance committee met monthly to discuss adherence to the rules and regulations within the approved centre. Representation at this meeting came from nursing, medical and health and social care professionals along with administration staff and service management and incorporated agenda items that included quality initiatives and ongoing improvements to the approved centre, regulatory compliance, auditing, policy development and resident feedback. There were a number of working committees that supported quality improvement and these included quality and safety, drugs and therapeutics, ethics committee, risk management, health and safety, and the restrictive practice committee. A quarterly Quality and Safety Walk Round (QSWR) was also carried out.

There were key personnel with responsibility for risk management in the approved centre. The approved centre also had support of a quality and patient safety advisor. The person with overall responsibility for risk was identified and known by staff. Incidents were recorded and risk-rated on the National Incident Management System (NIMS) using National Incident Report Forms (NIRF) and were reviewed by the risk manager and QPSC as appropriate, to identify any trends or patterns occurring in the service. Each discipline identified risks facing their respective departments. Risks were not, however, fully identified, assessed, treated or monitored in respect of health and safety within the unit, as multiple fire doors across the three wards, that were identified in March 2025 as being defective, were not treated or monitored. An emergency call bell system within the wards was also inactive and not working. These risks were not identified by the approved centre on the DNCMHS risk register.

Nine consultant-led teams based in four catchment areas, Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. This comprised of two rehabilitation teams and seven

community mental health teams. The liaison psychiatry service, within Connolly Hospital Blanchardstown, also had admitting rights to the approved centre. Each head of discipline outlined clear strategic goals for the service and the systems that were in place to monitor goal attainment. Clinical supervision was provided for medical staff and the health and social care professional groups.

At the time of inspection, the approved centre was adequately staffed, and the numbers and skill mix of staffing were sufficient to meet resident needs. Vacancies existed in nursing staff and were mitigated by the use of overtime and agency staff. Vacancies in occupational therapy and social work were under recruitment at the time of inspection. In relation to mandatory training, the majority of staff had completed mandatory training. Those who had not yet completed the training or were awaiting courses were scheduled to complete trainings on a specified date. The approved centre had an annual training plan in place.

Resident engagement in governance and quality improvement processes was facilitated throughout the service. Resident community meetings and suggestions boxes provided residents with the forums to voice requests, suggestions and concerns. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service (formerly the Irish Advocacy Network). An advocate attended the approved centre weekly. The advocacy contact details were displayed within the approved centre. The service also had an area lead for mental health engagement. The process for making a complaint was publicly displayed and available to residents and family members.

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 (54)	54	100%	54	100%	51	95%	51	95%	54	100%	54	100%
Medical (36)	34	94%	30	83%	30	83%	31	86%	35	97%	30	83%
Occupational Therapist (1.8)	1.8	100%	1.8	100%	1.8	100%	1.8	100%	1.8	100%	1.8	100%
Social Worker (8)	8	100%	8	100%	8	100%	8	100%	8	100%	8	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	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 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 08: Residents' Personal Property and Possessions	✓	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 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed-**Circuit** Television	✓	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 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Part 4 Consent to Treatment	✓	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
Regulation 09: Recreational Activities	✓		✓		✓		✓		✗	High
Regulation 15: Individual Care Plan	✗	Moderate	✗	Moderate	✗	Moderate	✗	High	✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✓		✗	Moderate	✓		✗	High	✗	High
Regulation 21: Privacy	✗	High	✓		✓		✗	Moderate	✗	Moderate
Regulation 22: Premises	✗	High	✗	high	✗	High	✗	High	✗	Critical
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✗	High	✗	Moderate
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	High
Rule on the Use of Seclusion	✗	Moderate	✗	Moderate	✗	Moderate	✗	Low	✗	High
Code of Practice on the Use of Physical Restraint	✓		✗	Moderate	✓		✗	Low	✗	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 no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule 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.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

4.0 Service-user Experience

4.1 Service-user feedback

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

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

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

The inspection team met with nine residents. Residents reported positive aspects of their experience that included:

- Staff were kind, helpful and very good and hard working.
- The ward environment was clean.
- Their rooms were comfortable.
- The food was very good.
- Residents said that they met their teams frequently.
- Communication between staff and residents can be good, however, there are times that staff are on their phones and unavailable.
- Residents knew how to raise concerns and complaints.
- Some residents described that members of the Multi-Disciplinary Teams (MDTs) discussed their care plans with them.
- Residents described the environment as surprising, as in it was very good and felt like a community.

Areas that residents identified as needing improvement included:

- Some resident described that bins and sanitary bins could be overflowing.
- Residents felt the removal of contraband items was not applied universally to all residents.
- Some residents described being aware of the MDTs and the meetings happening but described not being involved in that process and that they were not involved in their care plans and were asked to sign them after MDT meetings or did not get a copy of their care plan at all.
- Some described being unaware of who their key workers were.

- Some described attending MDT meetings as intimidating and difficult and described the changes to doctors each week as difficult.
- Residents would like more discussion about their diagnosis and care plans so as to understand them better.
- Residents said that sometimes residents' privacy and dignity was not protected.
- Residents said that activity levels are not good on the unit, groups being infrequent and residents identified that they wanted more activities and therapeutic groups, with the centre being described as a "holding pen" and there being "very little to do" with the "therapy space being underutilised".
- Residents wanted more time with staff for 1:1 therapy. Some described not having seen a therapist yet during their stay.

Four completed written questionnaires were received. Positive aspects described in the responses included that staff were nice, caring and great to talk to and the environment was clean and calm, and the food was good. Areas for improvement identified by these residents included that showers were flooding and needed repair, the courtyard felt enclosed and not welcoming and that they would like to see a gym and pool table installed. On a scale of 1 to 10, with 1 being poor and 10 being excellent, the overall experience of care and treatment was rated 8 out of 10 by one respondent and 10 out of 10 by three respondents.

4.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the Peer Advocacy in Mental Health representative.

It described the positive aspects of the service as:

- Several service users were very satisfied with the care that they received from staff and would be happy to return if they required inpatient care.
- Service users were overwhelmingly positive about the human interactions during their stay in hospital, from peers to healthcare staff.
- Some service users were happy to have access to tobacco and smoking facilities, and equally, service users were happy to have access to tobacco cessation supports.
- Service users commented on the kindness and compassion of nurses and healthcare assistants.
- Service users shared that they enjoyed activity groups.
- Several service users mentioned the high levels of cleanliness and were grateful for the efforts of the cleaning team.
- Service users described psychological support as being particularly useful.
- Service users said the social workers were useful when helping navigate issues related to housing.
- Some service users appreciated the smaller rooms for private meetings and conversations, as the day room was often too loud and busy.
- Residents in the High Dependency Unit (HDU) appreciated having access to the outside courtyard space.

- Residents in the HDU shared their appreciation of having their own room.
- Service users noted the wide array of literature available on the wards.

Areas where Service Users identified that need improvement included:

- Several service users complained of boredom on the wards.
- Service users said that when a change of medication was approved by an on-call doctor at the weekend, this was not recorded or communicated to their regular care team and as a result, they were unable to get that medicine.
- Service users expressed that there was a lack of support for people with a dual diagnosis and they felt their addiction was not being recognised as a mental health problem.
- Some service users have noted the perceived lack of fresh air in the courtyard, from excessive smoking.
- Several service users described not knowing the consequences of being made a voluntary patient, particularly regarding the hospital's power to detain them if deemed necessary, leading them to question their detention status.
- Some service users were unaware of their rights around mental health tribunals.
- Some service users complained that the complaints/suggestion box on Pine Ward was full and had been so for a long time; patients subsequently said that it had been removed.
- Several service users who had a dual diagnosis reported frustration and despair at the lack of support (in the form of rehabilitation and housing) following their discharge.

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
- Area Director of Nursing
- Principal Psychologist
- Principal Social Worker
- Senior Social worker
- Executive Clinical Director
- Clinical Director
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Mental Health Act Administrator

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

6.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 5: Food and Nutrition

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Residents 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 made available to residents at all times in easily accessible locations throughout the approved centre.

Residents' nutritional and dietary needs were not fully assessed with the use of an evidence-based nutrition assessment tool and addressed in the resident's individual care plan. Residents' files inspected evidenced the partial application of two nutritional assessment tools, which did not result in a comprehensive approach to the nutritional assessment of all residents. The needs of residents identified as having special nutritional requirements were not regularly reviewed by a dietitian, as the approved centre did not have access to a dietitian.

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

a) **The registered proprietor did not ensure that residents were provided with the food and drink adequate for their needs as nutritional and dietary needs were not assessed or addressed in the resident's individual care plans, 5(2).**
b) **The registered proprietor did not ensure that the needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian, 5(2).**

Regulation 9: Recreational Activities

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a nurse led activity timetable displayed in the centre and this detailed activities such as word wheel, art and mindfulness. However, on inspection it was found that these were not provided consistently to residents across the week and were dependent on availability of the nursing staff. Most of the recreational activities available to the residents were self-directed activity and were not appropriate to the needs of the resident group profile. These included the availability of materials and resources such as books, puzzles, mindfulness colouring and other artwork material, musical equipment including guitars and a piano, gardening gloves and safe tools for self-directed gardening and televisions. Residents reported during the inspection that the recreational facilities provided by the approved centre were not appropriately resourced as several resources were either broken or were missing items however the centre did have access to replenish items for activity through a petty cash system.

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

a) **The registered proprietor has not ensured that the approved centre provides access to recreational activities on weekdays and during the weekend, as recreational activities were not provided on a consistent basis across the week.**
b) **The registered proprietor has not ensured that the recreational facilities provided by the approved centre were appropriately resourced, as there were a number of activity resources with broken or missing items.**

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Ten ICPs were inspected. The ICPs were a composite set of documents which addressed the resident's goals, mental health care and treatment needs, based on a multi-disciplinary team (MDT) assessment of the person and where practicable, in consultation with them. The documents within the ICPs were identifiable, uninterrupted and were not amalgamated with progress notes.

All ICPs examined were developed within seven days of the resident being admitted. All ten ICPs were developed by an MDT. The ICPs were discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

The ICPs identified appropriate goals for the resident, the care and treatment required to meet the goals, and the responsibilities for implementing the care and treatment. The ICPs identified the resources required to provide the care and treatment identified.

Two individual care plans 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.

Two individual care plans inspected of residents who underwent physical restraint and seclusion were not updated to reflect the outcomes of the debriefs, and in particular, the person's preferences in relation to restrictive interventions going forward.

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

a) **Two individual care plans 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.**
b) **Two residents' individual care plans were not updated to reflect the outcomes of the debriefs following seclusion and in particular, the person's preferences in relation to restrictive interventions.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre did not provide therapeutic services and programmes that met the assessed needs documented in residents' individual care plans. Unmet needs for occupational therapy were identified in individual care plans.

The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. There was one basic grade occupational therapist in the service who provided 1:1 input to residents. There was a lack of occupational therapy input into the group programmes due to the occupational therapist not having capacity and this meant there was no therapeutic occupational therapy groups were offered to residents.

There was sufficient psychology and social work input into group programmes provided. There were two psychologists and an assistant psychologist based in the approved centre. They facilitated two groups per week: Managing Mental Health Skills, and an Inspirational Quotes group. They also saw residents individually following referral.

Each of the nine teams had a social worker who saw residents individually based on their needs. They also facilitated a weekly drop-in Social Work Clinic for all residents to support residents with practical day-to-day issues, including housing queries, welfare supports, documentation, and liaison with external agencies.

There was no dedicated activities staff in the approved centre. However, if nursing staff had time, they would facilitate groups. This did not always happen due to staff shortages. Nurse-led activities included chair exercises, breathing exercises, stress management, mindfulness and goal setting.

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

a) **The therapeutic services and programmes provided by the approved centre were not appropriate to meet the assessed needs of the residents, as documented in their individual care plans. Only two therapeutic groups were facilitated in the approved centre per week, 16(1).**
b) **The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning as there was a lack of Occupational Therapy input into the group programmes, 16(2).**

Regulation 21: Privacy

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

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

Bed screening was used in shared rooms to ensure residents' privacy was not compromised. Observation panels on treatment room doors and bedroom doors had blinds, curtains or opaque glass.

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

Single bedrooms did not have a lock on the inside of the bedroom door that residents could use. At the time of the inspection new doors were ordered by the approved centre which would have the correct locks.

The approved centre was non-compliant with this regulation because single bedrooms did not have a lock on the inside of the bedroom door that residents could use.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

Residents in the approved centre had access to personal space and adequate communal rooms. There was suitable and sufficient heating in day areas and in bedrooms. All private and communal areas were sized and furnished to remove excessive noise. Lighting in communal rooms was bright and facilitated all resident and staff requirements. Signage and sensory aids supported resident orientation needs. Ligature points were minimised to the lowest practicable level, based on risk assessment. Residents had space to move about, including outdoor spaces.

Not all rooms were ventilated and free from offensive odours at the time of inspection. The assisted bathroom in Pine Ward was malodorous, and the extractor fan was not in working order at the time of inspection. This was addressed during the inspection.

Hazards were not minimised in the approved centre. The entrance way from Pine Ward to the garden had a lip which was a trip hazard.

The approved centre was not kept in a good state of repair internally and externally. A radiator in Ash Ward was rusted and needed replacement. Water was pooling in two showers, one in the High Dependency Unit and the other in a shower on the main corridor in Pine Ward.

Fire doors in the approved centre were damaged and identified as needing replacement or remediation in March of 2025 by the service and on this inspection fire doors continued to have damaged seals and gaps, and some doors were damaged beyond repair. Whilst initial remedial actions were taken following the March 2025 report, there was no funding allocated yet for the works necessary to address the fire door deficits in the approved centre identified in the March 2025 fire inspection.

There was a programme of general maintenance, decorative maintenance, cleaning and decontamination. However, the approved centre did not ensure the repair of assistive equipment, as the patient call bell system was not working and had not been maintained.

The approved centre did not provide suitable furnishings to support resident independence and comfort. An armchair and a two-seater couch were badly damaged. A locker drawer was missing from one bedroom. New replacement furniture had been ordered at the time of the inspection.

The approved centre provided assisted devices and other equipment 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 approved centre was kept in a good state of repair as a radiator in Ash Ward was rusted and needed replacement and water pooling occurred in two showers, one in the Higher Dependency Unit and in one shower on the main corridor in Pine Ward, 22(1).**
b) **The registered proprietor did not ensure that the premises was adequately ventilated as an extractor fan was not working in an assisted bathroom, 22(1).**
c) **The registered proprietor did not ensure that the approved centre had suitable furnishings as an armchair and a two-seater couch were badly damaged, 22(2).**
d) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was 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 as hazards such as steps were not minimised, as the entrance to Pine Ward from the garden had a lip and was a trip hazard, fire doors had damaged seals and gaps, and some doors were damaged beyond repair and the call bell system was not working and had not been maintained, 22(3).**

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

NON-COMPLIANT

Risk Rating MODERATE

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 March 2026. The approved centre last conducted an audit on the implementation of, and adherence to the required medication policies in May of 2025.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident. The MPARs of ten 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.

Of the ten files inspected, five residents were on high dose antipsychotic treatment (HDAT). The approved centre did not implement appropriate and suitable practices for the medical assessment of all residents on high dose antipsychotic therapy. The initial assessment of one resident did not include an assessment of blood lipid levels or glucose regulation.

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 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 for the medical assessment of all residents on high dose antipsychotic therapy. The initial assessment of one resident did not include an assessment of blood lipid levels or glucose regulation, 23(1).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in February 2026, and outlined:

- The roles and responsibilities for risk management and the implementation of the risk management policy within the approved centre.
- The process for identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register and the record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Responsibilities were allocated at management level throughout the approved centre to ensure effective implementation of the risk management policy. The person with responsibility for risk was identified and known by all staff. Structural risks, including ligature points, were removed or effectively mitigated.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Fire doors in the approved centre were damaged and identified as needing replacement or remediation and the internal emergency call bell system was not working. These two health and safety risks (damaged fire doors and broken internal call bell system), were not identified, assessed, treated, reported, monitored or documented in the service risk register.

Clinical and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate. Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during resident seclusion, resident physical restraint, and resident admission, transfer and discharge.

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

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the MDT at their regular meeting. A record was maintained of this review and of any recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre did provide a six-monthly summary report of all incidents to the Mental Health Commission within the required timeframe.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre risk management policy was implemented throughout the approved centre due to the fact that identified health and safety risks were not documented on the service risk register, and the risk management procedures did not actively reduce identified risks to the lowest practicable level of risk, 32(1).

7.0 Inspection Findings – Rules

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

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

*Please see **Section 3.2: 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

Process: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was last reviewed in May 2025.

The policy addressed who may initiate, and who may carry out, seclusion, the provision of information to the resident, including information about the resident's rights, presented in an accessible language and format, and the safety, safeguarding and risk management arrangements that must be followed during any episode of seclusion.

The approved centre had a policy on the reduction of seclusion which covered all the stipulated requirements and clearly documented how the approved centre aimed to reduce seclusion and, where possible, eliminate the use of seclusion. The approved centre had a policy and procedures for training all staff involved in seclusion, and it covered all the stipulated requirements.

Training and Education: All staff had signed to indicate that they had read or understood the policy. One staff member who participated in the use of seclusion did not receive the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

Monitoring: An annual report on the use of seclusion in the approved centre was published on the registered proprietor's website. A multi-disciplinary review and oversight committee was established to analyse every episode of seclusion in detail, and the committee met all its stipulated responsibilities.

Evidence of Implementation: The seclusion facilities were furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's privacy was respected.

Orders for Seclusion: Two episodes of seclusion in relation to two different individuals were reviewed on inspection. Seclusion was only initiated following a comprehensive assessment of the person as soon as was practicable. This included a risk assessment, the outcome of which was recorded in the clinical file. The order of the Consultant Psychiatrist confirmed that there were no other less restrictive ways available to manage the person's presentation.

Seclusion was initiated by a registered medical practitioner (RMP) or the most senior registered nurse (RN) on duty. The RMP or RN recorded the seclusion orders in the clinical files and on the seclusion register. Where seclusion was initiated by a RN, an RMP was notified of the seclusion episode as soon as practicable, no less than 30 minutes following the commencement of the seclusion episode.

In one seclusion episode the Consultant Psychiatrist did not undertake a medical examination of the person within 24 hours of the commencement of the seclusion episode.

On each occasion the Consultant Psychiatrist (CP) signed the seclusion register within 24 hours of the commencement of the seclusion episode.

Dignity and safety: The clothing worn in seclusion respected the right of the residents to dignity, bodily integrity and privacy. The person's own clothing was worn in the two episodes of seclusion.

Monitoring of the person in seclusion: The approved centre met all the stipulated monitoring requirements across all the two episodes of seclusion.

Renewal of Seclusion Orders: The orders for seclusion were renewed in one episode of seclusion; in the second episode, renewal did not apply. The episode of seclusion was renewed by an RMP under the supervision of the Consultant Psychiatrist or the duty Consultant Psychiatrist following a medical examination, and the renewal did not exceed four hours.

Ending of seclusion: In all episodes of seclusion, seclusion was ended by a registered medical practitioner at any time following discussion with the person in seclusion and relevant nursing staff; or by the most senior registered nurse in the unit, in consultation with the person in seclusion and a registered medical practitioner.

An in-person debrief followed each episode of seclusion. However, both residents' individual care plans were not updated to reflect the outcomes of the debriefs, and in particular, the person's preferences in relation to restrictive interventions going forward.

In both cases, there was documented evidence to indicate that where a person's representative was informed of the person entering seclusion, the person's representative was informed of the ending of the episode of seclusion as soon as practicable.

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

The approved centre was non-compliant with the Rule Governing Seclusion for the following reasons:

a) **One staff member who participated in the use of seclusion did not receive the appropriate training in its use and in the related policies and procedures, 11.1 & 4.5.**
b) **In one seclusion episode the Consultant Psychiatrist did not undertake a medical examination of the person within 24 hours of the commencement of the seclusion episode, 3.10.**

c) In two episodes of seclusion, the individual care plans were not updated to reflect the outcomes of the debriefs, and in particular, the person's preferences in relation to restrictive interventions going forward, 7.8.

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 compliant on inspection. Please see ***Section 3.1: Compliant areas 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 May 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 Physical Restraint.
- Information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of Physical Restraint.

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

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

Policies and procedures regarding staff training included:

- Who would receive training based on the identified needs of persons who are restrained and staff.
- The areas to be addressed within the training programme, which included training in:
    - The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
    - Alternatives to physical restraint.
    - Trauma-informed care.
    - Cultural competence.
    - Human rights, including the legal principles of restrictive interventions.
    - Positive behaviour support including the identification of the social, environmental, cognitive, emotional or somatic causes or triggers of the person's behaviours.
    - The monitoring of the safety of the person during and after the physical restraint.
- The mandatory nature of training for those involved in physical restraint.
- The identification of appropriately qualified persons to give the training.

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

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

A multi-disciplinary review and oversight committee met at least quarterly and determined if each episode of physical restraint reviewed complied with the code of practice on the use of physical restraint, as well as with the approved centre's own policies and procedures relating to physical restraint. The committee identified and documented areas for improvement and the actions, the persons responsible and the timeframes for completion of any actions. The registered proprietor nominee was assured that each use of physical restraint was in accordance with the Mental Health Commission's code of practice, and the committee produced a report following each meeting.

Evidence of Implementation: Two episodes of physical restraint were inspected. In both episodes, the orders for physical restraint were appropriately initiated and carried out. The person being restrained was informed of the reasons for the restraint and the circumstances which led to its discontinuation. They were assessed and monitored, and 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 followed the episodes of physical restraint, where appropriate. This debrief was person-centred and gave the person the opportunity to discuss the restraint with members of the multi-disciplinary team (MDT) involved in their care and treatment. However, in both episodes of physical restraint, the person's individual care plan was not updated to reflect the outcome of the debrief and in particular: their preferences in relation to restrictive interventions.

In both episodes of physical restraint there was not a record of all attendees who were present at the debrief recorded within the clinical file, as the resident was not named in both cases.

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 restraint. Each episode of physical restraint was recorded and all relevant information was placed in the person's clinical file.

All episodes of physical restraint were appropriately recorded. Each episode of physical restraint was reviewed by members of the MDT involved in the person's care and treatment and documented in the clinical file as soon as practicable and no later than five working days after the episode of physical restraint. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

The registered proprietor appointed a named senior manager who was responsible for the approved centre's reduction of physical restraint.

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

a) **The registered proprietor had failed to ensure that individual care plans were updated after an episode of physical restraint to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward, as two of the resident's individual care plans were not updated after an episode of physical restraint, 5.5.**
b) **The registered proprietor had failed to ensure that there was a record of all attendees who were present at the debrief recorded within the clinical file, as in both episodes of physical restraint debriefs the resident presence was not recorded, 5.6.**

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 : 10007659		**The registered proprietor did not ensure that residents were provided with the food and drink adequate for their needs as nutritional and dietary needs were not assessed or addressed in the resident's individual care plans, 5(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The nursing admission assessment process was reviewed following the inspection finding. The Nursing Assessment Booklet has been updated to incorporate the full SANSI nutritional screening assessment, providing a structured process for the identification of residents' nutritional and dietary needs on admission. The requirement to identify and address nutritional and dietary needs within the resident's Individual Care Plan (ICP) was reinforced with all relevant disciplines through the Compliance Committee. Residents continue to have their	Implementation of the revised Nursing Assessment Booklet, including completion of the SANSI nutritional screening assessment, will be monitored through the existing nursing documentation audit process. ICP audits will monitor whether identified nutritional and dietary needs are appropriately reflected within the resident's ICP and associated interventions.	Achieved. The revised Nursing Assessment Booklet incorporating the full SANSI assessment has been implemented within the DOP and forms part of the nursing admission assessment process.	03/04/2026	Clinical Director and Director of Nursing (Assistant)

	weight monitored in accordance with the identified clinical need, with nutritional concerns escalated to the treating multidisciplinary team for assessment and appropriate intervention.				
Preventative Action	The Nursing Assessment Booklet has been revised to incorporate the full SANSI nutritional screening assessment for all residents, providing a standardised approach to the early identification of nutritional and dietary needs. Where a nutritional or dietary need is identified, this is communicated to the treating multidisciplinary team and reflected within the resident's ICP, including appropriate interventions, monitoring and referral where clinically indicated. The requirement to assess, document and incorporate residents' nutritional and dietary needs into their ICPs has been reinforced with staff through the Compliance Committee and through targeted education	Compliance will be monitored through nursing documentation and ICP audit processes, including: Completion of the SANSI nutritional screening assessment as part of the Nursing Assessment Booklet. Evidence that identified nutritional and dietary needs are reflected within the resident's ICP. Evidence of appropriate interventions, monitoring and/or referral where a nutritional risk or need has been identified. Audit findings and identified areas for improvement will be communicated to relevant staff and progressed through existing governance structures.	Achieved. The revised Nursing Assessment Booklet has been implemented and the SANSI nutritional screening assessment is incorporated into the admission assessment process. Education and ongoing audit provide mechanisms to support continued compliance.	15/05/2026	Clinical Director and Director of Nursing (Assistant)

	delivered as part of the Friday Fifteen education initiative.				
Reason ID : 10007660		**The registered proprietor did not ensure that the needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian, 5(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Funding has been agreed to facilitate private dietetic assessment within the Department of Psychiatry (DOP) when a nutritional need requiring specialist dietetic input is clinically identified. Treating teams can request private dietetic assessment, with funding available to support this where clinically indicated. Residents requiring acute medical management related to their nutritional status, including significant malnutrition or risk of refeeding syndrome, are transferred to James Connolly Memorial Hospital for appropriate medical and dietetic management. Where residents transfer between the acute hospital and the DOP, existing dietetic recommendations and nutritional care plans are	Nutritional needs are identified through nursing admission assessment, including completion of the SANSI, with identified nutritional risks and required interventions reflected within the resident's ICP and communicated to the treating multidisciplinary team. Requests for dietetic assessment and utilisation of private dietetic services within the DOP will be monitored. Referral activity will be reviewed annually to assess demand and ensure that residents requiring specialist dietetic input are appropriately referred.	Achievable within existing nursing assessment and multidisciplinary care-planning processes. Funding has been agreed to facilitate private dietetic assessment where a nutritional need requiring specialist input is identified.	11/12/2026	Clinical Director, Director of Nursing Assistant and Service Manager.

	communicated to support continuity of care. Where a resident is already known to community dietetic services, liaison with the relevant community dietitian is undertaken, where appropriate, to support continuity of nutritional care.				
Preventative Action	A business case has been developed and submitted for the establishment of a 0.5 WTE dietitian post for the Department of Psychiatry and 0.5 WTE dietitian provision for patients with eating disorders within James Connolly Memorial Hospital, providing a longer-term and sustainable pathway for access to specialist dietetic assessment and review. Pending progression of the business case, efforts are ongoing to secure a private dietitian who can provide planned sessional input to the DOP. This will provide an interim pathway for residents with identified nutritional needs who require	Progress against the identified actions, including progression of the business case and establishment of an interim sessional dietetic service, will be monitored and tracked through the DNC&W Mental Health Services Risk Register and associated governance structures. Dietetic referrals and identified nutritional needs within the DOP will be monitored to assess demand, access and timeliness of dietetic review, and to inform future service and resource requirements.	An interim sessional dietetic service is considered achievable; however, identifying and contracting a suitable private dietitian to provide regular input to the DOP has been challenging and efforts remain ongoing. The establishment of a substantive dietetic post is dependent on approval of the submitted business case and associated recruitment and resource approval processes at RHA management level. Existing dietetic pathways and access to privately funded assessment remain available while these longer-term actions are progressed.	26/02/2027	Clinical Director, Director of Nursing Assistant & Service Management.

	dietetic assessment and ongoing review but do not require acute medical transfer. Existing pathways to dietetic input will remain in place, including access through the acute hospital where medical management is required and liaison with community dietetic services where residents are already receiving their input. The identified gap in routine access to dietetic services for residents of the DOP has been formally escalated and accepted onto the DNC&W Mental Health Services Risk Register, providing ongoing governance and oversight of the associated risk and required actions.				

Regulation 09: Recreational Activities					
Reason ID : 10007646		**The registered proprietor has not ensured that the approved centre provides access to recreational activities on weekdays and during the weekend, as recreational activities were not provided on a consistent basis across the week.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Updated recreational activity timetables are displayed and maintained across the approved centre. Implementation will be monitored through review of the timetables and activity provision at ward level, with any identified gaps addressed through the multidisciplinary team and relevant governance structures. Resident participation and feedback will also be considered when reviewing activity provision.	Updated recreational activity timetables are displayed and maintained across the approved centre. Implementation will be monitored through review of the timetables and activity provision at ward level, with any identified gaps addressed through the multidisciplinary team and relevant governance structures. Resident participation and feedback through community meetings will also be considered when reviewing activity provision.	The action has been implemented through a collaborative approach using existing multidisciplinary and ward resources. Inclusion of all discipline-led activities on the timetable provides a more accurate representation of the range of recreational activities available and supports coordinated planning across the week. Activity provision remains responsive to resident choice, individual needs, clinical presentation and risk.	03/04/2026	All heads of discipline
Preventative Action	To sustain the improvements implemented following the inspection, the multidisciplinary recreational activity timetable will be reviewed on an ongoing basis through governance structures such as the compliance meetings, to ensure a consistent range	Ongoing compliance will be monitored through review of the weekly recreational activity timetable and completion of the weekly HCA checklist, including the newly incorporated check of recreational resources. Any gaps in activity provision or deficiencies in available resources will be identified and escalated to the	The preventative actions have been incorporated into existing ward processes and governance structures. The collaborative multidisciplinary approach, combined with the weekly review of recreational resources, supports sustainable provision without the requirement for a separate monitoring process. Activities will continue to be planned in	10/07/2026	All heads of discipline.

	of activities is available across the week, including weekends. The weekly HCA checklist has also been updated to include a review of recreational resources on each ward to ensure adequate, appropriate and accessible supplies are maintained for residents.	CNM2/CNM3 for action. Resident feedback, activity logs and participation will also inform ongoing review of recreational provision.	accordance with resident choice, individual needs, clinical presentation and identified risk.		
Reason ID : 10007647		**The registered proprietor has not ensured that the recreational facilities provided by the approved centre were appropriately resourced, as there were a number of activity resources with broken or missing items.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following the inspection visit, recreational resources across the approved centre were reviewed to identify damaged, incomplete or missing items. Identified items were removed and replaced, and additional recreational resources, including puzzles and games, were purchased to ensure residents have access to an adequate and appropriate range of resources to support recreational activity.	Completion of the action is evidenced through the availability of replacement and additional recreational resources across the approved centre, supported by purchase records and receipts. Recreational resources will be maintained in good condition and readily available for resident use.	The required resources have been purchased using existing purchasing arrangements and are available across the approved centre. Damaged, incomplete or unsuitable resources can be identified and replaced through established ward processes, supporting the ongoing availability of appropriate recreational resources.	10/04/2026	Director of Nursing-Assistant, Clinical Nurse Manager 2 & 3(s)
Preventative Action	The weekly HCA checklist has been updated to include a specific review of recreational resources to ensure that adequate,	Implementation will be monitored through completion of the weekly HCA checklist, which provides evidence of the	The preventative action has been incorporated into existing weekly ward processes and therefore provides a sustainable mechanism for monitoring	24/07/2026	Director of Nursing-Assistant, Clinical Nurse Manager(s) 2 & 3.

	appropriate and complete resources are available for resident use. Any damaged, incomplete or missing resources identified through this process are reported to the CNM2 and replaced as required. Residents can also identify gaps in recreational resources through community meetings or directly to ward staff, with feedback incorporated into ongoing review and replenishment of resources.	routine review of recreational resources. Community meeting records and resident feedback will provide an additional mechanism for identifying gaps or requests for resources. Purchase records/receipts will provide evidence of replacement or additional resources purchased where required.	recreational resources. It is recognised that resources may become damaged, incomplete or require replacement through regular use; however, the weekly review ensures that deficits are identified and addressed in a timely manner.		

Regulation 15: Individual Care Plan					
Reason ID : 10007648		**Two individual care plans 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.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All teams were reminded to ensure that goals, treatment, care and required resources as per the assessed needs of the resident were reflected and updated contemporaneously in the individual care plans following feedback at inspection.	monthly ICP audits	Achievable and realistic	20/03/2026	All heads of discipline
Preventative Action	ICP posters have been redeveloped for staff information. The ICP information booklet has been updated to reflect the learning. Education sessions and learning huddles have been facilitated across disciplines. The learning from the feedback at inspection and from subsequent ICP audits has been shared with all disciplines through compliance committee and distributed to staff by heads of discipline and by the sharing with all staff of ICP audit results monthly.	Monthly ICP audits	Achievable and realistic	23/10/2026	All heads of discipline.

Reason ID : 10007649		Two residents' individual care plans were not updated to reflect the outcomes of the debriefs following seclusion and in particular, the person's preferences in relation to restrictive interventions.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The ICP that was identified during inspection was reviewed and the team of relevance updated regarding the concerns expressed for team learning. All clinicians were sent a reminder email to reinforce and remind of the importance of the inclusion of the person's preferences following restrictive interventions on the ICP.	Monthly ICP audits Review and audit of every episode of restrictive practice	Achievable and realistic	13/03/2026	All heads of discipline.
Preventative Action	The Seclusion core care plan has been updated and approved through oversight committee to reflect the recommendations from both audit findings and inspection feedback. The new core care plan will be in use from Q3 2026. Prompt stickers will be introduced also in Q3 2026 to improve compliance with ICP documentation of learning following restrictive practice debrief and in other areas. The physical	Monthly ICP audits Review of every episode of restrictive practice occurs with reporting to the oversight committee. This audit includes whether the person's preferences following restrictive intervention, identified from debrief and MDT review, are reflected on the ICP. Improvements in this area from interventions may expect to be reflected in oversight committee of Q4 2026.	Achievable and realistic	29/01/2027	All heads of discipline

	restraint core care plan is being similarly updated and anticipated to be in use in Q3 2026. The ICP information booklet has been updated to reflect the learning. Education sessions and learning huddles have been facilitated across disciplines. Reflection of the person's preferences following restrictive interventions in the ICP was an agenda item for Oversight Committee meeting in Q2 2026. ICP posters have been redeveloped for staff information.				

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10007650		**The therapeutic services and programmes provided by the approved centre were not appropriate to meet the assessed needs of the residents, as documented in their individual care plans. Only two therapeutic groups were facilitated in the approved centre per week, 16(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Occupational Therapy Staffing levels were low at time of inspection which was the reason for the non-compliance. Approval to fill posts was gained and recruitment to all vacant posts has taken place which will allow an appropriate level of Occupational Therapy provision, both individual and group, to residents of the approved centre appropriate to the needs identified in their individual care plans.	Occupational Therapy therapeutic programme has increased with increase in staffing allowing for increased delivery of interventions in relation to individual care plans. One staff grade Occupational Therapist is in post. A second Staff grade Occupational Therapist post has been filled and awaiting start date. Occupational Therapy Assistant has returned to work full time. Clinical Specialist post has been recruited to and is being progressed by Recruitment service. Exercise instructor has been in place since June 2026 offering weekly session to all residents which can be group or individual. Occupational Therapy therapeutic programme has increased in line with staffing to support the assessed needs of residents.(see attached)	The actions are feasible - all posts have been recruited to which will result in an appropriate level of Occupational Therapy service provision.	30/10/2026	Occupational Therapy Manager in collaboration with Recruitment service Approval of posts - Head of Service Mental Health & IHA Manager

Preventative Action	Senior Occupational Therapist has been seconded from another service 0.5 and will remain in place until the Clinical Specialist is in post. Permanent Occupational Therapist and Occupational Therapy Assistant both in post full-time and increased Occupational Therapy service available reflects this increase in staffing. Exercise instructor providing weekly sessions, available to all residents, since June 2026. The Occupational Therapy therapeutic programme is updated every week depending on the assessed needs of residents. Prioritisation system is in place for referrals and individual Occupational Therapy interventions.	There has been an increase in the level of Occupational Therapy interventions available to residents.	With the re- introduction of the staff grade Occupational Therapist and Occupational Therapy Assistant, the level of service has increased appropriately. This will increase further when the two vacant posts are filled.	30/10/2026	Occupational Therapy Manager responsible for Occupational Therapy Service.
Reason ID : 10007651		**The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning as there was a lack of Occupational Therapy input into the group programmes, 16(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of inspection, the Occupational Therapy dept was short staffed which was the reason for the non-compliance.	Occupational Therapy therapeutic programme has increased with increase in staffing allowing for increased delivery of	The actions are feasible -full service level available once the two remaining vacant posts start dates agreed. Progressing through Recruitment service.	30/10/2026	Recruitment service/IHA Management progressing recruitment in relation to remaining vacant post start dates. Occupational

	Recruitment to the vacant Occupational Therapy posts has been actioned. Awaiting start date for staff grade Occupational Therapist and Clinical Specialist Occupational Therapist which will bring dept to full staffing complement and allow for the provision of an appropriate level of Occupational Therapy service to residents including both individual and group sessions as appropriate.	interventions in relation to individual care plans. (Programmes attached) Exercise instructor facilitating group/individual sessions available to all residents on weekly basis. Occupational Therapy service organise monthly sessions where external organisations visit the dept and provide information to residents, eg. Conaí Clubhouse, volunteering group etc.			Therapy Manager responsible for Occupational Therapy service
Preventative Action	Senior Occupational Therapist seconded from another service area 0.5 and will remain until Clinical Specialist Occupational Therapist in post. Occupational Therapist and Occupational Therapy Assistant both in post full-time and service available, individual and groups sessions, reflects this increase in staffing. Exercise instructor providing weekly sessions, available to all residents, since June 2026. The Occupational	There has been an increase in the level of Occupational Therapy service available to residents. This will increase further when the Clinical Specialist Occupational Therapist and second staff grade Occupational Therapist commence in post.	With full staffing levels, an appropriate level of Occupational Therapy service will be available to residents.	30/10/2026	Occupational Therapy Manager in collaboration with Recruitment service

	Therapy therapeutic programme is updated every week depending on the assessed needs of residents. Prioritisation system is in place for referrals and individual Occupational Therapy interventions.				

Regulation 21: Privacy					
Reason ID : 10007652		Single bedrooms did not have a lock on the inside of the bedroom door that residents could use.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The replacement of bedroom doors within the approved centre has been identified as a Priority 1 capital project. Funding has been ring-fenced through the Minor Capital Works Programme. An architect and project manager have been assigned to the project, and a scoping exercise is underway to identify and procure appropriate anti-ligature door locking systems that support resident privacy while complying with current mental health environmental safety standards and best practice. A prioritisation schedule of doors requiring replacement has been completed and provided to the design team. The clinical brief for the door replacement project will be finalised with key stakeholders to support progression through the design and procurement stages.	• Funding secured and ring-fenced for the project. • Architect and Project Manager appointed. • Door prioritisation schedule completed. • Appropriate anti-ligature locking systems specified within project design.	Funding has been identified and the project has commenced through the Minor Capital Works Programme. Design and procurement processes are being progressed through established Estates procedures.	20/04/2026	• Registered Proprietor • Service Manager • DON (A) • Assigned Architect • Estates Department • Assigned Project Manager

Preventative Action	A structured environmental compliance review process will be implemented to ensure that privacy requirements, including bedroom door locking arrangements, are assessed as part of ongoing environmental audits, risk assessments and capital planning processes. Any identified deficiencies relating to resident privacy or environmental standards will be recorded on the service risk register, monitored through governance arrangements and escalated through the Estates and Risk Management processes where required.	• Environmental audits conducted annually and following any significant refurbishment works. • Identified environmental deficits recorded and reviewed through the risk register process. • Quarterly review of progress against environmental compliance actions. • Evidence of resident privacy requirements being considered in all future environmental improvement projects.	The process will be incorporated into existing quality, risk management and estates governance structures, ensuring ongoing monitoring and timely escalation of environmental compliance issues.	31/03/2027	• DON (A) • Clinical Nurse Manager • Quality and Patient Safety Advisor • Estates Manager • Service Manger

Regulation 22: Premises					
Reason ID : 10007653		**The registered proprietor did not ensure that the approved centre was kept in a good state of repair as a radiator in Ash Ward was rusted and needed replacement and water pooling occurred in two showers, one in the Higher Dependency Unit and in one shower on the main corridor in Pine Ward, 22(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The rusted radiator in Ash Ward has been scheduled for refurbishment and repainting. in collaboration with Connolly Hospital Maintenance Department, a tender process has been completed in accordance with National Financial Regulations (NFR) for the engagement of a painting contractor. The Service Management Team and Accounts Department have processed and approved a purchase order to facilitate the completion of these works. Under the Memorandum of Understanding (MOU) between Connolly Hospital Blanchardstown and the Department of Psychiatry, responsibility for maintenance of the department rests with Connolly Hospital Maintenance Services.	• Purchase Order issued and contractor appointed for radiator refurbishment. • Rusted radiator repainted and restored to an acceptable standard. • Plumbing contractor engaged to assess shower drainage issues. • Water pooling defects rectified in both shower areas. • Completion of works verified and signed off by Maintenance Services. • Evidence of funding approval maintained by the Service Manager.	The required procurement processes have been completed for the radiator works, and maintenance services are progressing the engagement of the plumbing contractor through established arrangements under the Memorandum of Understanding (MOU) between Connolly Hospital Blanchardstown (CHB) and the Department of Psychiatry (DOP).	30/03/2026	• DON (A) • Service Manager • Connolly Hospital Maintenance Manager • Estates/Maintenance Department

	Connolly Hospital Maintenance Services are currently engaging a plumbing contractor to assess and rectify the water pooling identified in the Higher Dependency Unit shower and the Pine Ward shower. Funding for the required works will be approved by the Service Manager in accordance with local governance and financial procedures.				
Preventative Action	The approved centre will strengthen environmental maintenance oversight through regular environmental inspections and a formal maintenance escalation process. All maintenance deficits identified through audits, staff reporting, health and safety inspections or environmental reviews will be recorded, monitored and reviewed at management meetings. Outstanding issues requiring Estates intervention will be escalated to Connolly Hospital Maintenance Services in line with the	• Monthly environmental inspections completed. • Maintenance action log reviewed monthly. • 100% of identified maintenance issues assigned an owner and target completion date. • Quarterly review of outstanding maintenance actions by the Management Team. • Evidence of escalation and follow-up with Connolly Hospital Maintenance Services maintained.	The process will be embedded within existing environmental audit, maintenance and governance processes and supported through the existing MOU arrangements with Connolly Hospital Maintenance Services. Radiator refurbishment 17th August 2026	29/01/2027	• DON (A) • Clinical Nurse Managers • Service Management • Connolly Hospital Maintenance team • Health and Safety Advisor

	MOU arrangements, with progress monitored until completion.				
Reason ID : 10007654		**The registered proprietor did not ensure that the premises was adequately ventilated as an extractor fan was not working in an assisted bathroom, 22(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The faulty extractor fan identified in the assisted bathroom on the day of inspection was reported immediately to CHB Maintenance Department and repaired on the same day, restoring adequate ventilation within the bathroom.	• Maintenance request submitted on day of inspection. • Extractor fan repaired on day of inspection. • Ventilation functionality tested and confirmed operational.	The repair was completed through existing maintenance arrangements with CHB Maintenance Department.	10/03/2026	• DON (A) • CHB Maintenance Department
Preventative Action	The approved centre will include checks of extractor fans and ventilation systems as part of routine environmental inspections. Any defects identified will be reported immediately to CHB Maintenance Department under the existing maintenance arrangements. Environmental maintenance issues will be monitored through local governance processes to ensure timely resolution.	• Ventilation systems included in weekly environmental checklist. • 100% of identified ventilation defects reported through the maintenance reporting system. • Environmental maintenance issues reviewed at local management meetings.	The action will be incorporated into existing environmental inspection and maintenance processes.	04/08/2026	• DON (A) • Clinical Nurse Managers • CHB Maintenance Department
Reason ID : 10007655		**The registered proprietor did not ensure that the approved centre had suitable furnishings as an armchair and a two-seater couch were badly damaged, 22(2).**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The damaged armchair and two-seater couch identified during the inspection were removed from the approved centre and replaced with suitable furnishings to ensure a safe and comfortable environment for residents.	Two damaged items of furniture removed, and two replacement items installed.	The replacement of damaged furnishings was completed using approved procure-ment and maintenance processes.	28/11/2025	• DON (A) • Clinical Nurse Managers • Service Manager
Preventative Action	A programme of regular environmental inspections will be maintained to identify damaged or worn furnishings. Any furniture identified as unsuitable will be removed from service and replaced promptly. Furniture condition will be reviewed as part of routine health and safety and environmental audits.	Quarterly environmental audits completed, with all damaged furnishings recorded, actioned, and tracked to completion.	Inspections and reporting processes are already established within the approved centre and will continue to be monitored through local governance structures.	01/06/2026	• DON (A) • Clinical Nurse Managers
Reason ID : 10007656		**The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was 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 as hazards such as steps were not minimised, as the entrance to Pine Ward from the garden had a lip and was a trip hazard, fire doors had damaged seals and gaps, and some doors were damaged beyond repair and the call bell system was not working and had not been maintained, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The trip hazard had been identified during the snagging process at the Pine Ward garden	• Trip hazard at Pine Ward Garden entrance removed. • Purchase order issued for replacement/upgrade of call	Actions are being progressed through CHB Maintenance, HSE Capital & Estates	31/03/2027	• CHB Maintenance Manager • DON (A) • Clinical Nurse Managers •

	entrance. This issue has been rectified by the contractors who completed the windows and external door project. In relation to the call bell system, a procurement process was required. A tender process has been completed, a purchase order has been issued to the successful contractor, and commencement of the works is the 17th August. Fire door deficiencies have been inspected by the HSE Technical Services Officer, Chief Assistant Fire Safety, CHB Maintenance, and an independent fire safety company (KCC). No immediate fire safety concerns were identified. A programme of door replacement works has been agreed and will be completed accordingly.	bell system. (Installation commencement date 17th August 2026) • Door prioritisation review completed and documented. • Door replacement programme established.			HSE Technical Services Officer
Preventative Action	CHB Maintenance will continue to instruct KCC door specialists to undertake annual environmental and safety inspections to identify and address maintenance issues relating to doors in a timely manner. Planned	• Annual environmental safety inspections completed and recorded. • Progress reports available for door replacement works. • Call bell system installation monitored through to completion and commissioning. •	Actions will be delivered through existing maintenance, governance, and health and safety processes. Please note that the call bell will be installed on the 17th August 2026	30/03/2026	• CHB Maintenance Manager • DON (A) • HSE Capital Estates • Service Management Office

	preventative maintenance schedules will be maintained for building infrastructure, doors, and the call bell system.	Maintenance actions tracked and closed within agreed time frames.			

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10007661		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices for the medical assessment of all residents on high dose antipsychotic therapy. The initial assessment of one resident did not include an assessment of blood lipid levels or glucose regulation, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An audit was carried out of all residents who were prescribed high dose antipsychotics therapy. Results were forwarded to all treating teams and when investigations were incomplete they were requested to ensure that appropriate monitoring for all residents, including an assessment of blood lipid levels and glucose regulation, was appropriately offered or documented if declined.	Ongoing HDAT audits	Achievable	04/06/2026	Senior pharmacist Clinical Director Director of Nursing Assistant
Preventative Action	An audit was carried out of all residents who were prescribed high dose antipsychotics therapy. Results were forwarded to all treating teams and when investigations were incomplete they were requested to ensure that appropriate monitoring for all residents, including an assessment of blood lipid levels and glucose regulation, was appropriately offered or	Ongoing HDAT audits - to be repeated by Q4 2026	Achievable and realistic	11/11/2026	Senior Pharmacist Clinical Director Director of Nursing Assistant

	documented if declined. The Prescribing and Monitoring of Antipsychotics (including high dose antipsychotic treatment and clozapine) in Approved Centres Policy was circulated to all prescribers with a reminder about the expected standards for HDAT monitoring.				

Regulation 32: Risk Management Procedures					
Reason ID : 10007645		**The registered proprietor did not ensure that the approved centre risk management policy was implemented throughout the approved centre due to the fact that identified health and safety risks were not documented on the service risk register, and the risk management procedures did not actively reduce identified risks to the lowest practicable level of risk, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review of all identified health and safety risks within the approved centre was undertaken. Any identified risks not currently recorded were assessed and entered onto the service risk register in line with the HSE Enterprise Risk Management Policy and Procedures 2023. The Clinical Director (CD) ensured that risks were reviewed, assigned a Risk Owner, given an appropriate risk rating, and had documented controls and actions to reduce the risk to the lowest practicable level. In accordance with the HSE ERM Policy 2023, a process for risk communication, risk notification and risk escalation was implemented to ensure that increasing risks, or risks that cannot be	• 100% of identified health and safety risks reviewed and risk assessed. • 100% of identified risks entered onto the service risk register. • Evidence of documented controls, actions, risk owners and review dates for all identified risks. • Monthly governance meetings will include a standing agenda item on risk management review. • Evidence of risk notification/escalation where risks exceed local control measures.	The review and implementation process was utilised using the existing governance structures, risk management meetings, and support from the Quality and Patient Safety Department in line with the HSE Enterprise Risk Management Policy and Procedures 2023.	28/04/2026	• Registered Proprietor • DON (A) • Clinical Director (CD) • Clinical Nurse Manager • Service Management Office • Health and Safety Advisor • Quality and Patient Safety Advisor

	effectively managed at local level, were notified to and reviewed by the next level of management. The approved centre will ensure that risk management discussions and risk register reviews became a standing agenda item at governance and management meetings, with documented evidence of actions and oversight.				
Preventative Action	HSE Enterprise Risk Management Policy and Procedures 2023 states that communication and consultation include: • "Risk communication" - sharing and exchanging information and gaining a common understanding of risk. • "Risk notification" - recognising when a risk is increasing or is not being managed effectively and notifying the next level of management. • "Risk escalation" - where a risk can no longer be managed at the level at which it is expected to materialise and requires	• Quarterly review of the service risk register evidenced through QPS meeting minutes. • 100% of newly identified amber risk rating escalated to IHA QPS Committee for review and approval for acceptance on the risk register • Risk management training completed by relevant staff with attendance records maintained.	The actions are embedded into existing governance, quality, and risk management processes and supported through regular monitoring by the management team.	28/04/2026	• DON (A) • CD • Health and Safety Advisor • Quality and Patient Safety Advisor • Clinical Nurse Manager (CNM) • Multidisciplinary Team

	management at a higher level. A formal process is implemented to ensure all newly identified risks are promptly assessed, recorded on the service risk register, monitored, and reviewed. Risk management training refresher education are provided to relevant staff and managers. Quarterly risk register reviews are incorporated into governance and management meetings to ensure ongoing oversight and effective risk mitigation.				

Rules Governing the Use of Seclusion					
Reason ID : 10007642		**One staff member who participated in the use of seclusion did not receive the appropriate training in its use and in the related policies and procedures, 11.1 & 4.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The staff member identified during inspection completed MAPA Training on 19/03/2026. The staff member had previously reviewed the relevant restrictive practice policies and procedures in hard copy and was aware of their location within the approved centre. It was identified that the staff member had not been correctly registered on Policy Portal. This was addressed during the inspection period, and acknowledgement of the Seclusion Policy was completed electronically on Policy Portal on 11/03/2026. The inspection finding was communicated to the relevant medical team and the requirement for staff participating in restrictive practices to have appropriate training and familiarity with the	Compliance will be monitored through the medical staff mandatory training tracker and Policy Portal compliance reports. Completion of Safety Intervention Training and acknowledgement of relevant restrictive practice policies will be reviewed following NCHD changeover periods and following scheduled training.	Achievable through existing mandatory training, induction and Policy Portal monitoring processes. NCHDs rotate at four- and six-month intervals, and Safety Intervention Training is arranged as early as practicable following commencement of each rotation. Where attendance at an initial training date is not possible due to clinical commitments or approved leave, alternative training dates are identified. Restrictive practice requirements are also addressed through medical induction and consultant supervision.	19/03/2026	Clinical Director

	relevant policies and procedures was reinforced.				
Preventative Action	Following the inspection finding, preventative actions have focused specifically on strengthening the induction, training and policy acknowledgement processes for incoming NCHDs. MAPA dates are provided at the commencement of each NCHD rotation. Where an NCHD cannot attend the initial training date, further available dates are identified and attendance followed up. The medical mandatory training tracker is reviewed and updated at each NCHD changeover and following mandatory training sessions. NCHDs identified as requiring training or refresher training are followed up and provided with upcoming training dates. Incoming NCHDs are registered on Policy Portal and are required to review and acknowledge relevant policies and procedures,	Compliance will be monitored through: Medical staff mandatory training tracker reviewed following each NCHD changeover and scheduled training. Mandatory training monitoring by the relevant Heads of Discipline for their respective staff groups. Policy Portal compliance reports to monitor acknowledgement of relevant restrictive practice policies. Follow-up of identified training or policy acknowledgement deficits through the relevant management structure.	The actions are achievable within existing induction, mandatory training and governance structures. The rotational nature of NCHD posts and potential clashes between training dates, clinical commitments and approved leave can impact the timing of training completion. Where this occurs, alternative training dates are identified and completion followed up. There can also be a delay in activation of HSE email and Policy Portal access for newly commencing NCHDs. During this period, relevant policies remain available in hard copy and are addressed through induction and local orientation, with Policy Portal registration and electronic acknowledgement followed up once system access is established.	28/08/2026	Clinical Director for medical staff. All heads of discipline for all staff.

	including those relating to restrictive practice. Policy Portal compliance reports are generated to monitor completion. Restrictive practice, including the relevant policies, procedures and staff responsibilities, is addressed as part of NCHD induction. Staff are also advised of the location of accessible hard-copy policies while awaiting activation of HSE email and Policy Portal access.				
Reason ID : 10007643		**In one seclusion episode the Consultant Psychiatrist did not undertake a medical examination of the person within 24 hours of the commencement of the seclusion episode, 3.10.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The episode identified occurred on the weekend immediately preceding the inspection. The resident remained an inpatient and their care was reviewed following identification of the non-compliance to ensure that appropriate medical assessment and follow-up had occurred. The Consultant Psychiatrist involved had misunderstood the requirement for a medical examination	Every episode of seclusion will be audited and reviewed to confirm compliance with the required medical examination and associated documentation. Compliance and any identified deficits or learning will be reported through the Restrictive Practice Oversight Committee, with actions followed through the relevant governance structures.	Achievable within existing medical review, restrictive practice audit and governance processes.	17/07/2026	Clinical Director

	within 24 hours of the commencement of seclusion, including where the episode of seclusion had ended within that 24-hour period. The requirement was clarified directly with the Consultant Psychiatrist, who subsequently reviewed the Seclusion Policy and confirmed their understanding of the requirement. The local Seclusion Policy was also reviewed following the finding to ensure that the requirement for medical examination within 24 hours was clearly and unambiguously documented				
Preventative Action	Written communication was issued to all Consultant Psychiatrists providing care within the Department of Psychiatry reinforcing the requirement for a medical examination to be undertaken within 24 hours of the commencement of an episode of seclusion, including where the episode has ended within	All episodes of seclusion will be audited and reviewed to confirm that the required medical examination was completed within the prescribed timeframe. Compliance will be monitored through the Restrictive Practice Oversight Committee. Any identified non-compliance will be escalated to the Clinical	Achievable within existing medical on-call arrangements, restrictive practice audit processes and governance structures.	17/07/2026	Clinical Director

	that 24-hour period. The inspection finding and associated requirement were also communicated to the wider multidisciplinary team through the Compliance Committee and Restrictive Practice Oversight Committee to promote shared awareness and support timely escalation where a required medical examination remains outstanding. The requirement will continue to be reinforced through restrictive practice governance and learning arising from the review of individual episodes.	Director and relevant Consultant Psychiatrist, with corrective action and learning identified and followed through			
Reason ID : 10007644		**In two episodes of seclusion, the individual care plans were not updated to reflect the outcomes of the debriefs, and in particular, the person's preferences in relation to restrictive interventions going forward, 7.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The individual care plans identified during the inspection were reviewed following the finding. The relevant multidisciplinary teams were informed of the identified documentation deficits and the requirement to ensure that the outcome	Compliance will be monitored through monthly ICP audits, including review of whether outcomes from restrictive practice debriefs and residents' expressed preferences are appropriately reflected within the ICP.	Achievable within existing multidisciplinary care planning, ICP audit and governance processes.	13/03/2026	All heads of discipline.

	of the post-seclusion debrief, including the resident's views and preferences regarding the future use of restrictive interventions, is reflected within the resident's ICP. The inspection finding was communicated across disciplines to support shared learning and reinforce the requirement for the ICP to be reviewed and updated following episodes of restrictive practice.	Audit findings will be communicated to the relevant Heads of Discipline and areas requiring improvement followed through existing governance structures.			
Preventative Action	The Seclusion Core Care Plan has been revised and approved through the Restrictive Practice Oversight Committee, incorporating learning from restrictive practice audits and inspection feedback. The revised care plan includes clear prompts to support documentation of the resident debrief and ensure that the resident's views and preferences regarding future restrictive interventions are reflected within ongoing care planning.	Compliance will be monitored through monthly ICP audits, with findings communicated to the relevant Heads of Discipline. Every episode of restrictive practice will be reviewed and audited, including confirmation that the resident debrief has occurred and that relevant outcomes and preferences have been incorporated into the ICP. Findings, trends and identified learning will be reported through the Restrictive Practice Oversight Committee and	Achievable within existing multidisciplinary care-planning, restrictive practice audit, education and governance structures. The revised Seclusion Core Care Plan has been approved, with implementation and supporting prompt stickers scheduled for Q3 2026.	01/09/2026	All heads of discipline

	The revised Core Care Plan will be implemented in Q3 2026. Additional prompt stickers will be introduced in Q3 2026 as a further point-of-care reminder to support staff compliance with the requirement to update the resident's ICP following restrictive practice. The ICP information booklet and staff ICP posters have been updated to incorporate learning arising from the inspection and audit findings. Targeted education and learning huddles have been delivered across disciplines, including through the Friday Fifteen education initiative, reinforcing the requirement to incorporate the outcome of the resident debrief and the resident's preferences regarding future restrictive interventions into the ICP. The documentation of restrictive practice within the ICP was also included as a specific	communicated across disciplines. Episodes of restrictive practice are also reviewed at the daily Safety Pause, with restrictive practice incorporated into the Safety Pause template to support timely identification and follow-up of required actions.			

	agenda item at the Restrictive Practice Oversight Committee during Q2 2026, supporting multidisciplinary learning and governance oversight.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10007657		**The registered proprietor had failed to ensure that individual care plans were updated after an episode of physical restraint to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward, as two of the resident's individual care plans were not updated after an episode of physical restraint, 5.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The individual care plans identified during inspection were reviewed and updated as required. The findings were communicated to the relevant multidisciplinary teams to support shared learning and reinforce the requirement that the outcome of the post-restraint debrief, including the resident's preferences regarding future restrictive interventions, is reflected within the ICP.	Compliance will be monitored through monthly ICP audits, including review of ICP documentation following episodes of physical restraint. Audit findings will be communicated to the relevant Heads of Discipline and escalated through the appropriate governance structures where required.	Achievable within existing multidisciplinary review, audit, education and governance structures.	13/03/2026	All heads of discipline
Preventative Action	The Physical Restraint Core Care Plan is being revised in response to audit findings and inspection feedback and will be progressed through the Restrictive Practice Oversight Committee for approval. The revised care plan will include clear prompts to ensure that the outcome	Compliance will be monitored through monthly ICP audit and review of all episodes of restrictive practice. Findings and identified learning will be reported through the Restrictive Practice Oversight Committee, Daily Safety pause meetings and	Achievable within existing multidisciplinary review, audit, education and governance structures.	25/09/2026	All heads of discipline

	of the resident debrief, including the resident's views and preferences regarding future restrictive interventions, is documented and reflected within ongoing care planning. The revised care plan is planned for implementation in Q3 2026, supported by ongoing staff communication and education, including the Friday Fifteen initiative.	communicated to relevant disciplines.			
Reason ID : 10007658		**The registered proprietor had failed to ensure that there was a record of all attendees who were present at the debrief recorded within the clinical file, as in both episodes of physical restraint debriefs the resident presence was not recorded, 5.6.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All episodes of restrictive practice are reviewed and audited through the Restrictive Practice Oversight Committee. The inspection finding regarding documentation of attendance at resident debrief was communicated to relevant staff, with the requirement reinforced that the clinical record clearly documents that the resident was invited to participate in the	Every episode of physical restraint will be reviewed to confirm completion of the required debrief documentation, including resident participation or documented decline and a record of those in attendance. Identified deficits will be reported through the Restrictive Practice Oversight Committee.	Achievable within the existing restrictive practice audit, review, education and governance processes.	17/07/2026	All heads of discipline.

	debrief, whether they participated or declined, and all persons in attendance.				
Preventative Action	The Physical Restraint Core Care Plan is being revised to include clear documentation prompts for the post-restraint debrief, including confirmation that the resident was invited to participate, whether they participated or declined, and the names/roles of those in attendance. Learning arising from audit and inspection findings will continue to be communicated to staff through established governance and education structures, including the Friday Fifteen initiative.	All episodes of physical restraint will be reviewed and audited for compliance with debrief documentation requirements. Findings, trends and areas requiring improvement will be reported through the Restrictive Practice Oversight Committee and communicated to the relevant Heads of Discipline.	Achievable within existing restrictive practice review, audit, education and governance structures.	17/07/2026	All heads of discipline

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.

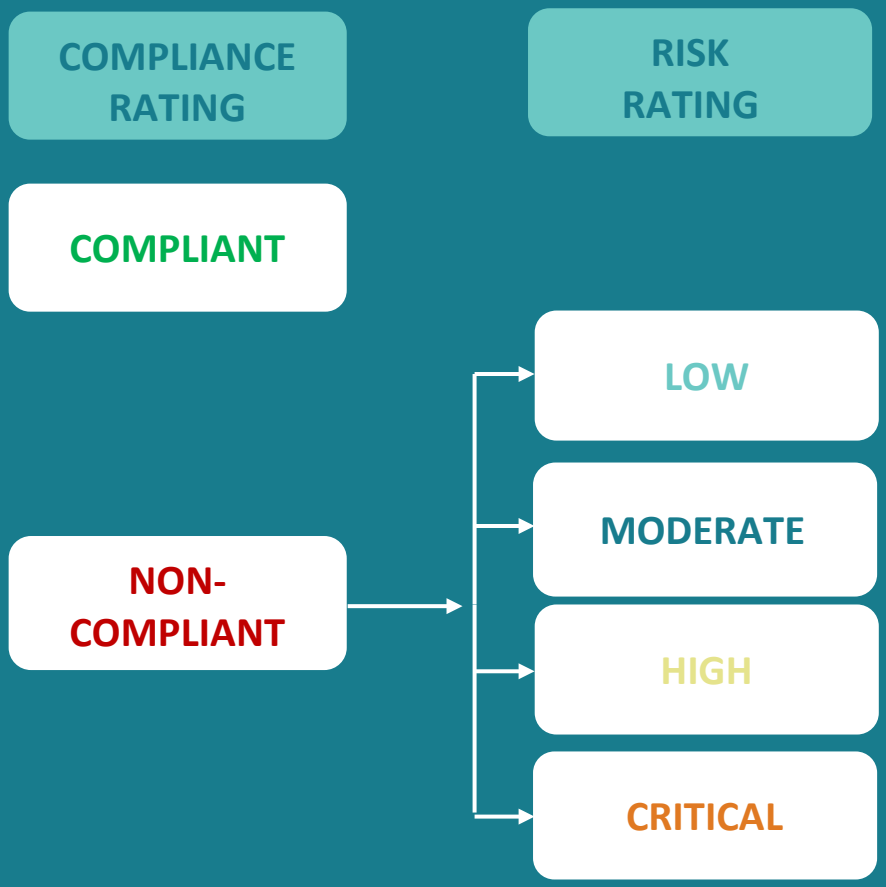
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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