Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	Lois Bridges
IDENTIFICATION NUMBER	AC0079
APPROVED CENTRE TYPE	Acute Adult Mental Health Care
REGISTERED PROPRIETOR	Ms Melanie Wright
REGISTERED PROPRIETOR NOMINEE	Not applicable
MOST RECENT REGISTRATION DATE	19 January 2016
NUMBER OF RESIDENTS REGISTERED FOR	7
INSPECTION TYPE	Unannounced
INSPECTION DATE	18,19, 20 May 2016
PREVIOUS INSPECTION DATE	9 and 10 September 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Ms Orla O'Neill
INSPECTION TEAM	Ms Mary Connellan
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCRN 009711

Contents

1.0 Mental Health Commission Inspection Process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act, states that when making an inspection under section 51, the Inspector shall:

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person,
b) See every patient the propriety of whose detention he or she has reason to doubt,
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder, 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 Part 4 of the 2001 Act as applicable, 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 risk level of the non-compliance shall be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgment Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART).

The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.

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. Accommodation included an open-plan kitchen, dining and seating area, two rooms for groups, a sitting room and a small office or interview room. The décor and furnishings made for a homely and relaxed environment and residents had ample facilities both to congregate and have personal space.

Lois Bridges provided care and treatment for up to seven adults with eating disorders. All admissions were planned and voluntary. 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 seven residents in Lois Bridges at the time of inspection. The director of services co-ordinated care. The treatment programme featured group and individual therapies provided by a range of professionally qualified therapists who were contracted for services provided. The service had developed an out-patient programme and follow-up to support residents on discharge.

2.2 Conditions to Registration

There were no conditions attached to the registration of Lois Bridges at the time of inspection.

2.3 Governance

Lois Bridges, approved centre provided care and treatment for up to seven residents. The approved centre was independently run and the management team comprised the Registered Proprietor, the Clinical Director and the Director of Services. The management team met quarterly and a brief record of the meeting was maintained. The terms of reference for the management team were not well defined. The minutes of the management team meetings did not evidence a clear structure and defined scope of governance. There was no risk register maintained for this approved centre.

2.4 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 the approved centre from:
10:00 to 16:30 18 May 2016
09:30 to 16:30 19 May 2016
10:00 to 13:30 20 May 2016

2.5 Non-compliant areas from 2015 inspection

The approved centre was compliant with all applicable regulations, rules and codes of practice in 2015.

2.6 Corrective and Preventative Action plan

No corrective and preventative action was required as Lois Bridges was compliant with all applicable regulations, rules and codes of practice in 2015.

2.7 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 22 Premises	Low
Regulation 26 Staffing	High
Regulation 27 Maintenance of Records	Low
Regulation 28 Register of Residents	Moderate
Regulation 32 Risk Management Procedures	Moderate
Code of Practice for Mental Health Services on the Notification of Deaths and Incident Reporting	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Low

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

2.8 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 7 Clothing
Regulation 9 Recreational Activities

2.9 Areas not applicable

The following areas were not applicable as the rule, regulation, code of practice or Part of the Mental Health Act 2001 was not relevant to this approved centre at the time of inspection.

Regulation/Rule/Act/Code
Regulation 17 Children's Education
Regulation 25 Use of Closed Circuit Television
Regulation 30 Mental Health Tribunals
Rules Section 59 The Use of Electro-Convulsive Therapy
Rules Section 69 The Use of Seclusion
Rules Section 69 The Use of Mechanical Restraint
Part 4 Mental Health Act 2001 Consent to Treatment
Code of Practice on the Admission of Children

Code of Practice Guidance for Persons working in Mental Health services with People with Intellectual Disability
Code of Practice The Use of Electro-Convulsive Therapy for Voluntary Patients

2.10 Areas of good practice identified on this inspection

- The GP discharge summary prepared by the Clinical Director, was countersigned by the resident who both had sight of the report and the opportunity to discuss.
- There was an excellent process in place to communicate and explain the rationale and procedure for searches and for recording residents' consent.

2.11 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.

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

There were no detained patients in the approved centre and section 26 Mental Health Act 2001 did not apply.

2.13 Resident Interviews

Residents were invited to speak with the inspection team. Two current residents and one discharged resident met individually with inspectors. All three spoke highly of the care and treatment provided and emphasised the therapeutic relationship with their key worker and their sense of being valued and respected. The three residents stated that they found both the group and individual therapies to be beneficial. Concern about the level of cleanliness in the bedrooms and shower rooms was commented on. The three residents stated that the provision of aftercare and support was important and made the adjustment to going home easier to manage.

2.14 Resident Profile

Residents were not admitted to Lois Bridges for a period in excess of 6 months.

	Resident Profile	Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	7	0	0	7
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 2	Voluntary Residents	7	0	0	7
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 3	Voluntary Residents	7	0	0	7
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0

2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. The Registered Proprietor, the Clinical Director, the Director of Services and a consultant psychiatrist attended this meeting. The meeting provided an opportunity for the inspection team to clarify any matters arising from the inspection and to give initial feedback to senior managers. The meeting provided an opportunity for the management team to comment and provide information and to query any aspect of the inspection with the inspectors. The issue of the cleanliness of the premises was discussed and the registered proprietor stated that a deep clean had now been scheduled. Inspectors raised the requirement under regulation 26 of having an appropriately qualified person on duty and in charge at all times and that this was not the case according to the duty roster. The management team stated that they had experienced difficulty in sourcing registered psychiatric nurses.

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. The policy made no reference to the protocol for same named residents.

Training: Staff were cognisant of the policy and procedure for the identification of residents. Staff had read the policy and this was documented.

Monitoring of Compliance: There was no evidence of an annual audit on the use of identifiers on the clinical files other than on the medication prescription and administration record (MPAR). Analysis had not been completed to identify opportunities to improve the process.

Evidence of Implementation: The inspection team spoke with staff and inspected each clinical file and the medication records. There was a minimum of two identifiers: name, photographic identification and date of birth in place for each resident. There was no alert system for same name residents and staff reported that this was dealt with on an individual basis.

The approved centre was compliant with this regulation. Not all of the *Judgement Support Framework* criteria for policy and processes, monitoring and implementation were in place and the quality assessment was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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 roles of staff, including the dietician, were outlined. The processes for the assessment of residents' nutritional needs and for the provision and monitoring of food and nutrition were outlined in the policy.

Training: A qualified dietician conducted sessions within the approved centre. Staff had read and understood the policy and this was documented. Staff were able to articulate the policy and processes.

Monitoring of Compliance: There were weekly reviews of the meal plans. An overall systematic review of the menu was underway but had not been completed.

Evidence of Implementation: Lois Bridges provided care and treatment for adults with eating disorders. All menus were reviewed by the dietician. There was a choice of wholesome and nutritional meals for each resident in accordance with their defined meal plans. When required, food was of a modified consistency. Inspectors observed food being cooked and served and the meals were attractively presented and cooked on-site from fresh ingredients. Residents had a hot main meal each day. The residents who spoke with the inspection team expressed their satisfaction with the food provided. Residents could have hot or cold drinks throughout the day and snacks were a regular feature and were specified in the individual care plans. The dietician used an evidence-based nutritional assessment. Food intake and weight charts were maintained for each resident. The dietician provided group educational sessions for the residents on food and nutrition and each resident also had a weekly one-to-one session.

The approved centre was compliant with this regulation. The approved centre did not meet all the *Judgement Support Framework* for monitoring for this regulation and the quality rating was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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 on food safety. The policy did not specify staff roles and responsibilities nor did it outline the processes in relation to the management of the refrigeration, storage, preparation, cooking and serving of food. The policy did include the safe management of food catering and safety equipment. The policy included provision for adherence to food safety legislation requirements.

Training and Education: Staff had read and understood the policy on food safety and this was documented. Staff could articulate the processes for the safe management of food. Not all staff involved in handling foodstuffs and in meal preparation had completed training in food safety.

Monitoring: There was no evidence of food safety audits having been periodically completed. The temperature of the food storage fridge was logged twice daily. Food temperature was probed prior to been served but was not logged. There was no evidence of analysis completed to identify opportunities to improve food safety.

Evidence of Implementation: Lois Bridges catered for up to seven residents. The kitchen, dining and sitting areas were integrated and open plan. The kitchen and dining area was observed to be clean and tidy. The kitchen work surface was divided into different work stations and the use of colour-coded food preparation boards was observed. There was appropriate food and related waste disposal in place. There was a separate hand washing basin for staff who handled food. Antibacterial hand wash was observed to be used before and after handling food. Staff were observed not to use personal protective equipment during the course of the three day inspection. There was an adequate supply of appropriate cutlery and crockery.

The approved centre was compliant with this regulation. Not all aspects of the *Judgement Support Framework* criteria were implemented and the quality assessment was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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 on clothing that addressed the provision of individual clothing in the event that a resident did not have sufficient supply of their own clothing. The policy outlined the process for informing potential residents of the need to bring an adequate supply of suitable clothing to allow optimal participation in the programme, including physical recreation. It was the policy for residents to be up and dressed during the day.

Training and Education: Staff had read and understood the policy and this was documented. Staff were able to articulate the processes for this regulation.

Monitoring: The director of services monitored the availability of an emergency supply of clothing. No resident had been required to wear night attire.

Evidence of Implementation: All admissions to Lois Bridges were planned and residents were advised in advance about what clothing to bring when being admitted. Each resident had an adequate supply of personal clothing and was up and dressed during the course of the inspection. There was a facility within the approved centre for residents to do personal laundry. Each resident had an individual wardrobe.

The approved centre was compliant with this regulation and achieved an excellent rating in relation to the *Judgement Support Framework* as all the criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	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 on personal property and possessions. The policy outlined staff roles and responsibilities, the process for informing residents about the arrangements for personal property and possessions whilst in the approved centre- including risk assessment and the management of items deemed potentially unsafe for residents. The policy outlined the procedures for residents to retain responsibility for their own property and for safe storage.

Training and Education: Staff had read and understood the policy on residents' personal property and possessions and this was documented. Staff were able to articulate the processes for residents' personal property and possessions as set out in the policy.

Monitoring: The implementation of the residents' personal property and possessions policy was monitored and each resident had a completed property checklist and residents' management of personal property was monitored and recorded in the clinical file where issues arose. There was no evidence of analysis being completed to identify opportunities to improve the processes for residents' personal property and possessions.

Evidence of Implementation: A property checklist had been completed for each resident and this was countersigned by the resident and staff. Each resident retained control of their own personal property and possessions. Staff did not handle resident monies. Each resident had a wardrobe and bedside locker. There was a small safe available to secure items if required. The resident information booklet outlined the procedures and rationale applied in relation to residents' property and possessions.

The approved centre was compliant with this regulation. The quality rating was satisfactory as not all the monitoring criteria of the *Judgement Support Framework* were met.

	Compliant		Non-Compliant	
Compliance with Regulation	x			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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: A written policy was available in relation to the provision of recreational activities to Lois Bridges' residents. The policy included the roles and responsibilities relating to the provision of recreational activities within the approved centre, the procedures for identifying appropriate recreational activities and for scheduling. There was a defined process for eliciting residents' interests and preferences and for defined facilities and equipment. There was provision for individual risk assessment in relation to recreation.

Training and Education: Staff had read and understood the policy on recreational activities and this was documented. Staff were able to articulate the processes for recreational activities as set out in the policy.

Monitoring: The implementation of the recreational activities policy was monitored and continuously improved. Resident meetings were convened to identify opportunities for recreational activities. Staff meetings were held and the minutes showed review of recreational provision and the identification of opportunities for quality improvement.

Evidence of Implementation: Lois Bridges was a small approved centre, both in size and in the number of registered beds. Consequently, communal rooms doubled up as therapy and recreation rooms. There were four such rooms and these provided adequate recreational facilities for the seven residents. There was television, DVD player, music player, a laptop computer and electronic games console. There was a supply of books, arts and crafts materials and table games. The private garden was landscaped and well kitted out with garden furniture which provided an attractive space for outdoor relaxation. On admission, residents signed a contract for care which included participation in the structured programme of recreational activities. Many recreational activities took place in the community and included the use of local leisure facilities such as a gym and coffee shops. Recreational activity was age appropriate and ran over seven days per week.

The approved centre was compliant with this regulation and was rated excellent as all of the *Judgement Support Framework* criteria were implemented.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	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 on religion. The policy addressed the processes for identifying and respecting a resident's religious beliefs and for the facilitation of religious practice, insofar as practicable. The policy did not specify staff roles and responsibilities in this regard.

Training and Education: Staff had read and understood the policy and this was documented. Staff were able to articulate the processes applied in relation to this regulation.

Monitoring: Inspection of the clinical files showed that the operation of the policy was reviewed with respect to individual resident's religious needs and how they were to be facilitated whilst in-patient and this was recorded in their individual care plans (ICPs).

Evidence of Implementation: All seven individual clinical files inspected identified a resident's religious or spiritual beliefs where these applied. The ICPs evidenced how residents were facilitated by the approved centre in this regard. Residents had access to local religious facilities and services. A number of current residents actively practised their religion and were accompanied to religious services at the weekend. Residents' rights to abstain from religious practice were respected also.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the monitoring criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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.S

Inspection Findings

Processes: There was a policy on visits. Staff roles and responsibilities were outlined. The policy addressed the process for the restriction of visitors and for documenting any such restrictions. The processes for visitor identification, for children visiting, the physical facilities to accommodate visits and visiting times were included in the policy.

Training and Education: Staff had read and understood the policy and this was documented. Staff were able to articulate the policy and processes for visits.

Monitoring: Each resident had a visiting plan in their ICP and this was reviewed and monitored by the multi-disciplinary team. There was no overall audit or analysis documented in relation to improving the visiting processes.

Evidence of Implementation: Visiting times were stated in the Lois Bridges information booklet and were appropriate and reasonable. There were two rooms available for visits. Children were required to be accompanied by an adult when visiting. Visitors signed a visitors' book on arrival. The therapeutic programme ran six days per week and visits generally took place on a Sunday afternoon. There was reasonable flexibility outside of this time based on the individual needs of residents and their ICPs. A number of family therapy and family meetings took place during the course of the inspection, visits took place at these times also. Residents' preferences in relation to receiving visitors were respected and this was recorded in the clinical files. There were no restrictions placed on visitors at the time of inspection.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the monitoring criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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. Staff roles and responsibilities were not specified in the policy. The policy outlined the communication services available such as telephone, fax and email. 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 communication restrictions applied if there was deemed to be a risk to a resident. For example, the policy made provision for a resident's mail to be examined where there was a concern about resident safety. The policy did not state who would make the decision in relation to this or other restrictions on communication and how this would be managed and communicated to a resident, recorded and reviewed.

There was no inclusion of the requirement for interpretative services or for monitoring the process in the policy. The policy did not address the assessment of residents' communication needs.

Training and Education: Staff had read and understood the policy and this was documented. Staff were able to articulate the policy and processes for communication.

Monitoring: There was no evidence of monitoring the processes for communication on an ongoing basis and no evidence of analysis to identify opportunities to improve communication processes.

Evidence of Implementation: Each resident was free to communicate internally and externally. According to staff, no restrictions had been applied to the communications of any resident since the last inspection. Residents reported that internet access was poor. Residents retained their own mobile phones during the day and were required to leave their phones downstairs at night but could access their phone at any time.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all of the: policy and processes, monitoring and implementation criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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, 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. Staff were able to articulate the processes.

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.

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 residents' property in response to concern about the possibility of alcohol, medication and items having been secreted in the 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 multi-disciplinary team.

The searches records indicated that searches were carried out with regard to resident dignity and staff were aware of the need for gender sensitivity.

The approved centre was compliant with this regulation. The quality assessment was rated as satisfactory as the monitoring criteria of the *Judgement Support Framework* were not implemented.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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 Siochána 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. Staff were able to articulate the policy and procedures related to this regulation.

Monitoring of Compliance: No resident had died and monitoring was not applicable.

Evidence of Implementation: No resident had died while under the care of Lois Bridges.

This regulation was rated under Processes and Training only, and the *Judgement Support Framework* criteria related to these had been applied in full and a quality rating of excellent was made.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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 on individual care plans (ICPs). Staff roles and responsibilities, staffing resources and the residents' involvement in the ICP process were outlined in the policy. The assessment process for the development, implementation, weekly reviews and the recording of ICPs were specified in the policy.

Training: Staff had read and understood the policy on ICPs and this was documented. Staff interviewed were able to articulate the processes for developing, implementing and reviewing ICPs.

Monitoring of Compliance: The multi-disciplinary team reviewed ICPs on a weekly basis. There was no documented quarterly audit of ICPs or analysis for quality improvement.

Evidence of Implementation: The clinical files of all seven residents were inspected. Each resident had an ICP which had been developed, implemented and reviewed by the MDT.

The resident completed their *Client's Perspective* form prior to the multi-disciplinary meeting, which outlined their own needs, goals and preferences and this informed the ICP. The ICP in all instances had been written up by a nurse. Residents all signed their ICP and were offered a copy. Residents could attend the multi-disciplinary team meeting if they wished. Residents' needs, goals, interventions and required resources were outlined in the care plan.

Three current residents and one discharged resident were interviewed and all stated that they had been involved in the development of their ICP and all agreed with the focus and scope of care. The residents said that, where staff recommended something as part of the ICP, they talked this through with the resident and each resident said they were happy to follow their advice. Each resident had a key worker and an individual therapist.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the monitoring criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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. Staff roles and responsibilities, staffing resources and the residents' involvement in their care and treatment process were outlined in the policy. The policy outlined the requirements for recording therapeutic provision, resident progress and outcomes. The policy did not specify the facilities for therapeutic activities.

T*raining and Education:* There was a signature log maintained to indicate that nursing staff had read and understood the policy related to this regulation. All staff interviewed were able to articulate the processes operating for the provision of therapeutic services. However, not all therapy staff were aware of the written policy.

Monitoring: The director of services and the multi-disciplinary team monitored the provision of therapeutic services and programmes at the weekly ICP review meetings. The therapeutic programme was adapted to reflect any needs or issues identified at this meeting. There was no formal documented review or strategic planning forum in relation to therapeutic services and quality improvement.

Evidence of 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 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. 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.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the training and monitoring criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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.

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 and procedures for the transfer of residents to another hospital. The policy addressed the process for making the decision to transfer, the timeframe for assessment, staff roles and responsibilities, the communication with the receiving facility and resident safety during transfer. The policy did not address the management of resident medication during the transfer, nor did it specify the documentation and information required to be forwarded to the receiving facility. Nonetheless, there was a clear procedure in place in relation to the transfer of information and staff were able to articulate this. The policy did not address the procedures to inform next of kin about a transfer.

Training and Education: A signature log was maintained to indicate that staff had read and understood the policy. Staff were able to clearly articulate the processes for the transfer of a resident, including information transfer.

Monitoring: No resident had been transferred since the previous inspection and, therefore, the monitoring criteria specified in the *Judgement Support Framework* were not applicable.

Evidence of Implementation: No resident had been transferred since the last inspection.

The evaluation of compliance for this regulation was based on the processes and training as no resident had been transferred to another healthcare facility. The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the criteria were met under processes and training.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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.

Inspection Findings

Processes: There was a policy on the provision of general health services and on responding to medical emergencies. Staff roles and responsibilities, access to general practitioner (GP) services, general health assessments and ongoing monitoring were outlined in the policy. The policy required an ambulance to be called in the event of a medical emergency. The policy addressed access to national screening programmes.

Training and Education: There was a documented record that staff had read and understood the policy and procedures. Staff were able to articulate the processes for the provision of general health services and for responding to medical emergencies.

Monitoring: General health needs were monitored as part of the ICP process. There had been no medical emergencies and no resident had been in the approved centre for a period in excess of six months and, therefore, there had been no monitoring in this regard.

Evidence of Implementation: All residents' clinical files were examined. Physical examinations were carried out by the GP in the GP surgery and a summary report was contained in each clinical file. There was evidence of ongoing monitoring of physical health and residents had timely access to investigative tests and tertiary medical services. The ICPs gave a clear account of physical health needs, interventions and outcomes. Healthy lifestyle choices were encouraged and supported through group work. A defibrillator was available in the approved centre and was regularly checked. There was information about screening programmes and women's health in the approved centre.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the criteria were met under monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	x			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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: There was a policy on the provision of information to residents. 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 in charge 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. The policy did not make reference to access to interpreter services.

Training: Staff signed to indicate their knowledge and understanding of policies and procedures. Staff were able to articulate the procedures for providing information to residents.

Monitoring of Compliance: The information leaflet was reviewed and updated. There was a process in place to ensure that each resident received this information. There was no documented analysis of the information provided to residents in relation 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 multi-disciplinary team, the housekeeping and visiting arrangements, searches, property and possessions, living facilities programme outline and how to make a complaint. Information on medications and diagnoses was provided on an individual basis.

There was an information folder containing leaflets on diagnoses and medicines. 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. There was information posted about the availability of an independent advocacy service for residents.

Lois Bridges provided care and treatment for voluntary residents only and the advocate had never attended the approved centre. Inspectors spoke with two residents and a former resident, all of whom stated that the information provided to them meant that they were fully informed about their diagnosis, care and treatment and the living arrangements whilst in-patient.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the policy and processes, monitoring and implementation criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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. The policy did not outline the procedures to be applied in the event of a breach of privacy and respect for a resident.

Training: Staff were aware of the policy and had signed it to state that they had read and understood it. Staff were able to articulate the policy and procedures for ensuring resident privacy and dignity.

Monitoring of Compliance: There was no documented monitoring or annual audit of the processes for 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 overriding key. There were five single bedrooms and one double room, which had adequate curtains around the beds. Staff were observed to be respectful of residents during the inspection. Two residents and a former resident informed inspectors that care and treatment was provided in a respectful and non-judgmental manner. 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 securely locked in the nurses' office. No confidential information was on display within the approved centre.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the policy and processes and monitoring criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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 director of services was charged with responsibility for the day-to-day oversight and management of the premises, including weekly checks of equipment. 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. The policy did not include infection control as applied to the premises, however, this was addressed in the health and safety policy.

Training: There was a record to indicate that staff had read and understood the policy. Staff were able to articulate the policy and procedures.

Monitoring of Compliance: The premises was monitored on a weekly basis by the director of services. A record of maintenance and equipment servicing requirements was kept and reviewed. The quarterly management team meeting monitored issues arising in relation to the premises, including quality improvement, and this was documented. A ligature audit had been completed. There was no evidence of an infection control audit.

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. 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. One bedroom ceiling was stained owing to a shower leak.

Painting of the premises and replacement of carpets was scheduled in the immediate future. 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 generally ventilated. The 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. There was however 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 hand washing basin for staff in the staff toilet and in the kitchen for catering staff.

The premises was clean downstairs. The bedroom and shower areas upstairs were not clean. One bedroom and one shower room did not smell fresh and clean. Ventilation was an issue in the en suite shower room. The window sills and window blinds were dusty and grimy. There were cobwebs in the walk-in wardrobe and this suggested that the rooms had not been deep cleaned for some time. The issue of cleanliness of the premises was a concern to one resident. Photographs were taken by the inspection team. The registered proprietor informed the inspection team that an immediate deep clean had been organised and that the cleaning services were being reviewed also.

The approved centre was non-compliant with this regulation because:

(a) of the unacceptable level of cleanliness.
(b) the outstanding ligature anchor points.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
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 and the process for withholding medication. The policy did not address the process for self-administration, for resident refusal of medication or for medication reconciliation. 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 were not in the policy. However, staff stated this was not the practice in the approved centre.

Training: There was documented evidence that staff had read and understood the policy. Medical and nursing staff were trained in ordering, prescribing, storage and administration of medication. Staff showed an awareness of relevant legislation, codes of conduct and also of the management of medication errors and near misses. Staff had access to up-to-date information on medicines.

Monitoring of Compliance: There was a quarterly audit of the medication prescription and administration records (MPARs) 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 quality 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. Information about medication was available for residents. Seven MPARs were inspected and contained the residents' name, date of birth, generic name of medication, signature of prescriber, medical council registration number (MCRN), dose, frequency of administration, date of prescription, administration record and, where appropriate, discontinuation signature and date. Two MPARs did not record whether the resident was known to be allergic to any medication or not.

Prescribed medications were dispensed by community pharmacies and delivered to Lois Bridges by a resident's next of kin or collected by staff. Each resident paid for their own medication.

At the time of inspection, there were no prescribed medications which required refrigeration storage. On the first day of inspection, there was a small locked red box in the kitchen fridge which contained medication. There was a cooler provided for the storage of medication but

this had no temperature gauge. A refrigerator for medication storage was delivered and installed on the second day of inspection.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the criteria for policy and processes and monitoring were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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 director of services 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 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. Staff were able to articulate the policies and procedures for this regulation.

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 written operational policies and procedures accurately reflected the operational practices in the approved centre. The Health and Safety Policy and Statement were up to date and included a hazard identification and risk mitigation plan.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the criteria were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.25 Regulation 25: Use of Closed Circuit Television

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at anytime on request.

Inspection Findings

CCTV was not used in the approved centre and this regulation was not applicable.

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 rostering and staff assignment to tasks. The policy did not outline: the organisational structure and lines of responsibility, the provisions for terms and conditions of employment and the job description, the orientation and induction of staff, performance management, or staff training and planning, the required qualifications, staff record requirements and monitoring of staff recruitment processes, including the use of agency staff.

Training and Education: Relevant staff had read and understood the staffing policies and this was documented. Staff were able to articulate the staffing policy and procedures.

Monitoring: Staff training needs were documented and the management team had reviewed the number and skill mix of staff. There was no documented evidence of review of the staff recruitment process from a quality improvement perspective.

Evidence of Implementation: Staff were recruited and vetted in accordance with the stated policy. Residents had access to a number and skill mix of staff to meet assessed needs. There was a planned rota for nursing staff and healthcare assistants. The approved centre staff included registered psychiatric nurses, a registered general nurse and a registered intellectual disability nurse.

There was not an appropriately qualified member of staff on duty and in charge at all times as the roster did not always include a psychiatrically trained nurse in charge. The management team informed inspectors that, in their experience, it was difficult to source psychiatric nurses. There was no organisational risk register and, therefore, there was no recorded risk mitigation actions in relation to staffing. For example, the risks attached to having non-psychiatrically trained staff in charge and the actions required to mitigate the difficulties sourcing appropriately qualified staff.

Staff training records were maintained and ongoing training was available to staff. At the time of inspection, the training record indicated that not all staff were trained in: Basic Life

Support, Fire safety, Management and prevention of violence and aggression or in the Mental Health Act 2001.

The approved centre was non-compliant with this regulation because:

a) There was not an appropriately qualified member of staff on duty and in charge at all times (26 (3)).
b) Training had not been completed for all staff in Basic Life Support, Fire safety, Management and prevention of violence and aggression and in the Mental Health Act 2001. (26(4) and (5)).

The following is a table of staff based in the approved centre on a 24-hour basis.

Ward or Unit	***Staff Grade***	***Day***	***Night***
Lois Bridges	CNM2 RPN/RIDN HCA	1 1 1	0 1 1
Ward or Unit	***Staff Grade***	***Day***	***Night***

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Registered Intellectual Disability Nurse (RIDN), Health Care Assistant (HCA)

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment				X

Risk Rating			
Low	Moderate	High	Critical
		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 records is outside the scope of this Regulation which refers 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 27 Maintenance of Records. For example, the policy on Regulation 20 Communication referred to a resident's access to their own clinical records. The senior person in charge controlled the keys to the clinical records storage.

Training: Staff signed to indicate they had read and understood the policies and processes in relation to the maintenance of records. Staff were able to articulate the policy and procedures for this regulation. Clinical staff were trained in best practice record keeping.

Monitoring of Compliance. Residents' records were reviewed regularly by the director of services to ensure compliance with the Lois Bridges records policy, however, this was not documented. 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. With the exception of the pre-admission records, all pages contained a resident identifier. The fire safety and health and safety records were up-to-date and maintained in the approved centre.

The most recent food safety report was not maintained in the approved centre. The registered proprietor advised that the food safety report was filed at the administrative offices in Howth and had previously been provided to inspectors.

The approved centre was non-compliant with 27 (3) because:

a) The food safety records were not maintained in the approved centre.

	Compliant		Non-Compliant	
Compliance with Regulation			x	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			x	

Risk Rating			
Low	Moderate	High	Critical
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

The register of residents was not maintained in accordance with Schedule 1 to the regulations and was not-up-to date to reflect the current residents in the approved centre. The records maintained were entitled "Mental Health Commission and National Research Board data Collection". Information was recorded in this handwritten book and then transcribed to an electronic record. It was clear from the data recorded that the relevant staff were not cognisant of the requirements of Regulation 28. For example, the last three residents admitted had not been recorded on the electronic register of residents. The recorder had pre-entered the date of discharge in the hard copy record in two instances, although the residents were still in the approved centre.

The approved centre was non-compliant with this regulation because:

a) The register of residents was not up to date (28(1)).
b) The required data fields were not accurately recorded (28(2)).

	Compliant	Non-Compliant
Compliance with Regulation		X

Risk Rating			
Low	Moderate	High	Critical
	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: A written policy was available in relation to the development and review of operating policies and procedures required by the regulations including: the roles and responsibilities in relation to the development, management and review of operating policies and procedures, the process for the development of the operating policies and procedures required by the regulations, incorporating relevant legislation, evidence-based best practice and clinical guidelines. The process for the approval, review and dissemination of operating policies and procedures. The policy did not address the process for making obsolete, and retaining, previous versions of operating policies and procedures.

Training and Education: Relevant staff were trained on the processes relating to the updating and maintenance of the operational policies and procedures. Staff had read and understood the policy on developing and reviewing operational policies. This was documented. Staff were able to articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: The operating policies and procedures were reviewed and updated by appropriate clinical and managerial staff to ensure they reflected the current operational practices in the approved centre.
An annual audit was undertaken to determine compliance with review timeframes.
Analysis was completed to identify opportunities to improve the processes of developing and reviewing policies.

Evidence of Implementation: The policies required by this regulation were in place. There was no standardised format or headings for the production of policies. There was clinical and managerial input to the development, approval and review of policies. A hard copy and an electronic copy of the policies were available to staff and staff signed to indicate their having received, read and understood the policies.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the criteria for policy and processes and implementation were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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

The approved centre did not admit or treat detained patients and this regulation was not applicable.

3.31 Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

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 and the monitoring of the complaints process. The policy made reference to a right to appeal. However, it did not provide any information on an appeals process. The policy did not contain the procedure for advocacy, confidentiality requirements and the requirement for timelines within the complaints process.

Training: There was a signature log to indicate that staff had read and understood the policy and procedures for complaints. Staff were able to articulate the policy and procedures.

Monitoring of Compliance: An audit of complaints was completed on a monthly basis. Complaints were analysed and reviewed and there was evidence that quality improvements were identified and actioned in a timely manner.

Evidence of Implementation: The director of services, 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 resident's bedroom door. 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 identified timelines included in the policy or information provided to residents. There was no advocacy service provided in the approved centre at the time of inspection. The approved centre management were in the process of liaising with an eating disorders

voluntary group to address the issue of providing an advocacy service. The complaints log was kept securely.

The approved centre was compliant with this regulation. However, it did not attain an excellent rating in relation to the *Judgement Support Framework* as not all the criteria for policy and processes and implementation were met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.32 Regulation 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

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 multi-disciplinary 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 including attempted suicide, 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 on risk assessment tools and procedures, including incident reporting-used in Lois Bridges. Staff had read and signed the risk management policy and were able to articulate the processes.

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

Evidence of Implementation: There was a policy on risk management which met the requirements of this regulation. The approved centre maintained an incident log. No significant incidents had occurred since the last inspection. The incident report forms were inspected and incidents had been risk rated. Each incident had been reviewed by senior managers and outcomes recorded. Incidents were reviewed in either the clinical meetings or by the Health and Safety Committee as appropriate.

Seven clinical files were inspected. A risk assessment and management plan had been developed for each resident at the time of admission. Risk evaluation was reviewed weekly

by the multi-disciplinary team or more frequently where indicated. The clinical director 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 director of services was the identified risk manager. There was no risk register maintained in the approved centre. Thus, there was no documented evidence of the identification and assessment of risk throughout the approved centre and identified precautions or risk mitigation to control risk.

The approved centre was non-compliant with this regulation because there was no risk register maintained for the approved centre (32(2) (a),(b)).

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	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

There was a defined process in place for the provision, review and renewal of insurance for the approved centre and for the processing of claims. Insurance certificates were available to inspectors and comprised indemnity for public liability, employer liability, property and clinical indemnity.

	Compliant	Non-Compliant
Compliance with Regulation	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

The certificate of registration was prominently displayed in the entrance hall of the approved centre.

	Compliant	Non-Compliant
Compliance with Regulation	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 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 administered in the approved centre and this rule was not applicable.

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.

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.

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 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

The approved centre did not admit or treat detained residents and Part 4: Consent to treatment was not applicable.

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 an up-to-date policy on physical restraint which met the requirements of this code of practice.

Training and Education: Staff had read and understood the policy on physical restraint and this was documented.

Monitoring: Physical restraint had not been used in the approved centre and monitoring was not applicable.

Evidence of Implementation: The policy on physical restraint was in date. Staff reported that, to their knowledge, physical restraint had never been used in the approved centre. There was no Clinical Practice Form Book for Physical Restraint in the approved centre. Nursing staff were trained in the prevention and management of violence and aggression.

	Compliant	Non-Compliant
Compliance with Code of Practice	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.

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. The policy identified the risk manager and outlined staff roles and responsibilities both in relation to the recording and notification of incidents and also death notifications.

Training: There was a record to show that staff had read and understood the policy. Staff were able to articulate the policy and procedures.

Monitoring of Compliance: Incidents were reviewed by the MDT in relation to individual residents. The health and safety committee and the management team reviewed incidents with a view to corrective action and quality improvement.

Evidence of Implementation: A summary of incidents was reported on a six-monthly basis as required, to the Mental Health Commission. The risk manager was the director of services. The incident reports were inspected and corresponded with the summary incident report provided to the MHC. The incident report logs were not maintained in an ordered manner; for example, they were not recorded on a clearly defined pro-forma with incident numbers assigned. There had been no deaths in Lois Bridges.

The approved centre was non-compliant with this code of practice as 3.2 of the code required compliance with Regulation 32 Risk Management Procedures.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
	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.

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.

6.6 Admission, Transfer and Discharge

Please refer to the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, for further guidance for compliance in relation to this practice.

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, transfer and discharge of residents, including discharge against medical advice. The role of the key worker was not outlined in the policies. Medication management on transfer and discharge was not included. There were also policies with regard to personal property and possessions as well as 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: There was no audit of admission or discharge to ensure adherence to the policies. No current resident had been transferred.

Evidence of Implementation: Admission: Two consultant psychiatrists provided care and treatment to Lois Bridges residents. There was an admission process in place. All admissions were planned and an assessment was carried out prior to admission by one consultant psychiatrist. 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 pre-admission assessment covered: presenting complaint, past psychiatric history, medical history, social history, current medication and mental state examination. Seven clinical files were inspected and, although there was a comprehensive psychiatric assessment and a full physical examination in place for all seven residents, not all of these examinations had taken place at the time of admission.

The procedure operating in Lois Bridges was that one consultant psychiatrist completed a comprehensive psychiatric assessment prior to the admission of any resident to Lois Bridges. Then the second consultant psychiatrist, who was the clinical director, made the decision to admit or not based on the first consultant psychiatrist's assessment. The clinical director had assessed new admissions on the day of admission in only two of five cases. A physical examination was carried out by a local GP in their own surgery on a contract basis with Lois Bridges; however, these assessments did not take place at the time of admission.

There was no GP examination evident in one clinical file inspected.

There was evidence of comprehensive pre-admission assessment and there was an ICP in place for each planned admission. Residents signed a contract for treatment on admission, indicating consent and agreement to the care and treatment protocols of Lois Bridges. There was evidence of family involvement in the admission process where a resident wished.

Transfer: No resident had been transferred.

Discharge: The clinical file of one resident who had been discharged was inspected. The ICP incorporated the discharge plan from the outset. The resident was provided with a follow-up

appointment prior to discharge. A comprehensive report on the resident's care and treatment in Lois Bridges, their progress and outcomes, medication and follow-up arrangement was sent to the GP on the day of discharge. This report, prepared by the clinical director, who was the treating doctor, was also signed by the resident. The approved centre met the discharge standards outlined in this code of practice.

The approved centre was non-compliant with the code of practice on admission as the psychiatric examination and physical examination did not take place at the time of admission.

	Compliant	Non-Compliant	
Compliance with Code of Practice		X	
Risk Rating			
Low	Moderate	High	Critical
x			

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016

Completed by approved centre: Lois Bridges **Date submitted: 30 August 2016**

For each finding of non-compliance the registered proprietor was requested to provide a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.

Regulation 22: Premises (inspection report reference 3.22)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. The unacceptable level of cleanliness	Corrective action(s): External cleaning company replaced by Lois Bridges staff by Registered Proprietor Annual painting work in progress and to be completed August 2016	Cleaning company replaced with immediate effect	none	August 2016
	Preventative action(s): Daily cleaning logs kept by Lois Bridges staff and checked by Director of Services on a weekly basis	cleaning and maintenance log audited weekly by HCA and RPN	none	August 2016
2. The outstanding ligature anchor points	Corrective action(s): Ligature audit completed. Lois Bridges have found the ligature points identified by auditors as low risk as all bedrooms are locked until 19.00 and patients are monitored by staff during the night time. All clients are reviewed weekly by MDT and risk assessed accordingly	Ligature risk completed quarterly and policy adjusted accordingly by Clinical Director and Director of Services	Doors can not be shortened as they are Fire doors and must close and seal completely as currently are	completed
	Preventative action(s): Ongoing ligature audits by Clinical Director as per our policy	As above		ongoing

Regulation 26: Staffing (inspection report reference 3.26)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
3. There was not an appropriately qualified member of staff on duty and in charge at all times	Corrective action(s): New RPN recruited June 2016 and continued recruitment for RPN's by Administration and Director of Services	Continued recruitment drives and monthly contact with Agencies and PNA with Administration staff and Director of Services	All effort for continued recruitments with agencys ongoing. Shortage of RPN's across Ireland by Director of Services and Administration staff	ongoing
	Preventative action(s): Ongoing recruitment for RPN's. The recruitment of a new RPN will ensure that an appropriately qualified staff member is on duty and in charge of the approved centre at night. Lois Bridges hope to have another RPN appointed pre the end of September. This will ensure that the appropriate qualified staff member is on duty and in charge at all times.	As above	As above	ongoing
4. Training had not been completed for all staff in basic life support, fire safety, the management and prevention of	Corrective action(s): Dates arranged for all non nursing staff to complete training in the following areas- Basic life support, Fire Safety, MAPA and Mental Health	Policy and all staff updated on staff training accordingly by Director of Services	None	November 2016

violence and aggression and in the Mental Health Act 2001	Act 2001. All nursing staff have training completed	All staff confirmed attendance		
	Preventative action(s) Quarterly training audits are completed to ensure training is up to date for all staff and is now to include contracted staff	Quarterly audits by Director of Services and Administration	none	ongoing

Regulation 27: Maintenance of Records (inspection report reference 3.27)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
5. The food safety records were not maintained in the approved centre	Corrective action(s): Food safety records adjusted to include more detail on food checks and record keeping. Policies and reports moved from storage office and stored in Lois Bridges only by Administrator	All records updated daily and managed and supervised by RPN	None	completed
	Preventative action(s): Policy on records updated and staff trained accordingly. A new food safety audit will be carried out in September 2016. The original certificates will be kept in Lois Bridges permanently.	Ongoing monitoring by HCA and RPN	none	October 2016

Regulation 28: Register of Residents (inspection report reference 3.28)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
6. The register of residents was not up to date	Corrective action(s): Register or residents now updated with every admission & discharge rather than weekly basis	Policies on Register of Residents updated and Staff trained accordingly	Implemented with immediate effect	completed
	Preventative action(s): Quarterly register checks by CNM	Included in quarterly audit by management team	none	completed
7. The required data fields were not accurately recorded	Corrective action(s): Register of Residents updated to include additional information required. Policy updated by Management team and confirmed by Director of Services	Policy on Register of Residents updated and staff trained accordingly by Director of Services	Implemented with immediate effect	Completed
	Preventative action(s): Staff fully aware of new policy and are updating register of clients accordingly. Quarterly checks by CNM and Management team	Included in quarterly audit by management team	Implemented with immediate effect	completed

Regulation 32: Risk Management Procedures and Code of Practice: Notification of Deaths and Incident Reporting (inspection report references 3.32 and 6.3)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
8. There was no risk register maintained for the approved centre	Corrective action(s): Organisational Risk Register and policy currently being developed by Management team	Quarterly reviews by Management	Shortage of RPN's in Ireland	September 2016
	Preventative action(s): Staff trained accordingly, policy records updated and reviewed in quarterly audit	Risk register to be included in quarterly audit by Director of Services		November 2016

Code of Practice: Admission, Transfer and Discharge (inspection report reference 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
9. The psychiatric examination and physical examination did not take place at the time of admission	Corrective action(s): Admitting consultant to undertake physical examination as well as psychiatric examination at point of admission	Clinical Director to liase with consultants and ensure process is followed for every admission		With immediate effect
	Preventative action(s): Admissions policy adjusted by Clinical Director to include Physical examinations by Consultant at time of admission	Client files monitored quarterly by clinical director		Immediate effect