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Eist Linn Child & Adolescent In-patient Unit

Annual Inspection Report 2026

Promoting Quality, Safety and Human Rights in Mental Health

EIST LINN CHILD & ADOLESCENT IN-PATIENT UNIT

Bessboro, Blackrock, Cork

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

Approved Centre Type:
Child and adolescent mental health care

Conditions Attached:
None

Most Recent Registration Date:
22 December 2025

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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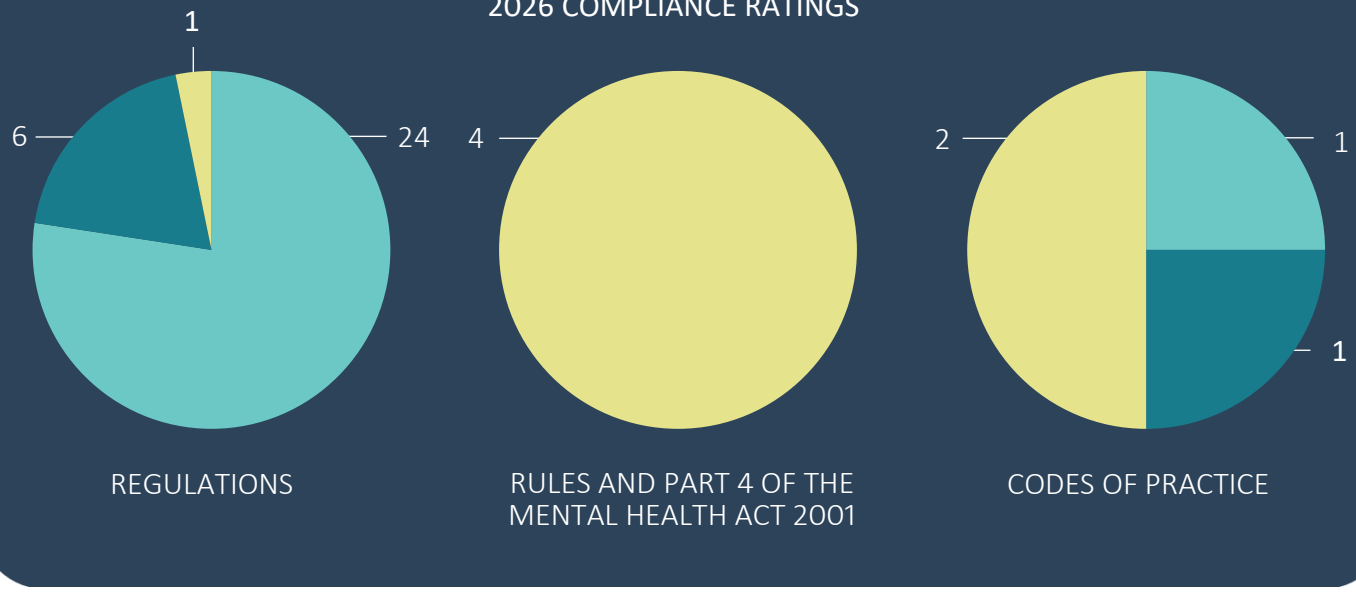
Inspection Date:
26 – 29 May 2026

Previous Inspection date:
21 – 24 October 2025

Inspection Type:
Unannounced Annual Inspection

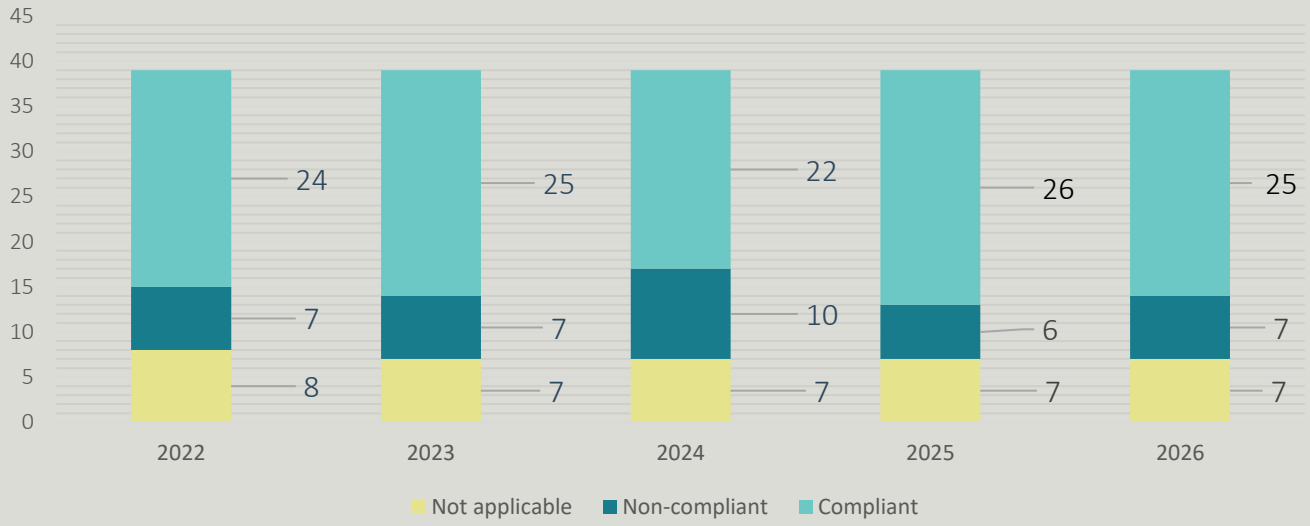
2026 COMPLIANCE RATINGS



RATINGS SUMMARY 2022 – 2026

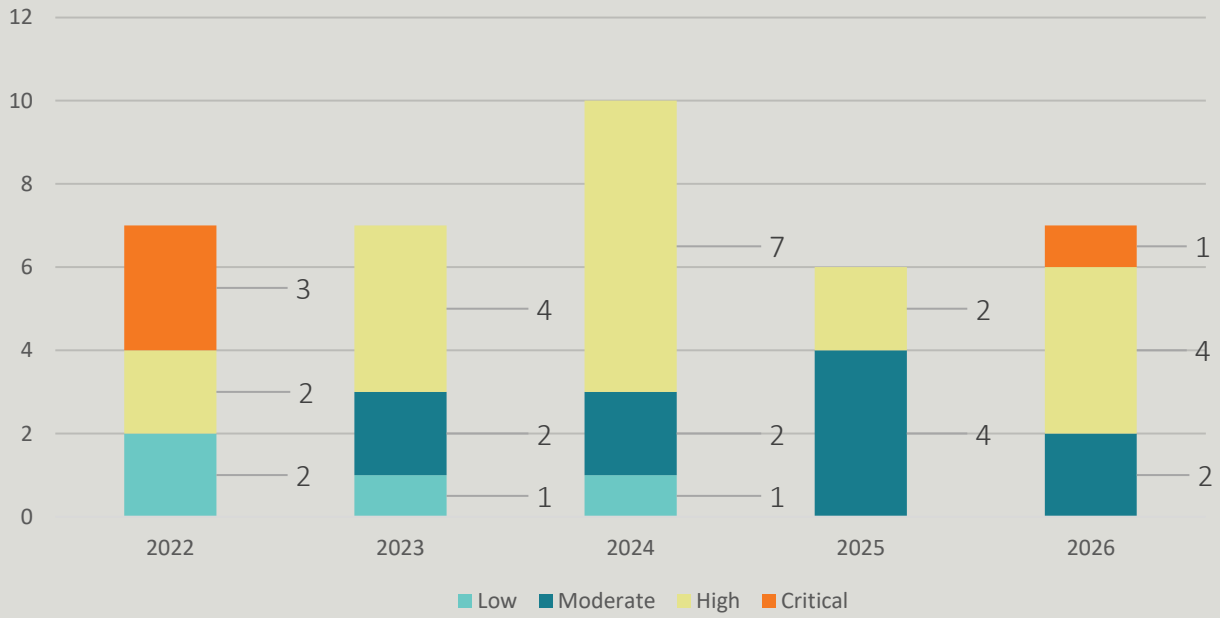
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Eist Linn Child and Adolescent Mental Health Inpatient Unit is a two-story building located in the grounds of the Bessborough Centre in Cork. The approved centre was registered to provide care and treatment for 16 young people, however, at the time of inspection, operational bed capacity was reduced to 10 beds due to staffing issues.

The ground floor contained a kitchen, dining room, therapy rooms, staff office space, sitting room, computer room and games room. A large garden area was available for the young people. The first floor contained 16 single en suite bedrooms, a sitting room, a sensory room, a property room and laundry facilities. The Suimhneas suite, a low stimulus area, was located on the first floor and consisted of an en suite bedroom, de-escalation room, lounge/dining area, and access to an enclosed outdoor space. There was a school located on the grounds of the approved centre in an adjacent building which contained a sports hall, a gym room, a home economics room and an art room.

1.2 Inspector of Mental Health Services Summary

Eist Linn Child and Adolescent Mental Health Inpatient Unit is a two-story building located in the grounds of the Bessborough Centre in Cork. The inspection of Eist Linn was unannounced and occurred over a four-day period. This report reflects the findings at the time of the inspection.

In 2025, the service was non-compliant with six regulations during the annual inspection. In the 2026 inspection, the number of non-compliant regulations increased to seven. Two of these areas were reoccurring and included the Code of Practice on Admission, Transfer and Discharge from an Approved Centre which was found to be non-compliant during each annual inspection since 2023. In 2026, the code of practice in relation to Admission and Regulation 32: Risk Management Procedures were both breached when the process for emergency admission to the approved centre was not followed; an assessment of risk prior to the admission was not adequately considered. This led to concerns regarding the strength of governance procedures for the approved centre.

Service capacity had been diminished secondary to significant staffing deficits affecting multiple disciplines within the care team. The service mitigated risks by reducing operational bed capacity and the suspension

of out of hours admissions. These actions were deemed necessary to maintain a safe environment and meet identified needs.

The dedication and commitment of the staff were evident and translated into quality patient centred care. The approved centre also demonstrated commitment to providing a quality service through the development of on-going quality initiatives and the implementation of an annual audit schedule.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***16 beds, only 10 beds were operational***
Total number of residents	**9**
Number of detained patients	1
Number of wards of court	1
Number of residents in the approved centre for more than 6 months	2

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	77%	78%	69%	81%	78%

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 10000411	*02 June 2026*	*Non-compliance with Regulation 32: Risk Management Procedures*	*QIP submitted and actions followed up through IAN 10000411.*

2.0 Governance

Eist Linn Child and Adolescent Inpatient Unit was located in the HSE Cork South and West Integrated Health Area (IHA) which was part of the wider HSE South West health region. The principal governance forum within the approved centre was the Eist Linn Business Management meeting which convened monthly, was chaired by the clinical director, and was attended by approved centre managers. At a regional level, the Child and Adolescent Mental Health Service (CAMHS) Operational Group, chaired by the registered proprietor nominee, governed services for the Cork and Kerry CAMHS services. This group met on a monthly basis and membership included senior clinical and non-clinical managers from the region. Relevant issues relating to the approved centre were escalated to this regional forum as required.

The Quality and Patient Safety (QPS) forum functioned to review all quality and safety issues for both inpatient and community CAMHS services for the Cork and Kerry region. This meeting convened every two months, and membership included senior clinicians, clinical and non-clinical managers. A nurse manager attended this meeting to represent the approved centre and provide relevant feedback.

Heads of discipline had received training in risk management, incident management and health and safety. The service maintained a risk register which was reviewed at the Eist Linn Business Management team meetings and at the QPS committee meetings. Where appropriate, risks could be escalated to the regional risk register which was reviewed by the CAMHS Operational Group. There were processes in place for the identification, assessment, treatment, reporting and monitoring of risk in the approved centre. However, the inspection team was not assured that the process for emergency admissions to the approved centre was consistently followed in accordance with local policy. In the case of one emergency admission, the process was not correctly followed as an assessment of risk prior to the admission was not adequately discussed with all necessary stakeholders. In addition, the decision to admit to the approved centre was not made solely by relevant clinical staff in accordance with local policy for emergency admissions.

On a monthly basis, nursing management and other relevant managers conducted a review of the approved centre environment with the aim of identifying and removing or mitigating structural and environmental risks. At the time of inspection, however, the most recent ligature anchor point audit was completed in April 2025. National HSE guidelines state that an audit should be conducted annually. Therefore, ligature point risks had not been reassessed within expected timeframes in accordance with best practice guidelines.

The approved centre operated a standardised and structured system for incident management. Incidents were managed in line with the HSE incident management framework. Incident trends were reviewed prior to the business meeting each month and arrangements were in place for the sharing of learning. A Serious Incident Management Team was formed to review the occurrence of any serious incident arising in the approved centre.

There was a regional CAMHS Policies, Procedures, Protocols and Guidelines (PPPG) group which provided a multi-disciplinary approach to policy development and review. Usually, this group met monthly, however, at the time of inspection, the last two meetings could not proceed because the required number of members

were not present. Most policies were up to date, with the exception of nine new policies required in accordance with Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines. In 2026, new regulatory requirements (Regulation 23) were introduced which required all services to have access to a Drugs and Therapeutics Oversight committee for the purposes of strengthening governance processes. The service, however, was unable to establish this committee due to the limitations in pharmacy resources. At the time of inspection, the pharmacy post (0.5 WTE) had been vacant since January 2024 and pharmacy input was sourced from another approved centre to manage specific clinic need.

Residents in the approved centre were under the care of a single multidisciplinary team which included the disciplines of medicine, nursing, occupational therapy, psychology, social work, speech and language therapy and dietetics. Staffing deficits affected four disciplines on the team and associated risks were identified on the local risk register. There were 10 vacant nursing staff posts, and the service was reliant on agency staff members and provision of overtime to ensure adequate staffing levels over a 24 hour period. While there was approval for recruitment to proceed, delays in progressing recruitment through the human resource (HR) process were reported by nursing management. There were two social work post allocations for the approved centre however, one senior social work post (1 WTE) had been vacant since December 2024. This post was in the advanced stages of recruitment, however, significant delays progressing to the final stages of the recruitment process were reported by social work management. There were three psychology post allocations, two part time and one full time post, however at the time of inspection, the full-time post holder was on leave for a period of six weeks. There was no interim cover for this post; clinical needs and referrals were discussed on a case by case basis and allocated to the psychologists working part time. There was an allocation for two consultant psychiatrist posts (2.0 WTE), both of which had been vacant since November 2025 and January 2026. In the interim, a consultant child psychiatrist, previously working in a separate part of the CAMHS service, had been transferred to the approved centre on a temporary full-time basis. Support from a second child psychiatrist, specialising in eating disorders, was provided on a part time basis. At the time of inspection, one post was under formal offer, and an expression of interest had been issued regarding the second post. Regarding the disciplines of Occupational Therapy and Speech and Language Therapy, while there were no vacant posts, relatively low whole time equivalent (WTE) levels, were identified as a risk of causing harm to young people admitted to the approved centre on the risk register.

In response to staffing issues, operational bed capacity was reduced from 16 to 10 beds; a further reduction in bed capacity was under review at the time of inspection. In the week prior to the inspection, management had also taken the decision to suspend out of hours admissions (i.e. after 7pm and weekends). These actions were deemed necessary to mitigate risk, maintain a safe environment and meet identified needs.

Various practices served to promote service quality. Each head of discipline outlined strategic goals and relevant key performance indicators to monitor achievement. There was a nurse led programme of clinical audit within the approved centre; other members of the MDT contributed where relevant. Audit results were discussed at the Eist Linn Business Management Team meeting. Arrangements for the supervision and performance management were in place for each discipline within the multidisciplinary team. Most staff had completed mandatory training in basic life support, the management of violence and aggression, fire safety, the protection and welfare of children, safeguarding and mental health legislation. Where minor deficits in training occurred, plans to deliver this training, in the weeks following the inspection were provided. Relevant quality issues were escalated to the QPS forum where required.

Processes were in place for the involvement of the young people in governance and quality improvement. Community meetings, whereby the young people would collectively meet with staff to discuss various issues and provide feedback were normally facilitated on a weekly basis. However, the residents reported to the inspection team, that these were not happening consistently and had not occurred for a least two weeks. Engagement with the complaints process was also used to support service improvement. The approved centre had a complaints policy and an appointed complaints officer. All complaints were reviewed at the Eist Linn Business Management Team meeting. A designated advocate from the Youth Advocacy Programme (YAP) attended the approved centre on a weekly basis and spoke directly with the young people. The youth advocate attended the Eist Linn Business Management team meeting to provide feedback on a quarterly basis. Upon discharge of a young person from the approved centre, feedback surveys were administered. Results were collated on annually and discussed the Eist Linn Business Management meeting.

2.1 Therapeutic Services and Programmes

Therapeutic Services and Programmes
The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. Services included occupational therapy, psychology, social work, speech and language therapy, and dietetics. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Services were provided mostly on an individual basis. There was a limited number of group programmes offered which included a Cognitive Behavioural Therapy group facilitated by the psychology discipline. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

2.2 Staff Training Record

Staff Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (29)	29	100%	29	100%	29	100%	29	100%	29	100%	29	100%
Medical (4)	4	100%	3	75%	4	100%	4	100%	4	100%	3	75%
Occupational Therapist (1)	0	0%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (3)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian (2)	2	100%	2	100%	1	50%	2	100%	2	100%	2	100%
Speech and Language Therapist (1)	1	100%	0	0%	1	100%	1	100%	1	100%	1	100%

3.0 Compliance

3.1 Compliant areas on this inspection

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

Regulation/Rule/Act/Code		2026
Regulation 04: Identification of Residents	✓	Compliant
Regulation 05: Food and Nutrition	✓	Compliant
Regulation 06: Food Safety	✓	Compliant
Regulation 07: Clothing	✓	Compliant
Regulation 09: Recreational Activities	✓	Compliant
Regulation 10: Religion	✓	Compliant
Regulation 11: Visits	✓	Compliant
Regulation 12: Communication	✓	Compliant
Regulation 13: Searches	✓	Compliant
Regulation 14: Care of the Dying	✓	Compliant
Regulation 15: Individual Care Plan	✓	Compliant
Regulation 16: Therapeutic Services and Programmes	✓	Compliant
Regulation 17: Children's Education	✓	Compliant
Regulation 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed Circuit Television	✓	Compliant
Regulation 26: Staffing	✓	Compliant
Regulation 27: Maintenance of Records	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Code of Practice on the Use of Physical Restraint	✓	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 08: Residents' Personal Property and Possessions	✓		✓		✓		✓		✗	Moderate
Regulation 22: Premises	✗	Critical	✗	High	✗	High	✓		✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✗	High	✗	High
Regulation 28: Register of Residents	✓		✓		✗	Moderate	✓		✗	High
Regulation 31: Complaints Procedures	✗	Critical	✓		✓		✓		✗	Moderate
Regulation 32: Risk Management Procedures	✗	Critical	✓		✗	High	✓		✗	Critical
Code of Practice: Admission, Transfer and Discharge	✓		✗	High	✗	High	✗	Moderate	✗	High

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

3.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent facility, 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:

- 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 Youth Advocacy Programme 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.

Residents stated that there was lack of variety in the food choices offered. They reported that, sometimes, during the day they felt very hungry and that there were heavy restrictions on food. They wanted more flexibility with the provision of snacks. Residents reported that sometimes the weekly unit community meetings did not occur, and at the time of inspection, the meeting had not occurred for two weeks at least. Residents had enough to occupy themselves during the day and activities offered were good. Residents stated that there had been no formal movie nights since January, but they could go to the lounge to watch movies. Residents wanted more clarity and better communication around the specific aspects of their care plans. Residents felt that the lights outside their bedrooms were very bright and nighttime checks with lights were bothersome.

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

- Two residents reported that staff members explained what was happening in a way they could understand upon arrival to the approved centre, while one resident indicated that this did not occur, and two residents did not remember.
- Two residents were satisfied with the information given about their diagnosis, care and treatment. Three residents did not express a specific answer.
- Four residents reported that information on medications was explained in way that was understandable, while one resident indicated that this had not been explained.
- Four residents were familiar with their individual care plan while one was not familiar with it.
- Four residents were involved in the process of setting goals, while resident indicated that they were not involved in this process.
- Three residents knew the members of their mental health team and who their keyworker was while

two residents did not.

- Four residents indicated that they were not able to discuss worries or concerns with a member of staff, while one resident indicated that they could only discuss with nurses.
- All residents reported that there were not enough leisure activities during the day.
- Three residents reported that there were not enough talking therapies available, one resident indicated that there were enough; one resident did not respond to this question.
- One resident was happy with how staff talked to them while four residents did not give a specific response.
- Two residents felt that their privacy and dignity were respected, while two others these aspects were not respected. One resident did not give a specific response.
- All residents were able to communicate freely with family, friends or advocates.
- One resident felt safe all the time, while four residents did not give a specific response
- One resident reported that they felt able to give feedback to staff and to make complaints freely while four residents felt unable.
- Residents reported on the most positive aspects of the service user experience. Comments included:
  - Having other young people to talk to
  - Visiting the horse
  - Meeting kind people
  - Nice nursing staff and young people
  - Most nurses are nice and listen
- Residents also suggested improvements for the service. Comments included:
  - The acquisition of another computer
  - The acquisition of bigger beds for taller people
  - Increasing the variety of food options.
  - More outdoor activities
  - More outings and time outside.

4.2 Advocacy

The approved centre had an advocacy service. The advocate provided the following feedback:

- The young people voiced their desire for choice and variety regarding food options.
- The young people wanted more external outings but were often told that this was not possible due to staffing issues. The young people are understanding of the pressures faced by staff.
- The young people reported that staff were very supportive of them.

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:

- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Director
- Clinical Nurse Manager 3
- Consultant Psychiatrist
- Dietetics Manager
- Executive Clinical Director
- Head of Service & Integrated Healthcare Area Lead
- Practice Manager
- Principal Psychologist
- Speech and Language Therapy Manager

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

6.0 Inspection Findings – Regulations

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

The following regulations are not inspected:

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

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

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

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

Regulation 8: Residents' Personal Property and Possessions

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre ensured that a resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe keeping of the resident's monies, valuables, personal property, and possessions, as necessary. There were locker spaces for residents' belongings in the storeroom under keypad access. Monies and valuables were stored separately in a secure safe in the medical room.

The approved centre compiled a detailed property checklist with each resident on admission, listing their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident.

The approved centre's policy stated that all monetary transactions must be signed by the resident and two members of staff. However, for four transactions, the access to and use of resident monies was not overseen and signed by the resident and two staff members. The balance sheet record of this resident's monies was not reflective of the actual amount.

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

There was correct identification and labelling of items stored in property rooms to ensure that approved centre staff were aware of resident ownership of property.

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

a) **The registered proprietor did not ensure that the policies and procedures relating to residents' personal property and possessions was followed as one resident's monies was not signed by two members of staff and the resident for four transactions, 8(2).**
b) **The registered proprietor did not ensure that a record was maintained of the resident's property, as the record was not reflective of the resident's money, 8(3).**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Residents in the approved centre had access to personal space and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms where residents sat during the day, and rooms were ventilated.

Private and communal areas were suitably sized and furnished to remove excessive noise/acoustics. The lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised.

Ligature points were not minimised to the lowest practicable level, based on risk assessment. These high-risk ligature points were identified in 2025 and were still unresolved at the time of this inspection.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. In general, the approved centre was clean and hygienic, however, external windows and fly screens required cleaning.

There was a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. The approved centre provided assisted devices and/or 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 premises were clean as the external windows and fly screens required cleaning, 22(1)(a).**
b) **The registered proprietor did not ensure that the condition of the physical structure was developed with due regard to residents' specific needs and the safety and wellbeing of residents, staff and visitors as ligature points were not minimised to the lowest level, 22(3).**

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

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The approved centre had a written medication management and administration policy available in relation to the ordering, prescribing, storing and administration of medicines. The policy had a last-reviewed date of November 2024 recorded.

There was also a policy relating to processes and procedures for rapid tranquilisation which had a last-reviewed date of July 2023 recorded.

The medication management and administration policy did not include processes and procedures for:

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

The registered proprietor did not ensure that the approved centre had access to a Drugs and Therapeutics Oversight Committee that met at least quarterly.

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

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

In one MPAR, medication was recorded as administered prior to the start date. In another MPAR, a medication was recorded as administered after the date of discontinuation.

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 operational policies appropriate to the resident cohort, 23(1).**
b) **The registered proprietor did not ensure that the approved centre had access to a Drugs and Therapeutics Oversight Committee, 23(1).**
c) **In one Medication Prescription and Administration Record, medication was recorded as administered prior to the start date, 23(1).**
d) **In one Medication Prescription and Administration Record, a medication was recorded as administered after the date of discontinuation, 23(1).**

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

A documented register of all residents admitted to the approved centre, with all residents' information accessible in one space, was not available. For each resident, a 'Register of Residents Statement' was taken, detailing the requirements under the regulation. For current residents, the statement was a one page document located in a binder and stored in the meeting room. Once a resident was discharged, the one page statement was removed from the binder and placed into the resident's clinical file. Each statement was stored separately in the relevant resident's clinical file.

The inspection team reviewed all current resident statements and nine discharge files which recorded the following resident information as per the minimum information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006: full name; address; gender; date of birth; country of birth; and legal status, i.e. voluntary or involuntary.

The following information deficits in resident statements were found:

- One current resident's next of kin/representative was not recorded.
- One current resident's admission date was not recorded.
- Three discharge files did not record a discharge date.
- One resident's diagnosis on admission was not recorded.
- Three discharge files did not record a discharge diagnosis.

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

a) **The registered proprietor did not ensure that the register was maintained in relation to every resident in the approved centre, 28(1).**
b) **The registered proprietor did not ensure that the register included all the information specified in Schedule 1 as information relating to next of kin, admission date, discharge date, diagnosis on admission and discharge were not recorded for each resident, 28(2).**

Regulation 31: Complaints Procedures

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had a complaints policy which was last reviewed in January 2025 and documented the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made.

Details of complaints, as well as subsequent investigations and outcomes, were not fully recorded. Three complaints received were reviewed by the inspection team. The outcomes of these complaints were not documented. For one complaint, there was documentation indicating that a follow-up meeting occurred but there was no action recorded on the complaints log.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded, 31(7).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in November 2023 and outlined the roles and responsibilities for risk management, including:

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

The policy also included:

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

In general, clinical risks were identified, assessed, treated, reported, and monitored. However, the inspection team was not assured that the process for emergency admissions to the approved centre was consistently followed in accordance with local policy. In the case of one emergency admission to the approved centre, the process was not followed as an assessment of risk prior to the admission was not adequately discussed with all necessary stakeholders. In addition, the decision to admit to the approved centre was not made solely by relevant clinical staff in accordance with local policy for emergency admissions.

Health and safety risks and corporate risks were identified, assessed, treated, reported, and monitored by the approved centre in accordance with relevant legislation. Where appropriate, all identified risks were documented in the risk register.

At the time of inspection, the most recent ligature anchor point audit was completed in April 2025. National HSE guidelines, however, state that an audit should be conducted annually. Therefore, ligature point risks had not been reassessed within expected timeframes in accordance with best practice guidelines. With respect to all other structural and environmental risks, senior nursing management conducted a monthly review of the approved centre environment with the aim of identifying and removing or mitigating risks.

Individual risk assessments are completed prior to and during episodes of physical restraint, at admission to identify individual risk factors, upon discharge of a resident, and in conjunction with medication requirements or administration.

Residents and/or their representatives were involved in the individual risk management processes. The requirements for the protection of children within the approved centre were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format. Clinical incidents are reviewed by the multidisciplinary team at their regular meeting. The person with responsibility for risk management reviews incidents for any trends or patterns occurring in the services. The approved centre provided a six- monthly summary report of all incidents to the Mental Health Commission.

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

a) **The registered proprietor did not ensure that the approved centre implemented appropriate risk management procedures relating to the emergency admission process to the approved centre, 32(1).**
b) **The registered proprietor did not ensure that the approved centre implemented risk management procedures as the ligature audit was not reviewed within appropriate timeframes, 32(1).**

7.0 Inspection Findings – Rules

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

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

8.0 Inspection Findings – Mental Health Act 2001

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

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

9.0 Inspection Findings – Codes of Practice

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

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

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

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

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

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

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

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in April 2025, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in March 2025, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in December 2025, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission:

The clinical file of one young person admitted to the approved centre was inspected. It was not clinically determined that the young person was in need of immediate inpatient mental health care. The decision to admit the young person to the approved centre was not made solely by a registered medical practitioner or a consultant psychiatrist. As the process for emergency admission to the approved centre was not followed, it was not determined if the young person was admitted to the approved centre most appropriate to meet their needs.

Upon admission to the approved centre, the assessment included the presenting problem, past psychiatric history, family history, medical history, current and historic medications, social and housing circumstances, current mental health state, and risk assessment.

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

Discharge: The clinical file of one young person who had been discharged from the approved centre was

examined. The discharge plan included an estimated date of discharge, a follow up plan and documented communications with the relevant healthcare provider. The discharge plan included a reference to early warning signs of relapse.

The discharge meeting was attended by the resident, their key worker, relevant members of the residents' multi-disciplinary team (MDT) and a family member or representative, where appropriate.

The discharge assessment addressed the residents psychiatric and psychological needs and included a current mental state examination and a comprehensive risk assessment and risk management plan. The discharge was coordinated by the key worker. A preliminary discharge summary was sent to the relevant healthcare provider.

The discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge and outstanding health or social issues. It provided follow-up arrangements and included risk issues such as signs of relapse. The discharge summaries included the names and contact details of key people for follow-up. Family members were involved in the discharge process, where applicable.

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

a) **One admission to the approved centre occurred when it was not clinically determined that the individual was in need of immediate inpatient mental health care and treatment, 12.3.**
b) **In one admission, the decision to admit was not made by a registered medical practitioner or a consultant psychiatrist, 13.1.**
c) **One individual was admitted to the approved centre, which was not appropriate to his/her needs, 13.3.**
d) **The registered proprietor did not ensure that the admission policy and procedures were followed in accordance with the processes for an emergency admission, 32.5.**

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

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

Regulation 08: Residents' Personal Property and Possessions					
Reason ID : 10007734		**The registered proprietor did not ensure that the policies and procedures relating to residents' personal property and possessions was followed as one resident's monies was not signed by two members of staff and the resident for four transactions, 8(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review of resident monies management practices has been completed. Staff have been reminded of the requirement for two staff signatures and resident signature for all transactions involving resident monies.	Monthly audit demonstrates 100% compliance with signatures and recording requirements.	Based on existing NFR requirements and local procedures.	30/09/2026	Practice Manager CNM2, Nursing Staff
Preventative Action	Peer learning will be delivered to staff regarding management of resident monies and HSE National Financial Regulations. Visual prompts will be displayed at the safe. Monthly audits will	Monthly audit demonstrates 100% compliance with signatures and recording requirements.	Based on existing NFR requirements and local procedures.	30/09/2026	Practice Manager CNM2, Nursing Staff

	verify compliance with recording and signature requirements.				
Reason ID : 10007735		**The registered proprietor did not ensure that a record was maintained of the resident's property, as the record was not reflective of the resident's money, 8(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review of resident monies management practices has been completed. Staff have been reminded of the requirement for two staff signatures and resident signature for all transactions involving resident monies.	Monthly audit demonstrates 100% compliance with signatures and recording requirements.	Based on existing NFR requirements and local procedures.	30/09/2026	Practice Manager CNM2, Nursing Staff
Preventative Action	Peer learning will be delivered to staff regarding management of resident monies and HSE National Financial Regulations. Visual prompts will be displayed at the safe. Monthly audits will verify compliance with recording and signature requirements.	Monthly audit demonstrates 100% compliance with signatures and recording requirements.	Based on existing NFR requirements and local procedures.	30/09/2026	Practice Manager CNM2, Nursing Staff

Regulation 22: Premises					
Reason ID : 10007736		**The registered proprietor did not ensure that the premises were clean as the external windows and fly screens required cleaning, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The issue regarding external windows and screening has been referred to Estates and the contracted cleaning provider for review and remedial action.	Inclusion on maintenance tracker with completion evidenced.	Existing contractor and estates processes.	31/12/2026	Maintenance Department, Area Administrator, CNM3 Practice Manager
Preventative Action	External cleaning requirements will be incorporated into the maintenance walkthrough programme and tracked through the maintenance action log. Regular review with Estates and the cleaning contractor will be undertaken.	Inclusion on maintenance tracker with completion evidenced.	Existing contractor and estates processes.	31/12/2026	Maintenance Department, Area Administrator, CNM3 Practice Manager
Reason ID : 10007737		**The registered proprietor did not ensure that the condition of the physical structure was developed with due regard to residents' specific needs and the safety and wellbeing of residents, staff and visitors as ligature points were not minimised to the lowest level, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature risks identified through audit have been reviewed and risk control measures continue to be applied.	Monthly reviews completed and annual audit performed.	Embedded in existing governance and maintenance processes.	01/01/2027	Area Administrator, Practice Manager, CNM2, Maintenance Department

Preventative Action	Ligature risks will be reviewed monthly through maintenance walkthroughs and annually through the ligature audit programme. The development of an electronic ligature audit system will support enhanced oversight and timely action tracking.	Monthly reviews completed and annual audit performed.	Embedded in existing governance and maintenance processes.	31/01/2027	Area Administrator, Practice Manager, CNM2, Maintenance Department

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10007738		**The registered proprietor did not ensure that the approved centre had appropriate and suitable operational policies appropriate to the resident cohort, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A Drugs and Therapeutics Committee has been established and is meeting regularly. A programme of work is underway to review and develop the suite of medicines management policies required under the revised Judgement Support Framework.	Nine policies reviewed, approved and implemented.	Dedicated committee operating weekly/fortnightly.	31/12/2026	Clinical Director, Pharmacist, General Manager
Preventative Action	The Drugs and Therapeutics Committee will continue to provide governance oversight and ensure completion, approval and implementation of the required policy suite. Progress will be monitored through governance structures.	Nine policies reviewed, approved and implemented.	Dedicated committee operating weekly/fortnightly.	31/12/2026	Clinical Director, Pharmacist, General Manager
Reason ID : 10007739		**The registered proprietor did not ensure that the approved centre had access to a Drugs and Therapeutics Oversight Committee, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	A Drugs and Therapeutics Committee has been established and is meeting regularly. A programme of work is underway to review and develop the suite of medicines management policies required under the revised Judgement Support Framework.	Nine policies reviewed, approved and implemented.	Dedicated committee operating weekly/fortnightly.	31/12/2026	Clinical Director, Pharmacist, General Manager
Preventative Action	The Drugs and Therapeutics Committee will continue to provide governance oversight and ensure completion, approval and implementation of the required policy suite. Progress will be monitored through governance structures.	Nine policies reviewed, approved and implemented.	Dedicated committee operating weekly/fortnightly.	31/12/2026	Clinical Director, Pharmacist, General Manager
Reason ID : 10007740		**In one Medication Prescription and Administration Record, medication was recorded as administered prior to the start date, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified medication documentation errors were reviewed. Weekly medication chart audits continue	Weekly audit compliance reports and training records.	Existing audit and induction structures utilised.	31/12/2026	Consultant Psychiatrist, Pharmacist, CNM2

	to be completed to identify and address documentation issues.				
Preventative Action	Prescribing and medication documentation training has been incorporated into NCHD induction. Audit findings will be fed back to prescribers and clinical teams to facilitate learning and quality improvement.	Weekly audit compliance reports and training records.	Existing audit and induction structures utilised.	31/12/2026	Consultant Psychiatrist, Pharmacist, CNM2
Reason ID : 10007741		**In one Medication Prescription and Administration Record, a medication was recorded as administered after the date of discontinuation, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified medication documentation errors were reviewed. Weekly medication chart audits continue to be completed to identify and address documentation issues.	Weekly audit compliance reports and training records.	Existing audit and induction structures utilised.	31/12/2026	Consultant Psychiatrist, Pharmacist, CNM2
Preventative Action	Prescribing and medication documentation training has been incorporated into NCHD induction. Audit findings will be fed back to prescribers	Weekly audit compliance reports and training records.	Existing audit and induction structures utilised.	31/12/2026	Consultant Psychiatrist, Pharmacist, CNM2

	and clinical teams to facilitate learning and quality improvement.				

Regulation 28: Register of Residents					
Reason ID : 10007729		**The registered proprietor did not ensure that the register was maintained in relation to every resident in the approved centre, 28 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An electronic Register of Residents has been established on the shared drive and is accessible to relevant staff. Responsibility for maintaining the register has been clarified with administrative staff responsible for data entry and input provided by nursing and medical staff. Existing records have been reviewed and updated where deficits were identified.	Quarterly audit results demonstrating 100% completion of required fields.	Utilises existing administration and MDT processes.	31/08/2026	CNM2, Administrator, MDT Members, Practice Manager
Preventative Action	Starting on he 31/08/26 Quarterly audits of the Register of Residents will be undertaken jointly by nursing and administration staff for a period of 12 months to ensure ongoing compliance. Administrative	Quarterly audit results demonstrating 100% completion of required fields.	Utilises existing administration and MDT processes.	30/08/2026	CNM2, Administrator, MDT Members, Practice Manager

	oversight processes have been introduced whereby gaps identified in the register are escalated to the MDT for completion.				
Reason ID : 10007730		**The registered proprietor did not ensure that the register included all the information specified in Schedule 1 as information relating to next of kin, admission date, discharge date, diagnosis on admission and discharge were not recorded for each resident, 28 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Register of Residents has been reviewed and missing information updated where available. Admission and discharge diagnosis requirements have been reinforced through MDT processes. Diagnosis on discharge has been incorporated into nursing and medical discharge checklists.	Quarterly audits achieve 100% completion of Schedule 1 information.	Incorporated into existing MDT and discharge processes.	17/08/2026	Consultant Psychiatrist, CNM2, MDT Members, Administrator
Preventative Action	Discharge diagnosis will be discussed at the final MDT meeting prior to discharge and recorded on nursing and medical discharge checklists. Quarterly audits of the Register	Quarterly audits achieve 100% completion of Schedule 1 information.	Incorporated into existing MDT and discharge processes.	17/08/2026	Consultant Psychiatrist, CNM2, MDT Members, Administrator

	of Residents will continue for 12 months.				

Regulation 31: Complaints Procedures					
Reason ID : 10007731		**The registered proprietor did not ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded, 31(7).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff involved in complaint management have been instructed to ensure detailed documentation of complaint investigations, actions and outcomes on complaint records. Guidance has been provided to CNM2s regarding the level of detail expected.	Audit of complaint records demonstrates complete recording of complaint, investigation, actions and outcomes.	Supported by existing complaints governance structures.	31/10/2026	Complaints Officer, CNM2, Practice Manager
Preventative Action	Peer learning and training support will be delivered by the Complaints Manager for the Region. Complaint records will be reviewed periodically, and complaints management will remain a standing agenda item at management meetings. An	Audit of complaint records demonstrates complete recording of complaint, investigation, actions and outcomes.	Supported by existing complaints governance structures.	31/10/2026	Complaints Officer, CNM2, Practice Manager

	additional local record sheet will be developed to supplement the national complaint resolution form where required.				

Regulation 32: Risk Management Procedures					
Reason ID : 10007732		**The registered proprietor did not ensure that the approved centre implemented appropriate risk management procedures relating to the emergency admission process to the approved centre, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Admissions Policy has been comprehensively reviewed and updated. Escalation pathways, risk management processes and governance arrangements have been clarified and approved through the relevant governance structures.	Evidence of policy dissemination and audit of emergency admissions.	Incorporated within current governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager
Preventative Action	The revised policy will be disseminated to clinical and management staff and reviewed after three months to ensure effectiveness. Future emergency admissions will be reviewed against policy requirements.	Evidence of policy dissemination and audit of emergency admissions.	Incorporated within current governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager
Reason ID : 10007733		**The registered proprietor did not ensure that the approved centre implemented risk management procedures as the ligature point audit was not reviewed within appropriate timeframes, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The overdue ligature audit has been completed.	Audit completed annually within agreed timeframe.	Incorporated into maintenance and governance schedules.	01/01/2027	Area Administrator, Practice Manager Maintenance Dept, CNM2
Preventative Action	The annual ligature audit will be scheduled for completion during January each year. Development of an electronic ligature risk audit system is in progress and will support timely completion and oversight. Ligature risk will be reviewed monthly through the maintenance walkthrough process.	Audit completed annually within agreed timeframe.	Incorporated into maintenance and governance schedules.	31/01/2027	Area Administrator, Practice Manager Maintenance Dept, CNM2

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10007725		**One admission to the approved centre occurred when it was not clinically determined that the individual was in need of immediate inpatient mental health care and treatment, 12.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Admissions Policy has been revised to clarify admission criteria, decision-making responsibilities, escalation pathways and governance requirements. The policy is progressing through governance approval processes.	Review of all out-of-hours admissions and compliance reporting.	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager
Preventative Action	The revised policy will be disseminated to all relevant clinical and management staff. The Clinical Director will review all out-of-hours admissions for a period of 12 months to ensure compliance with policy requirements. Policy implementation and adherence will be reported through governance and oversight structures.	Review of all out-of-hours admissions and compliance reporting.	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager

Reason ID : 10007726		In one admission, the decision to admit was not made by a registered medical practitioner or a consultant psychiatrist, 13.1.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Admissions Policy has been revised to clarify admission criteria, decision-making responsibilities, escalation pathways and governance requirements. The policy is progressing through governance approval processes.	Review of all out-of-hours admissions and compliance reporting.	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager
Preventative Action	The revised policy will be disseminated to all relevant clinical and management staff. The Clinical Director will review all out-of-hours admissions for a period of 12 months to ensure compliance with policy requirements. Policy implementation and adherence will be reported through governance and oversight structures.	Review of all out-of-hours admissions and compliance reporting.	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager
Reason ID : 10007727		**One individual was admitted to the approved centre, which was not appropriate to his/her needs, 13.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The Admissions Policy has been revised to clarify admission criteria, decision-making responsibilities, escalation pathways and governance requirements. The policy is progressing through governance approval processes.	Review of all out-of-hours admissions and compliance reporting.	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager
Preventative Action	The revised policy will be disseminated to all relevant clinical and management staff. The Clinical Director will review all out-of-hours admissions for a period of 12 months to ensure compliance with policy requirements. Policy implementation and adherence will be reported through governance and oversight structures.	Review of all out-of-hours admissions	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager
Reason ID : 10007728		**The registered proprietor did not ensure that the admission policy and procedures were followed in accordance with the processes for an emergency admission, 32.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Admissions Policy has been revised to clarify admission	Review of all out-of-hours admissions and compliance reporting.	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant

	criteria, decision-making responsibilities, escalation pathways and governance requirements. The policy is progressing through governance approval processes.				Psychiatrists, General Manager
Preventative Action	The revised policy will be disseminated to all relevant clinical and management staff. The Clinical Director will review all out-of-hours admissions for a period of 12 months to ensure compliance with policy requirements. Policy implementation and adherence will be reported through governance and oversight structures.	Review of all out-of-hours admissions and compliance reporting.	Supported through existing governance arrangements.	30/09/2026	Clinical Director, Consultant Psychiatrists, General Manager

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.

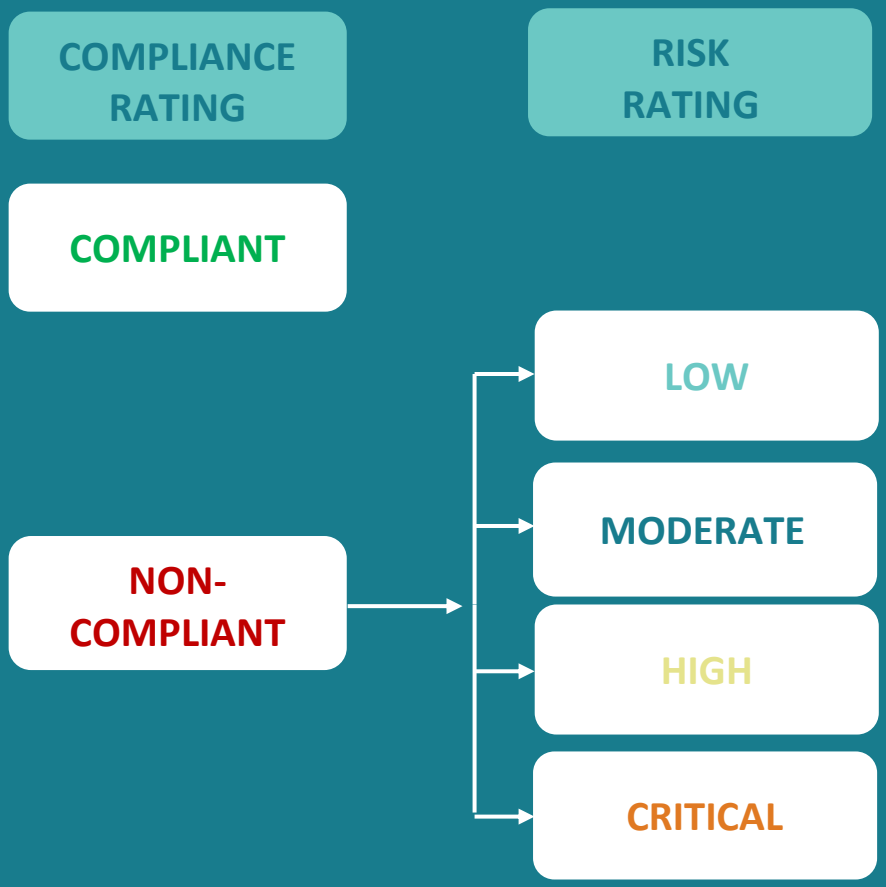
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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