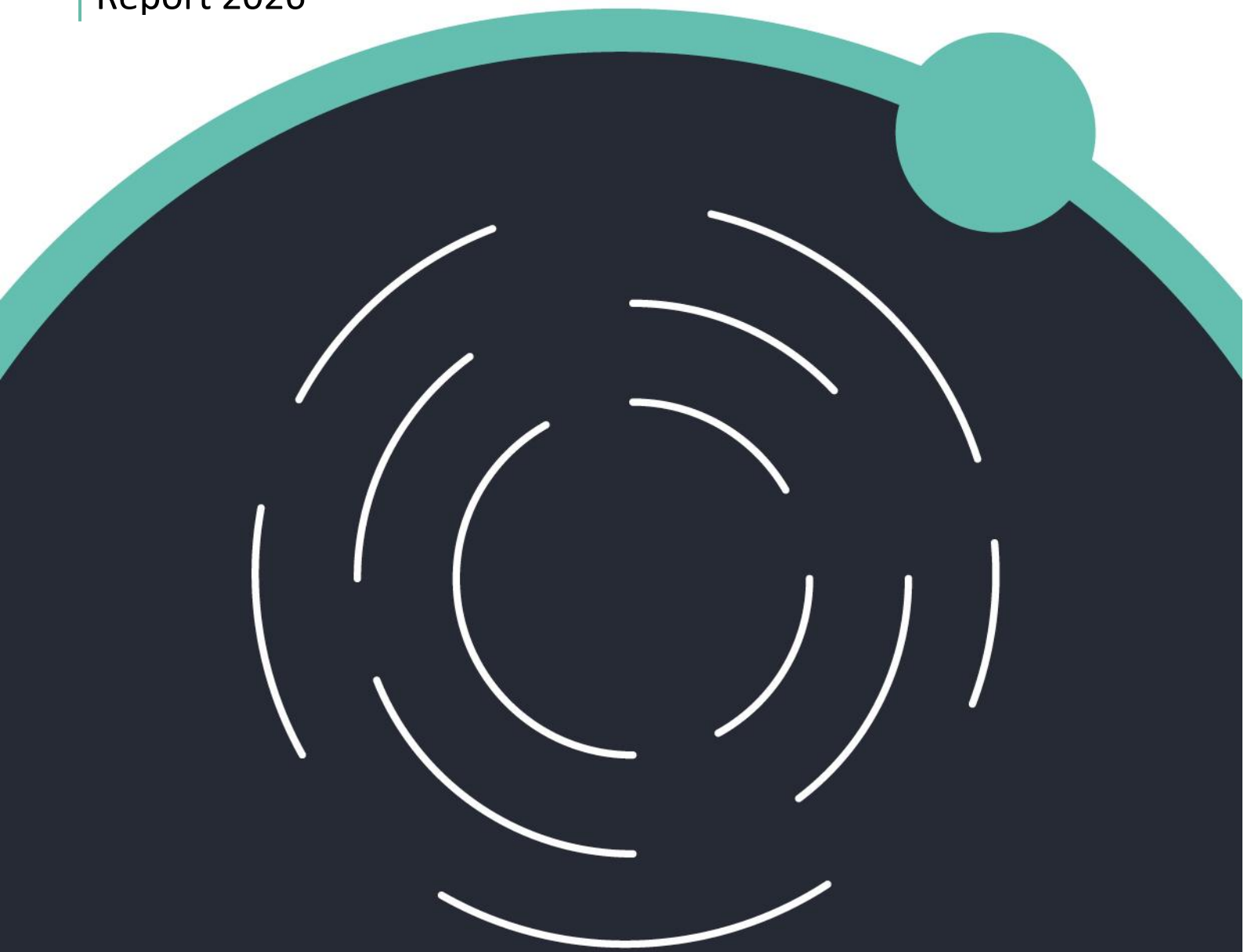
Nua Healthcare Services, Gormanston

Annual Inspection Report 2026



Promoting Quality, Safety and Human Rights in Mental Health

NUA HEALTHCARE SERVICES, GORMANSTON

Flemington Road, Gormanston, Meath

Date of Publication:
12 October 2026

ID Number: AC0378

2026 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay
Mental health rehabilitation
Mental health care for people with intellectual disability

Conditions Attached:
Yes

Most Recent Registration Date:
18 February 2025

Registered Proprietor:
Nua Healthcare Services Limited

Registered Proprietor Nominee:
Ms Danika McCartney

Inspection Team:
Noeleen Burke, Lead Inspector
Barbara McGeough
Damien Lanigan
Marianne Griffiths

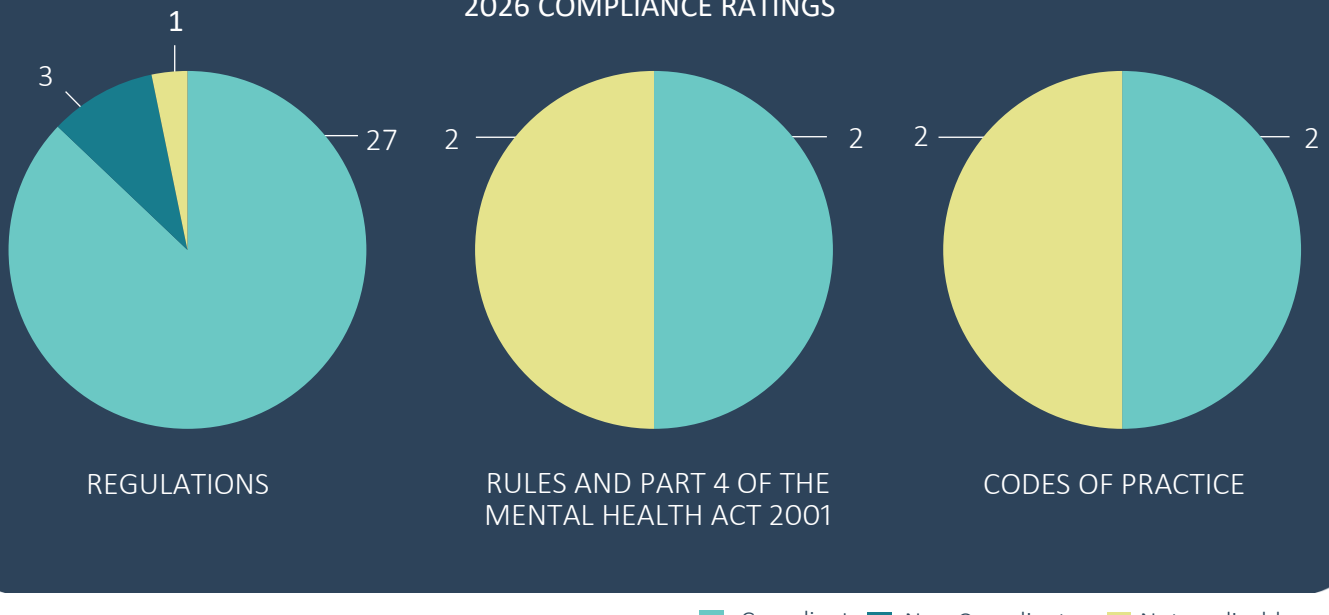
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
19 – 22 May 2026

Previous Inspection date:
23 – 26 September 2025

Inspection Type:
Unannounced Annual Inspection

2026 COMPLIANCE RATINGS

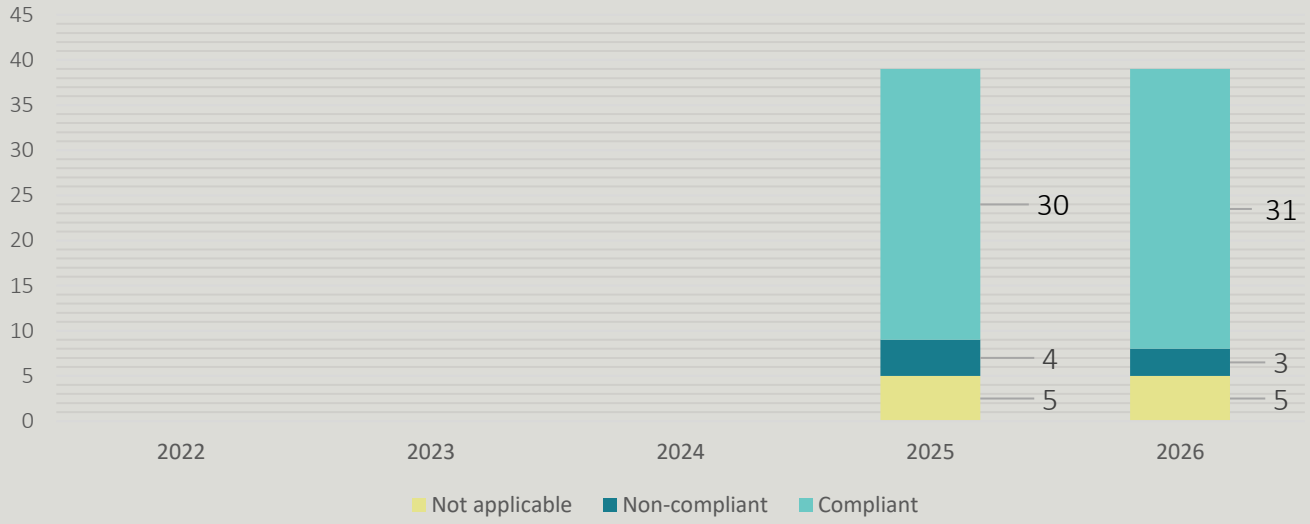


RATINGS SUMMARY 2022 – 2026

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

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2022 – 2026

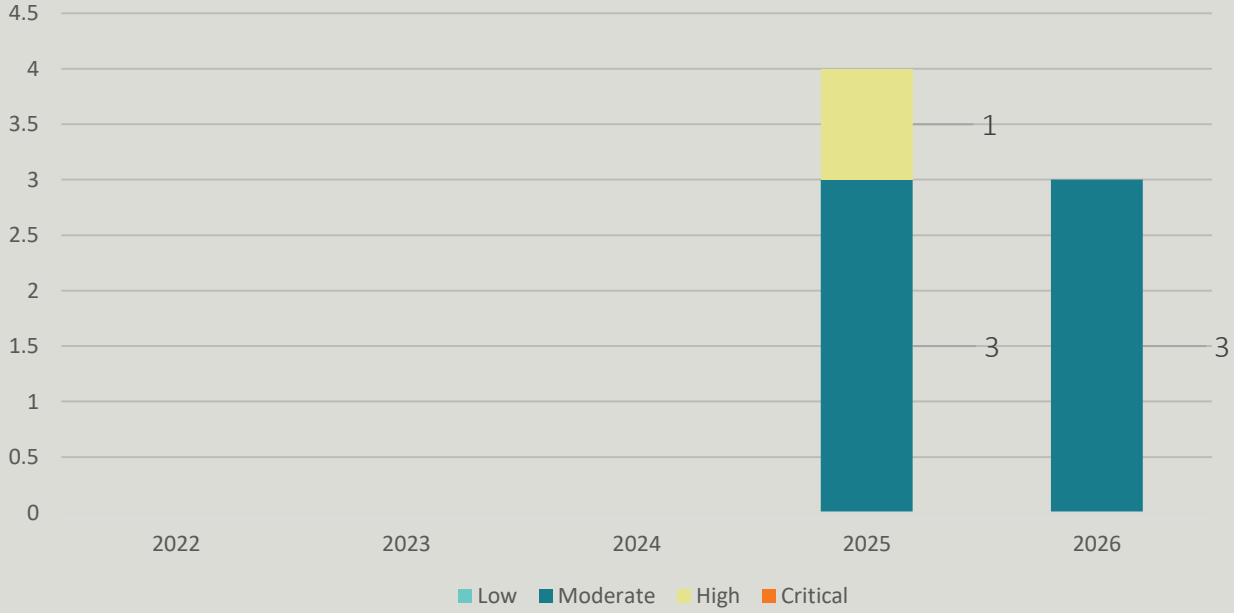
Please note: **The approved centre opened for the first time in 2025**



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

Please note: **The approved centre opened for the first time in 2025**



Contents

1.0 Inspector of Mental Health Services – Review of Findings 5

Inspector of Mental Health Services Professor James V Lucey.....5

1.1 Description of Approved Centre 5

1.2 Inspector of Mental Health Services Summary.....6

1.3 Resident Profile.....7

1.4 Compliance summary 7

1.5 Conditions of registration 7

1.6 Ongoing escalation and enforcement actions at time of inspection.....8

1.7 Escalation and enforcement actions commenced following this inspection 8

2.0 Governance 9

2.1 Staff Training Record 12

3.0 Compliance.....13

3.1 Compliant areas on this inspection 13

3.2 Non-compliant areas on this inspection.....14

3.3 Areas that were not applicable on this inspection.....14

4.0 Service-user Experience 15

4.1 Service-user feedback.....15

4.2 Advocacy.....16

5.0 Feedback Meeting.....17

6.0 Inspection Findings – Regulations.....18

7.0 Inspection Findings – Rules 22

8.0 Inspection Findings – Mental Health Act 2001 23

Appendix 1: Corrective and Preventative Action Plan (CAPA)* 25

Appendix 2: REGULATIONS, RULES, Part 4, and CODES of PRACTICE.....30

Appendix 3: Background to the inspection process 38

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

Nua Healthcare Services, Gormanston, is situated on 6.5 acres of landscaped gardens in the rural townland of Gormanston, County Meath. It is a privately operated approved centre, owned and managed by Nua Healthcare.

The approved centre provides continuing mental health care, mental health rehabilitation, and accepts nationwide referrals from Ireland and the United Kingdom. Mental health care is provided to adult male residents with severe and enduring mental illness.

The centre is registered for 50 beds across three units and two step-down units. Residents may progress from the higher-support units to the step-down units as part of their rehabilitation and discharge planning. The step-down units support residents in developing independent living skills, including cooking, self-care, and management of their living environment.

All staff and residents access the premises through the main entrance supervised by security staff. Residents are issued with radio frequency identification (RFID) wrist bands, enabling access to authorised areas within their designated units, unless otherwise restricted following risk assessment.

The approved centre comprised of 8 distinct buildings within a secure perimeter:

- Avoca was a 20-bed unit incorporating administration offices and main kitchen facilities for voluntary residents.
- Boyne was a 14-bed unit that provided care for involuntary patients.
- Corrib was a 14-bed unit that provided care for involuntary patients.
- Dargle was a 1-bed step-down standalone unit.
- Erne was a 1-bed step-down standalone unit.
- A gymnasium.
- A multifaith building.
- An admission suite.

Each resident had their own bedroom, with en suite facilities and opportunities given to residents to personalise their own bedroom space. The communal areas included internal courtyards, gardens, dining rooms, lounges, and games rooms, all designed to be bright, well-ventilated, and furnished in a way which was therapeutically designed. Residents had access to a range of therapeutic spaces, such as well-equipped

occupational therapy kitchens, group therapy rooms, four gyms, a multifaith prayer room, a library, and a vocational suite which allowed access to the internet and educational material. Each unit was equipped with a kitchen, along with laundry and linen storage facilities.

The approved centre had two consultant psychiatrist-led multi-disciplinary teams (MDTs), comprising of medical, nursing, psychology, occupational therapy, social work, and behavioural specialist staff. Admissions to the approved centre were planned and completed following referral and assessment.

1.2 Inspector of Mental Health Services Summary

The inspection of Nua Healthcare Services, Gormanston was unannounced and occurred over four days from 19 to 22 May. Overall, the inspection team's findings were very positive. The inspection was well coordinated by the staff and management of the approved centre, and staff were responsive and supportive throughout the process.

In 2025, the approved centre was non-compliant with four regulatory requirements during the annual inspection: Regulation 13: Searches, Regulation 19: General Health, Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines and the Code of Practice on the Use of Physical Restraint. In this year's inspection the number of non-compliances reduced to three; Regulation 8: Residents' Personal Property and Possessions risk rated moderate, Regulation 16: Therapeutic Services and programmes risk rated moderate, and Regulation 27: Maintenance of Records risk rated moderate, showing an improvement in overall regulatory compliance, and quality improvement initiatives across the centre.

The approved centre demonstrated a strong commitment to the use of least restrictive practices and the reduction of restrictive interventions. The inspection team were informed that there had been no episodes of seclusion since registration in February 2025 and three episodes of physical restraint since the last inspection, reflecting a clear focus on de-escalation and therapeutic engagement. The service evidenced a reduction in both regulated and unregulated restrictive practices through positive risk management approaches, including the use of individually risk-assessed radio frequency identification (RFID) wrist bands to promote freedom of movement throughout the approved centre. Autonomy and independence were promoted through the provision of open access to tea and coffee facilities, fruit, and snacks for residents. Safety considerations were appropriately incorporated through the reduction and monitoring of water temperatures, allowing residents to access facilities freely while minimising potential risk. This example demonstrated a balanced approach to positive risk management, supporting residents' rights and choice, and using least restrictive practice in the centre.

The centre had an Recovery and Engagement Officer who played a central role in supporting a human rights-based approach to care. Their role was well embedded within the centre. Attendance at key meetings including multi-disciplinary and individual care planning meetings, and governance and quality forums ensured residents voices and rights were represented within service delivery and decision-making processes. In addition, the recovery and engagement officer provided one to one engagement, advocacy, education, and practical support to residents, promoting empowerment and recovery focused care throughout the approved centre.

Overall, practices within the service reflected a human rights-based and person-centred approach, where restrictive interventions were used only as a last resort and there was clear evidence of continued efforts to minimise restrictions while maintaining safety for residents and staff.

1.3 Resident Profile

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**20**
Number of detained patients	9
Number of wards of court	1
Number of residents under the Assisted Decision Making Act	0
Number of children	0
Number of residents in the approved centre for more than 6 months	7
Number of patients on Section 26 leave for more than 2 weeks	0

1.4 Compliance summary

	2022	2023	2024	2025	2026
% Compliance	N/A	N/A	N/A	88%	91%

Please note: The approved centre opened for the first time in 2025.

1.5 Conditions of registration

There was one condition (Condition 2) attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 2: *In carrying on the business of the approved centre, 60 percent (%) of residents present in the centre at any one time must be accommodated under the Mental Health Act 2001 to 2018. For the purposes of clarity, the 60 percent shall be taken to the mean 60 percent of residents accommodated at any one time and shall not be calculated based on maximum registered occupancy.*	The approved centre was not in breach of Condition 2.

1.6 Ongoing escalation and enforcement actions at time of inspection

None.

1.7 Escalation and enforcement actions commenced following this inspection

None.

2.0 Governance

Nua Healthcare Services, Gormanston operated under the governance framework of Nua Healthcare Limited Board of Directors, which convened on a monthly basis. Membership included the Chief Operations Officer/Register Proprietor Nominee, Director of Services, Director of Admissions, Director of Transitions and Discharges, Director of Human Resources, Finance Director, Director of I.T, the Director of Regulation, Quality and Safety and the Head of Quality and Safety.

At national level, a mental health governance meeting was held weekly and chaired by the Deputy Chief Operations Officer. Attendance included senior management representatives including Director of Nursing for Approved Centres, Director of Operations for Community Mental Health Centres. The COO/Registered Proprietor Nominee attended as required. Standing agenda items included staffing, quality improvement, compliance, staff training, premises, feedback from residents, and clinical and operational risks. '. Minutes of the quality and safety meetings were discussed at this forum.

The senior management team held monthly clinical governance meetings to oversee areas including staffing and recruitment, clinical effectiveness, risk management and safety, data protection, education and training, patient and carers' experience, clinical audit and quality improvement. A number of subcommittees reported into the Clinical Governance Committee, including the clinical effectiveness committee, restrictive practice oversight and patient council committee.

The Quality and Safety Committee comprised of senior management and convened monthly to discuss quality and safety improvements. Nua Healthcare had recently formed a Risk Committee which is chaired by the Director of Regulation, Quality and Safety. In attendance are the following, the Chief Operating Officer (Registered Proprietor Nominee), Deputy Chief Operating Officer, Director of Risk, Director of Services, Director of Advocacy & Safeguarding, and the Heads of Quality & Safety. Resident admissions, transfers and discharges were reviewed at weekly Admissions, Transitions and Discharges meeting.

At a local level, monthly governance meetings were convened with attendance from the Nua Healthcare Services, Gormanston senior management team and senior leadership personnel, including the Engagement and Recovery Officer and Independent Human Rights Monitor. Meetings focused on quality improvements, implementation of regulatory standards, educational and training needs, clinical audit, serious incidents, risk management, patient and carer experience, policy development, incident review, compliments and complaints and feedback from service user community meetings.

There were clearly defined personnel with responsibility for risk management within the approved centre. Overall responsibility for risk management rested with the Director of Nursing, who was identified by staff as the lead person for risk oversight. Risk management responsibilities were delegated across management structures, with additional support provided by the Quality and Safety advisor.

Risks were identified, assessed, and documented within risk management plans using an established risk assessment matrix. The approved centre maintained a local risk register which included health and safety,

clinical, and environmental risks. The register was reviewed, monitored, and updated on a quarterly basis by the Director of Nursing. A separate corporate risk register was maintained by the senior management team, with clear processes in place for escalation of local risks to corporate level through national governance structures where required.

The approved centre utilised an Automated Incident Reporting System (AIRS) to record incidents, accidents, medication errors, and near miss events. Incident trends and patterns were regularly analysed and reviewed through governance processes, with feedback provided through relevant management structures. A programme of quarterly, biannual, and annual audits was undertaken by the Nua Healthcare Quality and Safety Department to support ongoing quality improvement and risk reduction initiatives.

Clear organisational structures outlining leadership responsibilities, accountability, and reporting arrangements were in place within the approved centre. At the time of inspection, staffing levels and skill mix were sufficient to meet resident needs. The multi-disciplinary team included psychiatry, nursing, occupational therapy, psychology, social work, and behavioural specialist input, with all disciplines based within the approved centre.

The approved centre demonstrated a strong commitment to recovery orientated and human rights-based practice through the active involvement of the engagement and recovery officer across multiple aspects of service delivery and governance. The role was observed to be well integrated in the centre and included chairing weekly community meetings on each ward where residents were supported to raise concerns, provide feedback and discuss activities, advocacy, safety, nutrition and ward-based issues. Feedback from these meetings was communicated to the multi-disciplinary team (MDT) and operation management meetings to ensure residents' views informed service planning and decision-making processes.

The engagement and recovery officer also attended MDT meetings, case conferences, clinical governance meetings, and individual care planning meetings, advocating on behalf of residents and ensuring that residents' preferences and recovery goals were represented within clinical and operational discussions. Assistant inspectors observed evidence of meaningful engagement initiatives including co-produced ward newsletters, recovery focused workshops, psychoeducation sessions, music and activity groups, and a programme aimed at promoting social connectedness, participation, physical wellbeing and confidence building among residents.

The centre demonstrated a clear emphasis on therapeutic engagement, reflective practice, and continuing professional development. Psychology services were embedded throughout the approved centre and provided support not only to residents but to frontline nursing staff through education, reflective practices, and therapeutic guidance. Upon reviewing incident reports the assistant inspector noted a calm and supportive approach to the management of aggression and distress, this in combination with psychology support for residents and staff, this contributed positively to de-escalation practices, staff confidence and reduction or restrictive interventions.

There was also evidence of ongoing efforts to minimise both regulated and unregulated restrictive practices within the approved centre. The centre promoted autonomy and positive risk taking through individualised and risk assessed approaches, including residents' freedom of movement within the centre through the use

of access bands and open access to tea and coffee facilities, snacks, and communal areas. Safety measures, including reduced water temperatures, had been implemented to support resident independence while maintaining safety. Assistant inspectors were informed that there had been no episodes of seclusion since opening and three incidents of physical restraint, reflecting the centre's continued focus on least restrictive practice and rights based care.

The approved centre further demonstrated a strong commitment to staff development and quality improvement through the provision of regular educational sessions delivered by members of the MDT and senior healthcare professionals. Education topics included clinical practice, human rights, safeguarding, restrictive practice reduction, recovery focused care, and therapeutic interventions, supporting staff to maintain and develop knowledge and skills in line with best practice principals.

Staff across all disciplines were up to date with mandatory training requirements, including Basic Life Support, Fire Safety, Mental Health Act 2001, Management of Violence and Aggression, Safeguarding, and Children's First training. A comprehensive training programme and formal staff appraisal system were in place, supported by annual training needs analysis to identify and address ongoing professional development requirements.

An organisational chart identified structures of leadership and the lines of responsibility and accountability within the approved centre. At the time of inspection, the approved centre was adequately staffed, and numbers and skill mix of staffing were sufficient to meet resident needs. The approved centre had one MDT which included psychiatry, nursing, occupational therapy, psychology, a recovery and engagement officer, a behavioural therapist and social work who was providing cross cover at the time of inspection.

The individual care plan (ICP) of one resident identified a requirement for social work in November 2025; however, there was no documented evidence of follow up in relation to this assessed need. The approved centre advised that a social work vacancy had been in place since September 2025. In the interim period, senior social worker support was provided through cross cover arrangements, with a senior social worker attending the approved centre every two weeks. At the time of inspection, the approved centre was in the final stages of recruitment for both a senior social worker and a basic grade social worker specific to Nua Gormanston.

Senior management outlined an active recruitment strategy aimed at strengthening multi-disciplinary staffing within the approved centre, with recruitment processes is underway across consultant psychiatry, psychology, occupational therapy, registered psychiatric nursing disciplines and healthcare assistants at the time of inspection. However, in terms of Speech and Language Therapy (SALT) assessment, the ICPs of three residents identified the need for SALT. All three were referred and assessment triaged by salt as low risk, and placed on an extended waiting list, two since January and one since October 2025. Appointments however were confirmed at the time of inspection to take place in June of this 2026. The approved centre reported that 14 healthcare assistants were awaiting certification at the time of inspection and were being supervised until completion of the required qualification process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Residents' involvement in service delivery was facilitated by service-user satisfaction

surveys, and the availability of the compliment and complaints process to support service improvement. Residents were involved in the development and review of their individual care plans. Resident forums and keyworker meetings were conducted weekly to facilitate resident contribution to review the services and programs available to them. Weekly resident community meetings took place in the approved centre, and this provided an opportunity for residents to raise concerns or make suggestions. Access to the National Advocacy Service was available if required by residents. Residents also had access to a recovery and engagement officer as already detailed to facilitate a supportive and inclusive environment that empowered residents to actively engage in their recovery journey.

2.1 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 (25)	25	100%	24	96%	25	100%	25	100%	25	100%	25	100%
Medical (4)	4	100%	4	100%	4	100%	4	100%	4	100%	4	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Healthcare Assistant (45)	45	100%	33	73%	45	100%	35	78%	36	80%	45	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 18: Transfer of Residents	✓	Compliant
Regulation 19: General Health	✓	Compliant
Regulation 20: Provision of Information to Residents	✓	Compliant
Regulation 21: Privacy	✓	Compliant
Regulation 22: Premises	✓	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓	Compliant
Regulation 24: Health and Safety	✓	Compliant
Regulation 25: Use of Closed Circuit Television	✓	Compliant
Regulation 26: Staffing	✓	Compliant
Regulation 28: Register of Residents	✓	Compliant
Regulation 29: Operating Policies and Procedures	✓	Compliant
Regulation 30: Mental Health Tribunals	✓	Compliant
Regulation 31: Complaints Procedures	✓	Compliant
Regulation 32: Risk Management Procedures	✓	Compliant
Regulation 33: Insurance	✓	Compliant
Regulation 34: Certificate of Registration	✓	Compliant
Rule on the Use of Seclusion	✓	Compliant
Part 4 Consent to Treatment	✓	Compliant
Code of Practice on the Use of Physical Restraint	✓	Compliant
Code of Practice: Admission, Transfer and Discharge	✓	Compliant

3.2 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2025 and 2026 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating			
	2025		2026	
Regulation 08: Residents' Personal Property and Possessions	✓		✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✓		✗	Moderate
Regulation 27: Maintenance of Records	✓		✗	Moderate

Please note: The approved centre opened for the first time in 2025.

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

3.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

4.0 Service-user Experience

4.1 Service-user feedback

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

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

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

The assistant inspectors met with seven residents across the approved centre and received seven completed paper feedback questionnaires. Resident feedback gathered through interviews and completed questionnaires indicated that residents were generally positive about their experience within the approved centre. Residents spoke about progress in their recovery and valued the level of freedom and autonomy available to them within the service. Residents reported regular access to the multi-disciplinary team and described being involved in their individual care planning and therapeutic activities, including outings and ward-based programmes.

Residents commented positively on the quality of food, the cleanliness of the environment, access to therapeutic facilities, and flexible visiting arrangements. Residents described staff as approachable and supportive, and stated that they felt able to raise concerns or speak with staff when worried. Residents also demonstrated awareness of the complaints process and advocacy supports available within the centre. Feedback further indicated that residents valued having freedom of movement within the approved centre, access to personal belongings and entertainment facilities, and opportunities to engage in community meetings and advocacy services. Overall, residents described the atmosphere within the approved centre as calm and supportive.

4.2 Advocacy

The approved centre had access to both an internal advocacy service through the recovery engagement officer and external independent advocacy support through the National Advocacy Service. The National Advocacy Service attended following request from residents with the assistance of the recovery engagement officer. Ensuring residents could access independent information, representation, and support in relation to their rights, care, and recovery. This further supported the centre's human rights based and recovery orientated approach to service delivery. The assistant inspectors did not receive a report from the National Advocacy Service.

5.0 Feedback Meeting

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

- Registered Proprietor Nominee/Chief Operations Officer
- Deputy Chief Operations Officer
- Clinical Director
- Head of Quality, Safety, and Compliance
- Director of Nursing
- Assistant Director of Nursing
- Quality Assurance Officer
- Recovery and Engagement Officer
- Operations Manager
- Occupational Therapy Manager
- Principal Clinical Psychologist

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.

Apologies received from Senior Social Worker.

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 4.1: Compliant areas on this inspection** for the list of compliant regulations on this inspection.*

*Please see **Section 4.2: Non-compliant areas on this inspection** for the list of non-compliant regulations on this inspection.*

*Please see **Section 4.3: 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 had written operational policies and procedures relating to residents' personal property and possessions. The policy was last reviewed in January 2026. On admission, the approved centre compiled a detailed property checklist with each resident, listing their personal property and possessions. The property checklist was kept separate to the resident's individual care plan and was available to the resident.

Residents were supported to manage their own property except where this posed a danger to the resident or others, as indicated in their individual care plan or in accordance with the approved centre's policy. Secure facilities in the form of locked store rooms and safes, were provided for the safekeeping of the resident's monies, and valuables as necessary. Correct identification and labelling of items stored in property rooms occurred to ensure that staff were aware of resident ownership of property.

The access to and use of resident monies was not overseen by either two members of staff or the resident and two staff members. In one instance the residents belongings inventory form only allowed for one signature. In one instance there was no evidence of the money or cheques recorded on the patient's two property forms.

There was not a process to record, secure and manage the personal property and possessions of the resident, including money. Property was found in an individual safe was not accounted for on a property list or safe record form. There were envelopes with varying amounts of money inside, and amounts written on the envelopes did not match the contents. In addition, only one identifier was used on the envelopes (either name or initials). In one instance there was no evidence of the money or cheques recorded on the patient's two property forms.

This meant that not every component of the approved centre's written policy and procedures relating to resident personal property and possessions was implemented in practice.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained of each resident's personal property and possessions in accordance with the approved centre's written policy, 8(3).

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre did not provide an appropriate range of therapeutic services and programmes that met the assessed needs documented in residents' individual care plans. At the time of inspection, three residents had identified speech and language therapy needs documented within their individual care plans and had been referred for assessment however placed on an extended wait list, for example since last year October 2025. The delay issue was resolved with all three residents receiving appointments by the end of inspection. One resident had an identified need for social work input as outlined in their individual care plan.

The approved centre had full-time psychology input available with two psychologists providing combined Monday to Friday cover through a three day and two day working arrangement respectively. There was a staff grade occupational therapist, and a behaviour specialist based full-time in the approved centre.

The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Individual and group interventions were provided to residents. Occupational therapy groups included Recovery Through Activity, Mindful Meditations, Building Work Confidence, Self Care and a Chef's Academy Cooking Skills group, which was co-facilitated with the catering department. Psychology provided a 'Bridge to Freedom' group and co-facilitated a 'Strong Mind, Steady Life' Decider group with nursing staff. The behavioural specialist facilitated a drop-in clinic weekly and there was a weekly nursing psychoeducation group.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents had access to an appropriate range of therapeutic services in accordance with his or her individual care plan, 16(1).

Regulation 27: Maintenance of Records

NON-COMPLIANT
Risk Rating MODERATE

INSPECTION FINDINGS

There were written policies and procedures available in relation to the creation, access, retention and destruction of records in the approved centre. The Maintenance of Records policy was last reviewed in January 2026.

Not all residents' records were constructed, maintained, and used in accordance with national guidelines and legislative requirements. There was secure access to electronic patient records, however, not all records were kept up to date.

Resident records were not developed in a logical sequence. Resident records were not reflective of the residents' current status and the care and treatment being provided.

Not all allied health professionals had access to edit electronic patient records. Allied health interventions were documented in email correspondence to the treating consultant psychiatrist, however, this was not included in the electronic patient records. This access issue was resolved during the inspection.

The record of one resident was not reflective of the resident's current status. Two residents had received allied health input, which was documented in email correspondence only and had not been incorporated into electronic patient records.

Records were appropriately secured throughout the approved centre from loss or destruction, tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness and accuracy, and not all records were kept up to date, 27(1).

7.0 Inspection Findings – Rules

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

*Please see **Section 4.1: Compliant areas on this inspection** for the list of compliant rules on this inspection.*

*Please see **Section 4.3: Areas that were not applicable on this inspection** for the list of codes of practice 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 compliant on inspection. Please see **Section 4.1: Compliant areas on this inspection**.*

9.0 Inspection Findings – Codes of Practice

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

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

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

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

*Please see **Section 4.1: Compliant areas on this inspection** for the list of compliant codes of practice on this inspection.*

*Please see **Section 4.3: Areas that were not applicable on this inspection** for the list of codes of practice that were not applicable on this inspection.*

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 : 10007742		The registered proprietor did not ensure that records were maintained of each resident's personal property and possessions in accordance with the approved centre's written policy, 8(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The Policy and Procedure on Residents Personal Property and Possessions will be reviewed to outline clear guidance on the process in relation to the recording of Patients Property. Team Debrief will be conducted on Procedure in relation to the recording and checking of all Patient's Property in line with this policy	Weekly Checks to be conducted to ensure practice is in line with policy Quality Assurance Department complete a 6 monthly internal audit to monitor compliance	There are no barriers to implementation and all actions to address the immediate concerns raised by the Inspector will be closed in the agreed timeframe.	23/10/2026	Director of Nursing Assistant Director of Nursing Clinical Nurse Leads Quality Assurance Team
Preventative Action	The Policy and Procedure will be rolled out across the	Ongoing monitoring by nurse management team. Six- monthly	There are no barriers to implementation and all actions to address the	23/10/2026	Director of Nursing Assistant Director of Nursing Clinical Nurse

	Service and all staff will be debriefed on the procedure. Weekly checks of compliance with this revised policy will be conducted by the centre administration staff and overseen by the Centre Management Team.	auditing completed by Quality Assurance Department.	immediate concerns raised by the Inspector will be closed in the agreed timeframe.		Leads Mental Health Act Admin (MHA) Administration Team Quality Assurance Department

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10007743		**The registered proprietor did not ensure that residents had access to an appropriate range of therapeutic services in accordance with his or her individual care plan, 16(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following inspection, all patients have access to requisite Multi-disciplinary team supports as outlined in Individual Care Plans (including input from SALT and Social Work departments) All ICP's reviews will ensure all MDT input is provided in line with Residents assessed needs	ICP reviews conducted through ward rounds Six monthly auditing by QA Department Weekly checks by Administration team Ongoing monitoring by Nurse Management team	There are no barriers to implementation and all actions to address the immediate concerns raised by the Inspector will be closed in the agreed timeframe.	14/08/2026	Clinical Director Director of Nursing Assistant Director of Nursing Multi-disciplinary Team
Preventative Action	All patients have access to requisite Multi-disciplinary team supports as outlined in Individual Care Plans (including input from SALT and Social Work departments). All ICP's reviews will ensure all MDT input is provided in line with Residents assessed needs	Six monthly auditing by QA Department Weekly checks by Administration team Ongoing monitoring by Nurse Management team	There are no barriers to implementation and all actions to address the immediate concerns raised by the Inspector will be closed in the agreed timeframe.	14/08/2026	Clinical Director Director of Nursing Assistant Director of Nursing Multi-disciplinary Team Quality Assurance Team Administration Team

Regulation 27: Maintenance of Records					
Reason ID : 10007744		**The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness and accuracy, and not all records were kept up to date, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A process has been developed in relation to ensuring access is obtained for all clinical staff upon commencement of providing care within the Centre to our Electronic Patient Record (EPR) system. Weekly checks have been enhanced in relation to checks on documentation within EPR to ensure all is up to date and reflective of current status of Residents	Regular internal audits completed by both clinical team and the QA department will ensure that all clinical interventions have been documented within the service. Weekly Quality checks completed by our Administration team on documentation compliance	There are no barriers to implementation and all actions to address the immediate concerns raised by the Inspector will be closed in the agreed timeframe.	11/08/2026	Clinical Director Director of Nursing Assistant Director of Nursing
Preventative Action	When all clinical team members begin working within Gormanston they have an Electronic Patient Record (EPR) login set up so that they can	Regular audits completed by both internal management team and QA Department. Weekly Checks conducted on documentation by	There are no barriers to implementation and all actions to address the immediate concerns raised by the Inspector will be closed in the agreed timeframe.	11/08/2026	Clinical Director Multi-disciplinary Department heads Director of Nursing Assistant Director of Nursing Mental Health Act Admin (MHA)

	add clinical notes. All staff members are briefed about the importance of adding clinical notes to patients file following interactions and ensuring that all documentation in reflective of Residents current status	Administration Department			

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.

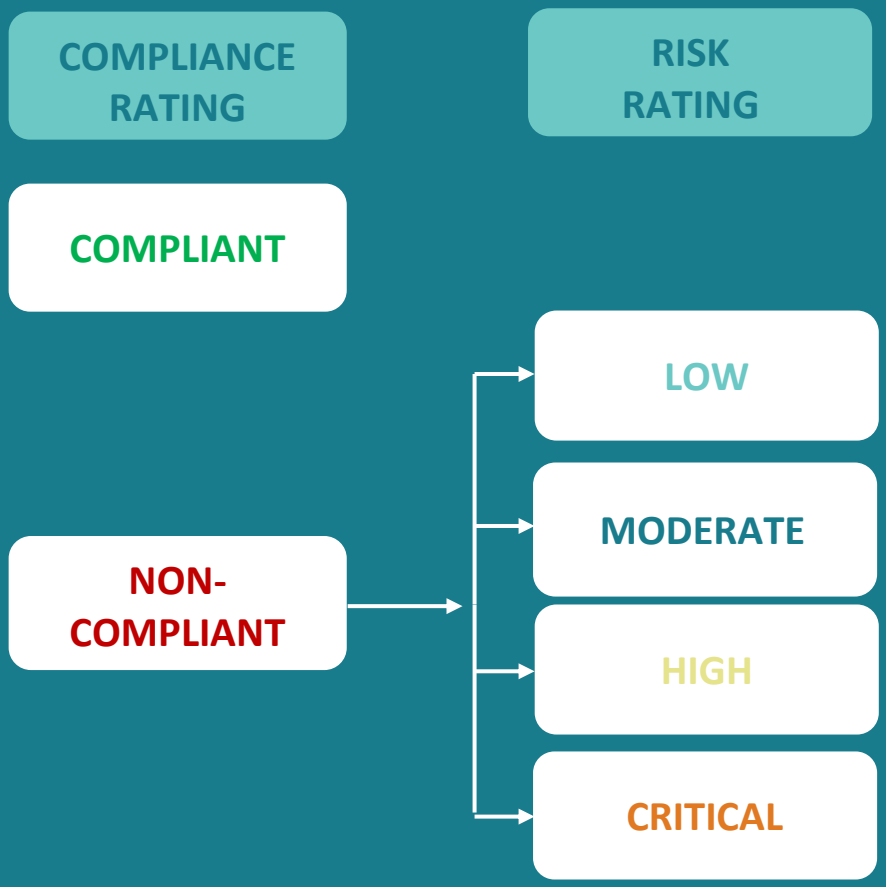
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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