

Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)



APPROVED CENTRE NAME:	Lois Bridges
IDENTIFICATION NUMBER:	AC0079
APPROVED CENTRE TYPE:	Adult Eating Disorders
REGISTERED PROPRIETOR:	Ms. Melanie Wright
REGISTERED PROPRIETOR NOMINEE:	Not applicable
MOST RECENT REGISTRATION DATE:	19 January 2013
NUMBER OF RESIDENTS REGISTERED FOR:	6
INSPECTION TYPE:	Unannounced
INSPECTION DATE:	9 and 10 September 2015
PREVIOUS INSPECTION DATE:	12 February 2014
CONDITIONS ATTACHED:	None
LEAD INSPECTOR:	Ms. Orla O'Neill
INSPECTION TEAM:	Dr. Susan Finnerty MCN 009711
THE INSPECTOR OF MENTAL HEALTH SERVICES:	Dr. Fionnuala O'Loughlin MCN 008108, Acting Inspector of Mental Health Services

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1.0 Mental Health Commission Inspection Process

The principal functions of the 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 under this Act.

The Mental Health Commission strives to ensure its principal legislative functions are achieved through the registration 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). 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 Mental Health Act (2001), 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, and
- 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 shall be assessed against all regulations, rules, codes of practice and Section 4 of the Mental Health Act 2001 at least once on an annual basis. Inspectors shall use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined the individual regulation, or rule, shall also be risk assessed.

The Approved Centre is required to act on all aspects identified as non-compliant or with a high / critical risk rating. Demonstration of immediate corrective rectifications, and ongoing preventative actions must be clearly identified. These actions are required to be specific, measurable, achievable and time-bound. All actions must have identified timeframes and responsibilities.

A copy of the draft report was forwarded to the service and comments and review on the report were invited from the Registered Proprietor. These comments were reviewed by the lead inspector and incorporated into the report, where relevant.

In circumstances where the Registered Proprietor fails to comply with the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules, the Mental Health 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.

2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

Lois Bridges was located in a residential area in Sutton village in north Dublin. The gated premises comprised a five-bedroom two storey house with private garden. Lois Bridges provided care and treatment for up to six adults with eating disorders. All admissions were planned and voluntary. The approved centre had a waiting list for admissions and staff reported that there was generally a waiting time of one month. The approved centre was independently owned and managed. Referrals for admission were made by general medical practitioners (GPs), self-referral or consultant psychiatrists. All admissions were under the care of the Clinical Director of Lois Bridges. Residents were generally funded by private health insurance, to a lesser extent by the Health Service Executive by prior arrangement or, occasionally, self-funded. There were six residents in Lois Bridges at the time of inspection. The service had developed an outpatient programme and follow-up to support residents on discharge. The treatment programme featured group and individual therapies provided by a range of professionally qualified therapists who were contracted for services provided. The Operations Manager coordinated care.

2.2 Governance

The management team comprised the Registered Proprietor, the Clinical Director and the Operations Manager. The management team met quarterly and a brief record of the meeting was maintained. The terms of reference for the management team were vague. The minutes of the management team meetings did not evidence a clear structure and defined scope of governance, nor standing items on the agenda or clear records of decisions and outcomes. Nonetheless, the approved centre was small and the same key personnel featured across a number of governance meetings such as the weekly clinical governance meeting and the health and safety committee. In practice this meant that communication was robust and issues were addressed and managed in a timely manner. It was evident that the management team was committed and cohesive. Clearly defined governance structures and processes are key to robust governance.

2.3 Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against.

The inspection was undertaken onsite in Lois Bridges from:

- 10.00 to 18.00 on 9 September 2015
- 10.00 to 17.00 on 10 September 2015

2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on 12 February 2014 identified the following areas of non-compliance:

Regulation/Rule/Act/Code	Inspection findings 2015
21 Privacy	Compliant
22 Premises	Compliant
23 Ordering, Prescribing, Storing and Administration of Medicines	Compliant
26 Staffing	Compliant
31 Complaints Procedure	Compliant
32 Risk Management Procedure	Compliant
Notification of Deaths and Incident Reporting	Compliant
Admission, Transfer and Discharge	Compliant
Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	Not applicable

2.5 Conditions to Registration

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

2.6 Non-compliant areas on this inspection

Lois Bridges was compliant in all the Regulations, Rules and Codes of Practice applicable to the approved centre.

2.7 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
4 Identification of Residents
5 Food and Nutrition
7 Clothing
9 Recreational Activities
11 Visits
16 Therapeutic Services and Programmes
22 Premises
28 Register of Residents
29 Operating Policies and Procedures
32 Risk Management Procedure
34 Certificate of Registration
Notification of Deaths and Incident Reporting
Admission, Transfer and Discharge to and from an Approved Centre

2.8 Areas of good practice identified on this inspection

- New risk assessments and a “Safe Plan” had been introduced for each resident.
- An additional consultant psychiatrist had commenced in July 2015.
- The service had hosted a number of educational events on the treatment of eating disorders.
- A Garden Room had been built and provided an additional therapeutic space.
- Lois Bridges surveyed residents post discharge about their view on the services and treatments received. This data informed quality improvements.
- The service had introduced a structured follow-up programme for discharged residents and evaluated outcomes.

2.9 Reporting on the National Clinical Guidelines

- The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

2.10 Resident Interviews

The inspection team met with one resident. The resident expressed satisfaction with their care and treatment. The resident was pleased with the introduction of new recreational activities such as flower arranging and music.

2.11 Feedback Meeting

The inspection team met with the Registered Proprietor, the Acting Clinical Director and the Operations Manager. The meeting enabled the inspection team to clarify a number of issues related to the inspection and afforded the service an opportunity to provide more details on certain matters. Among the items discussed were the need for more robust infection control practices and the provision of separate handwashing facilities for nursing and catering staff. The service stated their intention to provide appropriate handwashing facilities.

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 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.

Inspection Findings

Processes: There was a policy on the identification of residents. Passport sized photographs were used to identify residents. Residents provided written consent and also signed the photograph and this was witnessed by nursing staff. One photograph was placed on the medication prescription and administration record and the other was placed in the individual clinical file.

Training: Staff were cognisant of the policy and procedure for the identification of residents.

Monitoring of Compliance: There was no evidence provided of an annual audit of compliance with the regulation. Review of incident logs indicated no evidence of non-compliance.

Evidence of Implementation: The inspection team spoke with staff and inspected each clinical file and the medication records. There was photographic identification in place for each resident. Lois Bridges had six beds and each resident was known to all staff working within the unit.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.5 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.

Inspection Findings

Processes: There was a policy with regard to food and nutrition. The role of the dietician was outlined in the policy but the roles and responsibilities of other staff were not specified. The management of residents' food and nutrition processes were outlined. The policy did not contain reference to monitoring of the processes of providing food and nutrition.

Training: There was a qualified dietician who had sessions in the approved centre. The clinical director was trained in nutrition.

Monitoring of Compliance: Records of food intake were maintained but there were no annual audits or analyses of the process. Staff stated that incident reports would not be completed should the approved centre be non-compliant with this Regulation.

Evidence of Implementation: Each resident's nutritional status was formally assessed. The dietician devised food plans for each resident. Food intake was recorded, along with weekly weights. Nutritional status was recorded in the individual care plans.

Meals were provided in accordance with meal plans as defined by residents' needs. The meals were nutritious and attractively presented. There was an accessible supply of fresh drinking water and tea or coffee could be made by residents at any time. Food and nutrition education groups were held by the dietician.

The approved centre was deemed to be compliant-excellent achievement because of the ongoing assessment of nutritional status, the presence of a dietician, individual meal plans, monitoring of residents' weight and food intake and education groups about food and nutrition.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.6 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.*

Inspection Findings

Processes: There was a policy with regard to food safety. The roles and responsibilities of staff were not included in the policy. There was reference to handling, storage, disposal and distribution in the policy and to Hazard Analysis and Critical Control Points (HACCP) in the policy. Food safety legislation was also included in the policy. Staff training in food safety was outlined but the process for managing equipment was not in the policy. The policy did not refer to monitoring of food safety processes.

Training: Catering staff had received training in food safety as part of HACCP training.

Monitoring of Compliance: There was no monitoring of food safety processes and no audits or analyses were available. Staff stated that incident reports would be completed if there was a breach of food safety processes.

Evidence of Implementation: There was one catering officer on duty for six residents. The kitchen was sufficient in size and equipment. The refrigerator temperature was monitored daily. The area was clean, with refuse stored in a closed press. There was sufficient cutlery and crockery in place.

Handwashing was done at the kitchen sink and there was no separate handwashing facilities. Hands were dried using a tea towel hanging in the kitchen. There was no wall dispenser of disinfectant soap or gel, although there was a small container of antibacterial soap. On the first day of inspection the bottle of liquid hand sanitiser had been removed from view and was some distance from the sink in the nurses' office. There were no paper towels. At the feedback meeting, the management team committed to remedying this situation.

There was a report from a food safety specialist with one recommendation and this had been addressed.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.7 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.

Inspection Findings

Processes: There was a policy in place. Admissions were planned and residents were requested to bring sufficient and appropriate clothing for the duration of their stay. Residents wore day clothes and one hour was scheduled in the morning for residents to dress and prepare for the day. In the event that a resident did not have an adequate supply of personal clothing the operations manager would make arrangements for the resident to have individual clothing.

Training: All staff were aware of the policy and procedures in relation to clothing. Each staff member signed the policy book on induction to Lois Bridges.

Monitoring of Compliance: There was a weekly multidisciplinary team (MDT) meeting to review the care and treatment of residents. Issues related to residents' welfare and wellbeing were reviewed, including clothing.

Evidence of Implementation: The inspection team interviewed staff, read the relevant documentation and observed the residents as they went about their day.

All residents were up and dressed. There was a laundry room for residents' personal use. Each resident had a wardrobe and storage in their bedroom.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.8 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.

Inspection Findings

Processes: There was a policy with regard to personal property and possessions. The policy included the right of residents to have their own possessions unless they were a danger to them, the process of recording and storing personal property and the process of allowing access to personal property and possessions. Staff awareness requirements and monitoring and review requirements were not included in the policy.

Training: Staff were aware of the policy and had signed it to state that they had read and understood it.

Monitoring of Compliance: There was no monitoring of the processes and annual audits or analyses were not carried out. Staff said that they would not complete an incident report should there be non-compliance with this Regulation.

Evidence of Implementation: Residents were allowed personal property and possessions and to keep valuables and money if they wished. Alternatively, possessions could be kept in a safe in the nurses' office. Residents could not lock their bedroom doors themselves and their lockers and wardrobes did not have locks. A property list was completed at each resident's admission and kept separately from the individual care plans.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.9 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.

Inspection Findings

Processes: There was a policy in place which addressed in-house and community based recreational activity. The policy addressed the procedures applied when recreational activities were taking place in the community. The policy required activities to be age and gender appropriate and to be based on residents' input. Staff responsibilities were specified. Each resident was risk assessed in relation to recreational activities.

Training: All staff signed the policy book on induction into Lois Bridges. One member of staff was qualified in therapeutic recreational activity.

Monitoring of Compliance: There was no evidence of annual audit of recreational provision. An incident report form had been completed in relation to an incident during a recreational outing. The weekly MDT meeting which included the Clinical Director and the Operations Manager reviewed and addressed recreational provision and opportunities for quality improvement.

Evidence of Implementation: The inspection team looked at the recreational facilities within Lois Bridges, spoke with staff and observed residents relaxing and engaging in personal pursuits when not in therapeutic sessions. The team read documentation related to recreation.

Lois Bridges was located in a house in a residential area and had many of the features and comforts of a family home. There were four rooms available for recreational activity. Rooms contained couches, arts and crafts materials, table games, books, games console, television and DVD players and films. There was a laptop computer available for residents' use. The garden area was well kept and laid out with seating and dining areas and was well furnished with sun loungers, chairs and tables. Staff organised recreational activities each week as part of the care and treatment programme. Residents signed a contract of care on admission which included participation in activities and routines in Lois Bridges.

Six individual clinical files were inspected and each resident had been risk assessed in relation to recreational activity and community outings and weekend leave. Discussions with staff showed that staff had good knowledge of the individual lifestyles and interests of each resident. Each resident completed a "safe plan" or "lifelines" for themselves which identified activities, environments and persons which promoted the resident's sense of wellbeing and stability. The clinical files inspected did not contain a good record of each resident's occupational engagement in daily life and recreational and social routines. It was evident that residents' views and preferences were respected and activities such as flower arranging had been introduced in response to requests for more variety. A music session was also being introduced. Residents had a twice weekly yoga session and had access to a local gym.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
			X	

3.10 Regulation 10: Religion

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

Inspection Findings

Processes: There was a policy in the approved centre with regard to religion. The policy specified that all staff should respect and facilitate religious practice and that religious beliefs should be reflected in day to day practice. There were no specification of religious affiliations provided in the policy and no record of local religious facilities. Staff awareness requirements were outlined in the policy.

Training: Staff were aware of the policy and had signed it to state that they had read and understood it.

Monitoring of Compliance: There was no documented monitoring of the processes in facilitating practice of religion.

Evidence of Implementation: There were phone numbers available for ministers of different faiths. Residents could attend external religious services, accompanied if necessary.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.11 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.

Inspection Findings

Processes: There was a policy on visits. Residents could receive visitors outside of scheduled therapy times and were encouraged to do so in the evenings and on Sundays between 14.00h and 17.00h. Entry to Lois Bridges was via electronically controlled gates and the hall door was also locked. Therefore, nursing staff monitored visitors and admitted with a resident's agreement. All visitors signed a visitor's book on entry and exit from Lois Bridges.

Training: Staff signed the policy book on induction.

Monitoring of Compliance: The Clinical Director and the Operations Manager met weekly to review care and treatment within Lois Bridges. A review of the visiting arrangements and any issues arising were discussed in this forum with a view to quality improvement.

Evidence of Implementation: The inspection team observed the facilities for visits, spoke with staff and one resident and read documentation related to visits.

There were four spaces for visiting and these provided for privacy and comfort. Visits took place in communal rooms and were generally at weekends on Sundays. Residents would let the nursing staff know who might be visiting. Nursing staff monitored visitors entering and leaving the approved centre and all persons signed the visitor's book. There were no restrictions on visits for any resident at the time of inspection. Nursing staff spoke with residents to enquire how visits had progressed and the MDT were available to support and educate residents and their families. Family therapy was provided and visits often coincided with these sessions. While there were appropriate facilities and procedures in place for children visiting, this was stated to be rare, as many residents had weekend leave and tended to see family then. The health and safety statement for Lois Bridges included the safety of visitors.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.12 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.

Inspection Findings

Processes: There was a policy with regard to communication. Roles and responsibilities were not specified in the policy. The policy outlined the communication services available. Apart from privacy regarding mail, no reference to the right to privacy during communication was included. Risk assessments were not specified but the policy stated that restrictions apply if there is danger to a resident. There was no inclusion of the requirement for interpretative services or for monitoring the process in the policy.

Training: Staff were aware of the policy and had signed it to state that they had read and understood it.

Monitoring of Compliance: No monitoring of the processes regarding communication was completed.

Evidence of Implementation: Each resident was free to communicate internally and externally. According to staff, restrictions to allowing use of phones and internet access would be documented. No mail had been examined by staff since the last inspection in 2014.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.13 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 be 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.

Inspection Findings

Processes: There was a policy on searches which specified that rooms and belongings might be searched to ensure the safety of residents and that this was based on risk assessment. The policy specified the roles and procedures for staff in conducting a search with and without a resident's consent. The policy also specified the procedures in relation to the finding of an illicit substance. Residents were informed about the policy at the time of admission and the residents' handbook set out the policy and procedures in relation to objects, materials and substances which were prohibited in the approved centre. The policy required written resident consent for the carrying out of each search. Staff were required to explain the procedure to a resident and keep a resident informed throughout any search. Where a resident did not consent to a search, and staff considered a search necessary to maintain a safe environment, then the staff member in charge could overrule the resident's preference and a search would be completed. Incident reports were to be filled out on each occasion where a search was completed.

Training: Staff signed the policy folder on induction to Lois Bridges to indicate that they had read and understood the policies and procedures.

Monitoring of Compliance: There was no evidence presented to show that annual audits were completed in relation to searches. There was no documented quality improvement process in place in relation to searches. Incident forms were completed on each occasion of a search.

Evidence of Implementation: The inspection team spoke with nursing staff and inspected the incident report forms, the policies and procedures, individual clinical files and the searches records.

There was documented evidence of room searches and of searches of individual resident's property in response to concern about the possibility of alcohol, medication and items having been secreted in approved centre. No illicit substances were found. There was a record of the searches in each individual clinical file. Each resident had been risk assessed and had provided written consent and the record showed that nursing staff had kept each resident informed throughout the process. The searches had been completed by two nursing staff and the records were countersigned. An incident form was completed on each occasion by the nurse in charge. The searches were subsequently discussed with the residents and members of the MDT.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.14 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.*

Inspection Findings

Processes: There was a policy on the care of a resident who is dying. Where a resident required physical health care a resident would be assessed by the general practitioner or in an emergency department and transferred to a general hospital where required. The process for managing a sudden unexpected death was included in the policy. The procedure for respecting privacy and dignity was included. Each resident's clinical file contained a list of next of kin or nominated person and contact details. Notification processes and contact details of the next of kin, An Garda Síochána and the Mental Health Commission were included in the policy folder.

Training: Staff were aware of the policy and had signed to say that they had read and understood the policy.

Monitoring of Compliance: There was no evidence of auditing or monitoring of compliance with the regulation.

Evidence of Implementation: No resident had died while under the care of Lois Bridges. Therefore, this Regulation was rated under Processes, Training and Monitoring only.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.15 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".]

Inspection Findings

Processes: There was a policy with regard to individual care plans (ICPs). The roles and responsibilities were outlined. Weekly reviews of ICPs was specified in the policy. Involvement of the residents in their ICPs was stated in the policy. Staff training, assessment of resident at admission, access by the resident to their care plan or monitoring the process was not in the policy.

Training: No training in ICPs had taken place or was provided. The multidisciplinary team were trained in the use of individual assessments and specialised interventions pertaining to their profession.

Monitoring of Compliance: There was no monitoring of the processes relating to individual care planning.

Evidence of Implementation: All residents' clinical files were inspected and each resident had an ICP. Assessment of the residents had been completed at admission, although not all the physical assessments were documented in the clinical files. The resident completed their "Clients Perspective" form prior to the multidisciplinary meeting, which outlined their own needs, goals and preferences and this informed the ICP. Only one resident had a copy of their care plan. Residents could attend the multidisciplinary team meeting if they wished. Residents' needs, goals, interventions and required resources were outlined in the care plan, although resources required was often noted as "MDT", when an individual discipline should have been specified. A key worker was allocated but this was not specified in the ICP. The ICPs were reviewed weekly.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.16 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.

Inspection Findings

Processes: There was a policy on therapeutic services and programmes. The Clinical Director and multidisciplinary team (MDT) members reviewed individual resident's progress on a weekly basis and programmes were adjusted according to need. The approved centre provided care and treatment for eating disorders and the provision of therapies was stated to be evidence based. The Clinical Director and the Operations manager met weekly to discuss clinical operational matters and overall therapeutic provision was reviewed in this forum; however, the operations manager stated that no written record of these meetings was maintained. The weekly schedule of therapeutic services was displayed in the hallway. The resident information booklet provided an outline of therapeutic services. Professionally qualified psychotherapists were employed on a contract basis to provide a range of therapies to Lois Bridges' residents.

Training: All staff were aware of the processes and procedures in relation to the provision of therapeutic services and programmes.

Monitoring: Therapeutic services and programmes were reviewed at the weekly MDT meeting. Residents completed a feedback questionnaire post discharge on their experience and satisfaction with therapeutic services and programmes.

Implementation: Lois Bridges provided care and treatment for eating disorders. There was a core therapeutic day provided which consisted of group therapies and recreational activities consistent with the needs of the residents with eating disorders. In addition, each resident had an individually tailored psychotherapy programme. The individual clinical files of all residents were inspected. Each resident's ICP detailed the required therapeutic focus and input for that resident. The clinical files contained regular and up to date entries from all the clinical and psychotherapy staff providing care and treatment to the individual resident. Each resident was assigned a key worker. The inspection team reviewed six individual clinical files and was unable to identify who was the assigned key worker for individual residents. The operations manager assisted in identifying which team member had been assigned as key worker in individual cases. Therapeutic provision included group and individual therapies such as: family therapy, cognitive analytical therapy, individual psychotherapy, art therapy, gestalt therapy, dietetic assessment and treatment, yoga, counselling and supportive therapy.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.17 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.

Inspection Findings

Children were not admitted to Lois Bridges and this regulation was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
				X

3.18 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.

Inspection Findings

Processes: There was a policy with regard to transfer of residents. Roles and responsibilities of staff were outlined in the policy as was the management of the process of transfer. Communication with the receiving facility and consent to disclose information was specified.

Assessment requirements; the process for making the decision to transfer; the transfer criteria; the transfer of medication; consent by the resident to transfer; personal property and possessions management; the transfer of involuntary patients; emergency transfer; resident and staff safety during transfer; staff training; and monitoring of processes were not included in the policy.

Training: Staff were aware of the policy and had signed it to state that they had read and understood.

Monitoring of Compliance: There was no monitoring of the processes relating to transfer of residents.

Evidence of Implementation: One patient had been transferred under section 21(1) of the Mental Health Act 2001 to another approved centre. The statutory transfer form was completed and a referral letter and prescription accompanied the patient. There was also evidence of phone contact between the approved centre and other facility prior to transfer. The transfer had been discussed with members of the multidisciplinary team and recorded in the clinical file. The clinical file recorded that the transfer was discussed with the resident.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.19 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.*

Processes: There was no policy with regard to medical emergencies. There was a policy with regard to processes relating to general health. This policy outlined the roles and responsibilities of staff, access to general practitioner (GP) services, and general health assessments of residents. It also included screening processes. It did not include referral processes, the right of the residents to privacy and dignity during general health assessments, healthy lifestyle options or monitoring of the general health processes.

Training: Staff were trained in basic life skills. Medical and nursing staff carry out general health assessments and are trained to do so. Staff were aware of screening programmes.

Monitoring of Compliance: There was no monitoring of the processes of general health assessments.

Evidence of Implementation: All residents' clinical files were examined. Physical examinations were carried out by the GP in the GP surgery. The record of physical examination of two residents remained in the GP's surgery and not in the clinical file. These were provided on request from the inspection team. One resident did not have a physical examination on admission. Physical health requirements, interventions and outcomes were outlined in the individual care plan and clinical file. Healthy lifestyle choices were encouraged and supported through group work. A defibrillator was available in the approved centre and was regularly checked. There was some information about screening programmes and women's health in the approved centre.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.20 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.

Inspection Findings

Processes: All admissions to Lois Bridges were pre-planned and involved an assessment and information-giving visit to the approved centre prior to admission. There was a resident information leaflet. The key worker and the nurse supervisor were identified as the staff responsible for ensuring a resident's information requirements were met on an ongoing basis during their stay. The policy for this regulation was largely focused on the sharing and disclosure of clinical information.

Training: Staff signed to indicate their knowledge and understanding of policies and procedures. Multidisciplinary team staff were trained mental healthcare professionals and trained in information giving.

Monitoring of Compliance: There was no evidence of an annual audit of the provision of information to residents. The approved centre surveyed residents on discharge about their experience and satisfaction with their care and treatment in Lois Bridges. The feedback forms specifically enquired about residents' satisfaction with the provision of information on medications and side effects. Some residents also commented on these forms about their satisfaction with other aspects of information giving. These forms were reviewed by the operations manager with a view to quality improvement.

Evidence of Implementation: There was an information booklet about the care and treatment and living arrangements in Lois Bridges. The booklet provided information on the focus of care in Lois Bridges; the MDT; the housekeeping and visiting arrangements; searches; property and possessions; living facilities programme outline; and how to make a complaint. Information on medications and diagnoses were provided on an individual basis. There was an information folder containing leaflets on diagnoses and medicines. The information folder leaflets on medicines largely comprised manufacturer's information sheets and was not in user friendly format. There was a computer available whereby staff could access evidence based information websites and print off information leaflets for residents. The hallway contained information leaflets about eating disorder self-help groups and the Irish Advocacy Network. Each resident was voluntary and signed a contract for care prior to admission. This contract was contained in each individual clinical file and showed that residents were fully informed about care and treatment in Lois Bridges.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
		X		

3.21 Regulation 21: Privacy

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

Inspection Findings

Processes: There was a policy with regard to privacy. The roles and responsibilities of staff and the processes for ensuring privacy were included in the policy, including specification that bedrooms are private areas for residents. Monitoring of processes and processes to be applied when privacy and dignity were not respected, were not in the policy.

Training: Staff were aware of the policy and had signed it to state that they had read and understood it.

Monitoring of Compliance: There was no documented monitoring of the processes of ensuring privacy.

Evidence of Implementation: Both staff and residents called each other by their first names. Residents could spend time alone. Bathrooms and toilets were lockable and staff had an over-riding key. There were four single bedrooms and one double room, which had adequate curtains around the beds. Staff were observed to be respectful of residents during the inspection. The premises and garden were private and not overlooked and CCTV was not used. There was a room that could be used for visiting. Residents' clinical files were locked in the nurses' office

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.22 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.

Inspection Findings

Processes: There was a policy on this regulation. The Registered Proprietor was responsible for the premises. The Operations Manager was charged with responsibility for the day to day oversight and management of the premises, including weekly checks of equipment. The Clinical Director was responsible for the Health and Safety of residents, staff and visitors. The policy addressed the cleaning, maintenance, structural and decorative upkeep of the premises. There was a list of approved contractors posted in the kitchen and there was a record of maintenance work.

Training: The relevant staff were aware of the policies and procedures relating to the upkeep and maintenance of the premises.

Monitoring of Compliance: The premises was monitored on a weekly basis by the Operations Manager. A record of maintenance and equipment servicing requirements were kept and reviewed. The quarterly management team meeting monitored issues arising in relation to the premises. There were no incidents of non-compliance noted.

Evidence of Implementation: The premises comprised a house in a residential setting. The décor and layout was in keeping with a private residence or home. There was a large kitchen cum dining and sitting room, a separate sitting room, an activities room and a large garden room. The garden was well landscaped and maintained and had outdoor seating and tables. Residents had access to a laundry room. The premises was clean, and well maintained. Furniture and décor were modern and it was evident that care and attention had been taken to ensure a comfortable and relaxing environment for residents. The premises was sufficiently spacious and the layout of rooms allowed residents access to a quiet space when required. The premises was well lit internally and externally, and was ventilated and

rooms were maintained at a comfortable temperature with manual and thermostatically controlled heating throughout the house.

The house and gravel driveway had not been designed for wheelchair accessibility; however, there was a bedroom downstairs and a toilet and shower room on this level which were accessible. There was a list of approved contractors posted in the kitchen and there was a record of maintenance work. The maintenance records showed that maintenance issues were dealt with immediately and resolved. Members of the health and safety committee had completed several ligature audits.

A number of ligature anchor points had been identified and some remediation work completed with additional remediation work planned. The approved centre currently controlled this risk through individual risk assessment and management. Bathrooms and toilets were locked and accessed by residents on request. There was a separate handwashing basin for staff in the staff toilet. Staff were observed to use the kitchen sink when washing their hands. Such a facility is a basic infection control measure.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.23 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).

Inspection Findings

Processes: There was a policy with regard to ordering, prescribing, storing and administration of medication. This included management of controlled drugs, the process for withholding medication and the process if a resident refuses medication. The process for managing medication errors was also in the policy. The process for medication review was not included in the policy but audit documentation was available. The processes for crushing medication, reconciliation of medication and managing medication at admission, transfer and discharge, and staff training were not in the policy.

Training: Medical and nursing staff were trained in ordering, prescribing, storage and administration of medication. Staff showed an awareness of relevant legislation and codes of conduct and also of the management of medication errors and near misses.

Monitoring of Compliance: There was a weekly audit of medication and this documentation was available. Incidents of medication errors and near misses were recorded. There was no documentation of analysis of the process to promote improvement.

Evidence of Implementation: Relevant legislation and codes of conduct were available in the approved centre. The staff kept abreast of advances in medication by referring to formularies and from lectures by medical staff. There was evidence that medication errors and near misses were recorded in the incident log. Some information about medication was available for residents. The medication prescription and administration record (MPAR) contained all that was required, including resident's name, date of birth, generic name of medication, signature of prescriber, medical registration number (MRN), dose, frequency of administration, date of prescription, administration record and, where appropriate, discontinuation signature and date.

Prior to administering medication, staff washed their hands at the kitchen sink and dried their hands on a tea towel, which was not acceptable handwashing procedure. Medication requiring refrigeration was stored in the food fridge in a locked box. At the feedback meeting, the registered proprietor undertook to provide a separate fridge for medication and put in handwashing facilities in line with infection control requirements.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.24 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.

Inspection Findings

Processes: There was a policy on health and safety and a site specific health and safety statement. The Clinical Director was the person with overall responsibility for health and safety in Lois Bridges. The Operations Manager was the health and safety officer and there was a safety representative in place. Site specific hazard identification, risk assessment and controls had been completed on an annual basis. There was a fire safety plan, a food safety plan, an infection control plan and an emergency plan. The approved centre contracted in employee assistance and occupational health services as required.

Training: Staff signed to indicate their awareness of the health and safety policies and procedures operating in Lois Bridges. The relevant staff were trained in fire safety training, food safety, manual-handling and reporting of incidents. The health and safety officer was specifically trained in health and safety at work.

Monitoring of Compliance: There was a health and safety committee which monitored health and safety issues. The health and safety statement was updated annually.

Evidence of Implementation: The fire safety equipment, fire drill and training records were up to date. There was a brief emergency plan with contact numbers in the health and safety statement and also posted up in the kitchen. Staff were trained in manual handling, first aid, basic-life support and risk management. Healthcare Assistant (HCA) staff were trained in food safety. Training was not up to date for staff in relation to infection control and the infection control measures operating in the approved centre were inadequate. There was no dedicated hand wash basin for nursing or catering staff. There was no antibacterial handwashing liquid evident and nursing staff were observed using a tea towel to dry hands. There was a single pair of surgical gloves in the first aid box. Catering staff used personal protective clothing such as gloves when handling food. One of the resident toilets contained a hand-wash basin with a single cotton hand-towel for use by all residents. The minutes of the health and safety committee were inspected. There was no evident structure, agenda or roll over items tabled for meetings. Nonetheless, relevant items identified by inspectors in the incident report forms and in the maintenance records had been discussed at these meetings and appropriate actions taken. Lois Bridges did not operate a staff vaccination programme. A local GP was the identified person to provide a service to staff in the event of a needle-stick injury.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.25 Regulation 25: Use of Close Circuit Television (CCTV)

(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 anytime on request.*

Inspection Findings

CCTV was not used in Lois Bridges and this regulation was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

3.26 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.

Inspection Findings

Processes: There was a policy with regard to recruitment, selection and vetting of staff. The roles and responsibilities of staff were outlined in the policy. The policy included staff planning, staff rostering, staff evaluation and staff assignment to tasks. It did not contain provisions for terms and conditions of employment and job description, orientation and induction of staff, staff training, required qualifications, staff record requirements and monitoring of staff recruitment processes.

Training: There was no specific training in staff recruitment provided by the approved centre. However, the operations manager had been trained in staff recruitment previously.

Monitoring of Compliance: There were reviews of the staff plan and duty roster. There were also reviews of training plans. There were no formal outcome measures to judge the effectiveness of training. There was no documented monitoring of the processes of recruitment of staff.

Evidence of Implementation: There was an organisational chart for staff in the approved centre. Staff performance records were available. The staff plan and duty roster were in place. Personnel files demonstrated that staff were recruited as outlined in the policy. There was evidence that staff had appropriate qualifications to meet the needs of the residents. There was no documented orientation and induction programme. Some, but not all, staff had received training in Prevention and Management of Aggression and Violence (PMAV) or similar training. Staff were trained in fire safety, manual handling, basic life support and individual risk management. Not all staff were trained in infection control. The approved centre did not check that agency staff were registered with the appropriate professional body or that they had been vetted by An Garda Síochána.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
		X		

3.27 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 is outside the scope of these Regulations which refer only to maintenance of records pertaining to these areas.

Inspection Findings

Processes: There was a policy on records which identified the person responsible for the review and maintenance of records as the Operations Manager. The policy identified the need to maintain records confidentially and who may make entries in the clinical file. There was a process in place for managing the Environmental Health Officer's report, the Fire Safety report and the Health and Safety statement. The policy addressed the retention of records. The policy referred to the disclosure of records to third parties. The policy stated that case files were open to inspection by an authorised person but did not define an authorised person. Aspects of records management were not all addressed in the policy relating to Regulation 28. For example, the policy on Regulation 20 referred to a resident's access to their own clinical records. The policy on records referred to finance forms and this was unclear in the context of a policy otherwise addressed to clinical files. The senior person in charge controlled the keys to the records storage.

Training: Staff were aware of the processes in relation to the maintenance of records.

Monitoring of Compliance. Residents' records were reviewed regularly by the Operations Manager to ensure compliance with the Lois Bridge's records policy.. There was no annual audit completed on records management. The senior management team had reviewed the long term records storage arrangements and changed their provider for quality improvement.

Evidence of Implementation: The inspection team observed that clinical records were stored in a fire-proof cabinet in a nursing office behind two locked doors. Each resident had an individual clinical file and all clinical information was recorded in that file. On inspection, all entries were dated, signed and no correction fluid was used to correct entries. The clinical files were well maintained with clear sections for different categories of information. All clinical and therapy staff entered contemporaneous progress notes and these were clearly signed and dated and each page contained the residents name. The fire safety, food safety and health and safety records were up to date and retained in the approved centre.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.28 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.*

Inspection Findings

Processes: There was a policy with regard to the register of residents and this referred to the requirements of Schedule 1 to the Regulations. The roles and responsibilities of staff were outlined. The procedure for updating the register was in the policy.

Training: Staff were aware of the policy and had signed it to state that they had read and understood it.

Monitoring of Compliance: The operations manager monitored the register of residents and ensured that it was in compliance with Schedule 1 to the Regulations.

Evidence of Implementation: The register of residents was updated by the admitting staff when the resident was admitted as outlined in the policy. The register was in compliance with Schedule 1 to the Regulations. It was kept in a secure location and made available to the inspection team.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.29 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.

Inspection Findings

Processes: There was a policy on the development of policies for the approved centre. This policy identified who was responsible for approving the policies and stipulated the time period for reviewing the policies. The policy did not address standardising the layout and content headings of policies.

Training: The policies were reviewed and developed jointly by trained clinical and management staff cognisant of their roles and responsibilities.

Monitoring of Compliance: All policies were in date and the policies which required annual review had been reviewed within the previous twelve months.

Evidence of Implementation: All the policies inspected had been reviewed and were up to date. The policies were readily accessible to all staff and were provided in hard copy folder or electronically. Staff had all signed to indicate their knowledge and understanding of the Lois Bridges policies.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.30 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.*

Inspection Findings

All admissions to the Lois Bridges were voluntary. The approved centre did not detain patients. This regulation was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

3.31 Regulation 31: Complaints Procedure

(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.

Inspection Findings

Processes: There was a policy with regard to complaints, and the roles and responsibilities of staff were included. There was a procedure for ensuring that residents were aware of how to make a complaint; how complaints were documented; the communication requirements relating to the complaint; staff training requirements; monitoring of the complaints process; and the appeals process. The policy did not contain the procedure for advocacy, confidentiality requirements and the requirement for time lines within the complaints process.

Training: There was no documented training in relation to the complaints process.

Monitoring of Compliance: Staff stated that complaints were analysed by the operations manager to improve the service offered by the approved centre but there was no documented evidence of this. There were no documented audits of the process.

Evidence of Implementation: The operations manager, based in the approved centre, was the nominated person for dealing with complaints. The complaints procedure, with a blank complaints form, was displayed inside each of the residents' bedroom doors. There was a complaints log, which showed details of the complaints, prompt investigation of the complaints, associated correspondence and other documentation, action and outcome. There were no timelines included. The complaints log was kept securely.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.32 Regulation 32: Risk Management Procedure

(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.

Inspection Findings

Processes: Lois Bridges had a policy on risk management. The policy required that residents be risk assessed at the time of admission and thereafter be reviewed by the multidisciplinary team on a fortnightly basis or more frequently if clinically indicated. The policy addressed the issues of risk in the areas of absence without leave, self-harm, injury and assault. There was a named risk manager. Risk assessments were recorded on a pro forma report form. Incident report forms were reviewed by senior managers. The approved centre reported a summary of incidents to the Mental Health Commission every six months.

Training: Staff were trained in the risk assessment tools and procedures, including incident reporting, used in Lois Bridges.

Monitoring of Compliance: There was evidence of a monitoring and quality improvement process for clinical risk management.

Evidence of Implementation: A risk assessment and management plan had been developed for each resident at the time of admission. Risk evaluation was reviewed fortnightly by the MDT or more frequently where indicated. The recently appointed consultant psychiatrist had provided training in risk assessment and management for all key staff. The service had introduced a "Safe Plan" for each resident. This was a risk management plan developed by the resident in conjunction with their key worker and included a focus on maintaining mental health on discharge.

The Health and Safety Statement for Lois Bridges included hazard identification, controls and risk ratings for the approved centre. Members of the Health and Safety committee had conducted a ligature audit and identified hazards requiring remediation. The service currently managed associated risk through individual risk management with some rooms locked at certain times.

The incident report forms were inspected. Each incident had been reviewed by senior managers and outcomes recorded. Incidents were reviewed in either the clinical meetings or the Health and Safety Committee as appropriate. The approved centre did not maintain a risk register.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
			X	

3.33 Regulation 33: Insurance

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

Inspection Findings

Processes: There was no policy with regard to insurance.

Training: Staff were aware of the processes with regard to insurance

Monitoring of Compliance: The insurance requirements are reviewed annually by the Registered Proprietor.

Evidence of Implementation: There was an insurance certificate in the approved centre which covered public liability and clinical indemnity.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.34 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.

Inspection Findings

Processes: There was a process in place for displaying the Certificate of Registration.

Training: The relevant staff were aware of the requirements in relation to this Regulation.

Monitoring of Compliance: The Certificate of Registration was issued by the MHC in accordance with the approved centre's application and was reviewed every three years.

Evidence of Implementation: The Certificate of Registration was displayed in the entrance hall of the approved centre.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 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 or unwilling 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."

Inspection Findings

ECT was not provided in the approved centre. This rule did not apply.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

4.2 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".

Inspection Findings

Seclusion was not used in the approved centre and this rule was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
				X

4.3 Section 69: The Use of Mechanical Restraint

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".

Inspection Findings

Mechanical restraint was not used in the approved centre and this rule was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

5.1 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 or unwilling 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.

Inspection Findings

There were no detained patients in the approved centre and section 60 did not apply.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
				X

6.0 Inspection Findings and Required Actions – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (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.

6.1 The 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.

Inspection Findings

Processes: There was a policy on physical restraint. The policy identified: the circumstances where restraint might be used; the need for least restrictive practice; who was authorised to initiate physical restraint; the requirement to notify the responsible consultant psychiatrist; the requirement to record the episode of physical restraint in the individual clinical file; and the need for medical examination within the specified time frame. The policy required that next of kin be notified of the use of restraint with the resident's consent. The policy did not address the duration of orders for physical restraint. The policy required the Clinical Practice Form Book for Physical Restraint, however, the approved centre did not have a copy of this report book. The policy required a resident's dignity and safety be respected at all times. The policy required staff to be trained in the use of physical restraint every two years.

Training: The training record indicated that training in the application of physical restraint was not up to date for all staff. Staff signed a log to indicate that they had read and understood the policies.

Monitoring of Compliance: Staff reported that physical restraint had not been used in the approved centre. The policy was reviewed annually and was up to date.

Evidence of Implementation: Staff reported that physical restraint had never been used in Lois Bridges.

The compliance rating for this Code of Practice is based on inspection of the processes and training only.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

6.2 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.

Inspection Findings

Children were not admitted to Lois Bridges and this Code of Practice was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

6.3 Notification of Deaths and Incident Reporting

Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

Inspection Findings

Processes: A policy and process was in place in relation to the notification of deaths and incident reporting.

Training: There was a record staff had read and understood the policy.

Monitoring of Compliance: Incidents were discussed and reviewed at meetings of the MDT and the Clinical Director.

Evidence of Implementation: Incidents were reported as required to the Mental Health Commission. The risk manager was the Operations Manager. The incident reports were inspected and corresponded with the summary incident report provided to the MHC. There had been no deaths in Lois Bridges.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

6.4 Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

Inspection Findings

The approved centre did not admit residents with an intellectual disability and this Code of Practice was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

6.5 The 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.

Inspection Findings

The approved centre did not administer ECT and this Code of Practice was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

6.6 Admissions, 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.

Inspection Findings

Processes: There were policies with regard to admission, transfer and discharge. The roles and responsibilities of staff were outlined in the policies. The policies included the process for admission of residents, transfer of residents and discharge of residents, including discharge against medical advice. The role of the key worker was not outlined in the policies. Medication management on admission, transfer and discharge was not included. There were also policies with regard to personal property and possessions and privacy and confidentiality which applied.

Training: Staff were aware of the policies and had signed it to state that they had read and understood them.

Monitoring of Compliance: The acting Clinical Director had completed an audit of the admission process and documentation and was about to introduce improvements based on analysis of the audit. As yet, there was no monitoring of the transfer and discharge processes.

Evidence of Implementation: There was an admission process in place. All admissions were planned and an assessment carried out prior to admission. Records of referral letters and communication with the referring mental health team and GP were in the clinical file. Each resident had an ICP and a key worker. The approved centre did not admit detained patients. Each admission assessment covered presenting complaint, past psychiatric history, medical history, social history, current medication and mental state examination. Physical examination had been completed in all but one of the residents. Two residents did not have documentation of the physical examination in their clinical files, as these records were in the GP's surgery. They were made available to the inspection team. There was evidence of family involvement in the admission process.

One patient had been transferred under section 21(1) of the Mental Health Act 2001 to another approved centre. The appropriate statutory form for transfer was completed and a referral letter and prescription accompanied the patient. There was also evidence of phone contact between the approved centre and other facility prior to transfer. The transfer had been discussed with members of the multidisciplinary team and recorded in the clinical file. The key worker coordinated the transfer. The clinical file recorded that the transfer was discussed with the resident.

Each resident had a discharge plan, with a discharge date that was regularly up-dated during their stay in the approved centre. Each resident met with members of the multidisciplinary team prior to discharge. Family were included at this meeting if the resident wished. Each resident was assessed prior to discharge. The relevant mental health team and GP were notified of the impending discharge. They then received a discharge summary, a copy of which was in the clinical file. The resident received a prescription and an outpatient follow-up appointment on discharge.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
			X	