Best Practice Guidance for Mental Health Services

Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement

HSE Mental Health Services

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Foreword

It is my pleasure to introduce this HSE Best Practice Guidance for Mental Health Services. Delivering safe, high quality and recovery focused care is the primary aim of HSE Mental Health Services. To safeguard service users there are a range of policy, regulatory and legal frameworks within which you as clinicians and managers deliver services. Over recent years mental health services have changed – reconfiguring to be recovery focused and more responsive. The result is that our mental health services as they currently operate are relatively young.

The aim of the HSE Best Practice Guidance for Mental Health Services is to enable you to easily navigate the wide range of existing policy, regulatory and legal frameworks. By enabling this to be done in an integrated and streamlined manner we will ensure that service users, rather than specific regulations or policies are our focus. Ultimately we hope to see a number of benefits once the Best Practice Guidance has been implemented. We believe that we will get to know our services better and so improve safety and quality. In doing so we will ensure regulatory compliance as a result of day to day practice rather than a separate area of work.

The Best Practice Guidance has been co-created by the Mental Health Quality & Service User Safety (QSUS) team and a broad range of stakeholders. I would like to give particular thanks to the service users who were part of the development process, generously giving their time and sharing their experiences. I would also like to thank the steering group, sub-committees and pilot sites. Over the coming years this guidance will become the cornerstone of our approach to quality and regulatory compliance and I look forward to everybody working in the service engaging actively in their implementation.

Anne O'Connor

National Director Mental Health

INTRODUCTION

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What is the Best Practice Guidance for Mental Health Services?

There is increased expectation by mental health service staff, service users, families and carers that services are based on scientific evidence, knowledge gained from clinical experience, and service users' values and preferences.

The aim of the HSE Best Practice Guidance is to inform mental health services in Ireland of best mental health care practices. The principles within the guidance document are reflective of the current mental health quality and safety agenda, mental health legislation and service user expectations. When fully implemented and adopted, the Guidance will significantly contribute towards ensuring that children and adults who use Irish mental health services receive a high quality, recovery oriented, safe service that is responsive to their needs.

The document provides a basis for better governance in planning and managing services, measuring improvement, identifying and addressing gaps, areas of concern or deterioration in the quality and safety of the services provided. It consists of best practice guidance, checklists and a self assessment framework, which are intended to support and guide further quality improvement within mental health services. The document should not sit apart from other quality developments, but should be seen as a part of the ongoing quality improvement reforms within mental health services and the wider health services.

This Best Practice Guidance is a practical tool and is based on legislation and best available evidence. It has been developed in consultation with staff, service users, families and carers. It is one composite document that includes:

- The *Mental Health Act (2001)* as amended, Statutory Instruments, Rules, Regulations and Codes of Practice.

- The Mental Health Commission Quality Framework (2007).

- The Mental Health Commission Judgement Support Framework (2017 Version 4).

- Other National legislation and HSE policies and procedures.

- National and International Best Practice.

It sets out the key principles of quality and safety that should be applied in any mental health setting. It is informed and underpinned by the principles of recovery, which encompasses personal recovery as something worked towards and experienced by the person with mental illness and, clinical recovery, which is the contribution made by healthcare staff in supporting and facilitating the person in their journey towards recovery.

Mental health services are now being asked to self assess against this guidance in order to identify both good practice and areas where improvements can be made. The result of the self assessment will provide an opportunity for mental health services to acquire a shared understanding of the quality of care being provided and the further improvements that need to occur in providing a quality, safe and effective service.

Direct components of the *Mental Health Commission Judgement Support Framework, Mental Health Act 2001* and relevant rules and Codes of Practice have been taken from these documents to support services to meet the regulatory requirements.

Why was the Best Practice Guidance developed?

There is an increased expectation on performance of services in relation to legislation, rules and codes of practice. This can prove challenging as it is often difficult for all involved in mental health services to gain clarity and understanding of all the legislative and best practice requirements in existence. This Best Practice Guidance has been developed with the intention of bringing together key mental health legislative and best practice requirements into one user friendly guide. The Guidance will assist the mental health service to improve its overall performance, and further develop a culture of continuous quality improvement with a focus on service users and on quality outcomes.

As information and measurement are central to improving the quality of care, this guidance document provides practical tools and checklists. Furthermore, a self assessment framework has also been developed to enable mental health services to self-assess their services against the Best Practice Guidance. This will contribute to ensuring compliance with legislative regulations, rules and requirements. Additionally, services will have the ability to recognise what is working well and what requires improvement in a systematic, structured way. The implementation of the Best Practice Guidance will complement and support existing processes in mental health services and give a shared voice to the expectations of service users, service providers and the public.

How was the Best Practice Guidance developed?

This national project was instigated by the National Director for Mental Health and forms part of the Mental Health Division Operational Plan for 2016 and 2017. The Best Practice Guidance was developed by the Quality Service User Safety (QSUS) department within the HSE National Mental Health Division, in collaboration with the National Steering and Project groups, who were instrumental in the development and approval of this Guidance. The QSUS team works strategically at national level to support service users, managers and clinicians across the country to ensure Ireland's Mental Health Services are safe and of the highest possible quality.

The development of this Guidance commenced in May 2016 in consultation with service users, carers, families, advocacy groups and staff from mental health services. The aim of this collaborative approach was to identify what was required and subsequently enable the smooth introduction of the Guidance into all mental health services.

An initial draft Guidance document and self assessment framework was developed and piloted in four services across Ireland. The four pilot sites were:

- **Sligo** – A Community Adult Mental Health Team

- **Dublin** – The Child and Adolescent Mental Health Service in Linn Dara

- **Ballinasloe** – The Psychiatry of Later Life team (Sector 2)

- **Cork** – The Approved Centre at Cork University Hospital

Each pilot site had a self assessment team; who tested their services against the draft Guidance, using the draft self assessment framework. The self assessment teams included a Consultant Psychiatrist, Management Staff, relevant members of the Multi-Disciplinary Team (including, where possible Social Workers, Psychologists, Occupational Therapists and Nurses) service users and carers.

The learning from the pilot sites enabled the Best Practice Guidance and the self assessment framework to be further refined. The pilot project was extremely beneficial in that it also resulted in identifying factors that would support the roll out of the Best Practice Guidance nationally.

Feedback from Pilot Sites

Some of the pilot participants included comments about their experience.

'involvement in the Draft HSE Best Practice Guidance process was very useful for the team as it gave us an opportunity to scrutinise our performance with regard to adherence to best practice. We were also pleased to discover that we do, in fact, already meet many of the aims in the areas we looked at. In our efforts towards continuous improvement, the experience gave us the target for the future'

'the guidelines were a great way of generating ideas for improvement'

'it's great that frontline staff are involved in the development of these guidelines. It was refreshing that the division asked working Multi Disciplinary Teams (MDT) to consider the practicalities of using the Guidance'

'the involvement of carers in the process was invaluable and the carer in our team appreciated the experience of being a respected member of the team'

'working through the Guidance really helped bring the team together'

'being involved in the pilot was an opportunity to join the dots for safer better healthcare in a Child Adolescent, Mental Health Service (CAMHS) setting'

Figure 1 – Comments from pilot participants.

Following the extensive pilot and consultation process, the document was approved and signed off by the Steering Group and Project Group

What is the scope of the Best Practice Guidance?

The Best Practice Guidance is applicable to all staff and management working in mental health services provided by the HSE and those mental health services funded by the HSE.

The Guidance is sponsored by the National Director Mental Health and the National Management Team.

Effective use of the Guidance requires the whole service to be committed to improving its performance. This is an essential element for success and it requires strong leadership.

What does the Best Practice Guidance mean to service users?

The Best Practice Guidance recognises that service user centricity is the cornerstone of service delivery. It describes high quality, safe and reliable mental health care.
The Guidance also: -

- Creates a basis for improving the quality and safety of mental health services in line with legislation, regulation, rules, codes of practice and best practice.

- Can be used by service users to understand what high quality, accessible, inclusive and safe mental health services look like.

- Can be used in day to day practice by staff to encourage a consistent level of quality and safety across all mental health services.

- Gives a voice to the service user and encourages collaboration. on service user's recovery journey.

- Seeks to involve service users, families and carers in assessing the quality of the mental health services.

- Enables more transparency to service users, families, carers and the public.

Overview of the Best Practice Guidance:

The Best Practice Guidance for Mental Health Services is divided into a suite of 5 themes.

Theme	Description of Theme
T1: Recovery Oriented Care and Support	How mental health services place adults and children at the centre of what they do. This includes protecting service users' rights, respect for diversity, and promotion of access, advocacy, connections with family and community. It is about a partnership approach to recovery.
T2: Effective Care and Support	How mental health services deliver the best possible service, to achieve the best possible outcome for service users in a meaningful and individualised way.
T3: Safe Care and Support	How mental health services protect service users, staff and visitors from the risk of harm. This involves identifying, assessing and monitoring risk and taking appropriate action to learn from any adverse incidents.
T4: Leadership, Governance and Management	How mental health services make decisions; how risks are managed; how the service is governed, led and managed; where accountability lies for the quality, safety and satisfaction of service users, for the care delivered; and how strategic, regulatory and financial obligations are met.
T5: Workforce	How mental health services plan, organise, lead, train, develop, motivate and manage their workforce to achieve service objectives for high quality, safe and reliable mental health care.

Figure 2: Key Themes contained within the Best Practice Guidance document.

How the Best Practice Guidance assists in identifying what is a high quality, recovery oriented, effective, safe and reliable Mental Health Service.

The Best Practice Guidance determines what constitutes a high quality, recovery oriented, effective, safe and reliable mental health service. The Best Practice Guidance is divided into five Themes.

Each of the five **Themes** are described in terms of **Aims**. The **Aims** are supported by a number of **Indicators** and **Features**.

Each mental health service establishes a self assessment team, which assesses themselves against the features in each **Indicator**. The self assessment team then makes a decision about their level of achievement with each **Indicator**.
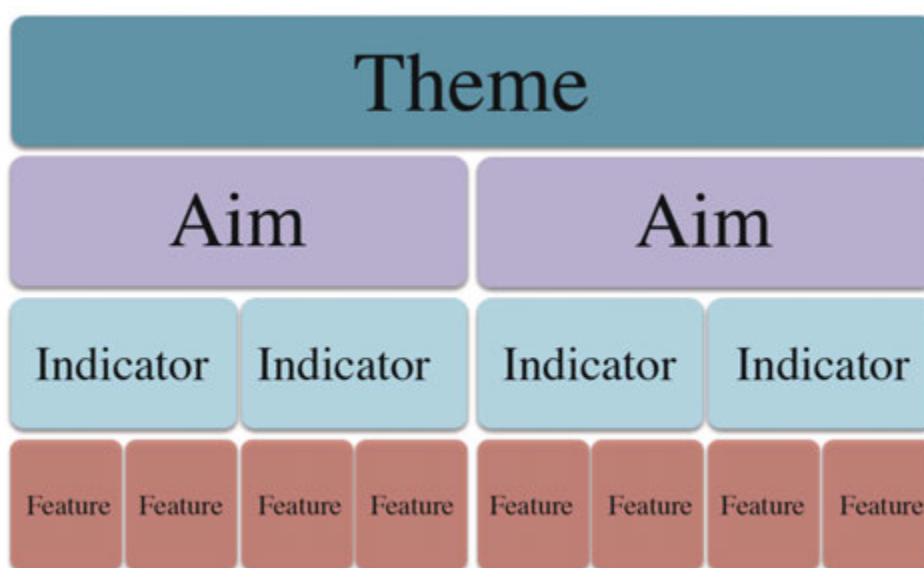
Figure 3: Hierarchy of Themes, Aims, Indicators and features.

Layout of the Best Practice Guidance

- Each of the 5 themes contains a number of Aims which are statements of intent reflective of a high quality mental health service.

- Each Aim has a number of Indicators which when met, achieve this Aim.

- Each Indicator is broken down further into a number of features, which if met, demonstrate achievement with the Indicator.

- Within the indicators there are boxes which broadly summarise, at a minimum, what the policies and procedures need to include, to meet regulatory and best practice requirements.

In Theme 2 – *Effective Care and Support*, it is notable that in addition to the above, the Guidance includes six supporting checklists *(Appendices 1-6)* – three of the checklists *(Electro Convulsive Therapy, Mechanical Means of Bodily Restraint and Physical Restraint and Seclusion)* are developed in accordance with the Mental Health Commission Rules and Codes of Practice, and the other three checklists *(Medication Management, Environment and Infection Control)*, are based on best practice.
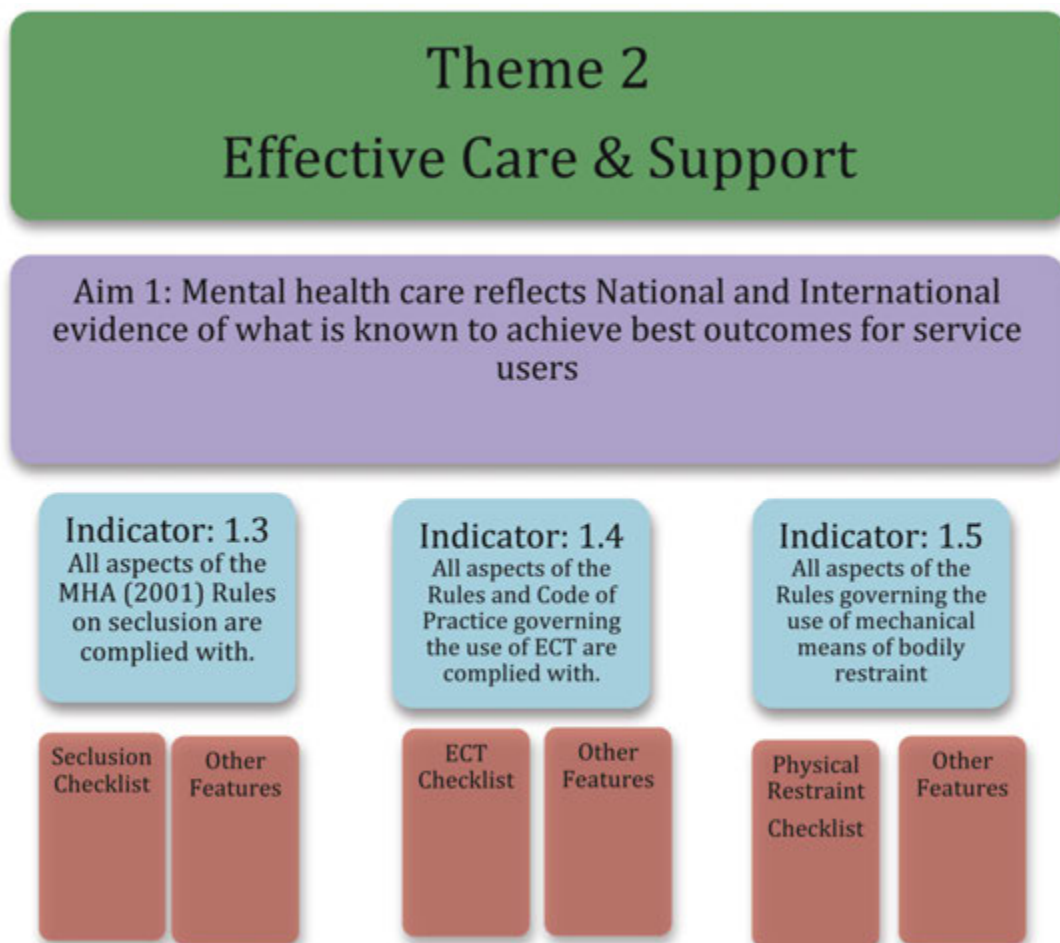
Figure 4: Break down of Theme 2 (Aim 1) –Effective Care and Support

The 5 Themes contained within the Best Practice Guidance:

Theme 1 : Recovery Oriented Care and Support
Aims

1. The planning, design and delivery of services are informed by service users' identified needs.

2. Admissions, transfers and discharges are timely and appropriate and based on service users assessed needs.

3. Service users experience care which values them, respects his/her diversity and protects his/her rights.

4. Service users are enabled to participate in making informed decisions about their care.

5. Service users' informed consent to care and treatment is obtained in accordance with legislation and best available evidence.

6. Service users' dignity, privacy and autonomy are respected and promoted at all times.

7. Service users complaints are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

8. Mental health service users are supported in maintaining and improving their own health and well-being.

Theme 2 : Effective Care and Support
Aims

1. Mental health care reflects national and international evidence of what is known to achieve best clinical outcomes for service users.

2. Care is planned and delivered to meet the individual service user's initial and on-going assessed mental healthcare needs, while taking account of the needs of other service users.

3. Service users receive integrated care which is coordinated effectively within and between services.

4. All information necessary to support the provision of effective care, including information provided by the service user, is available at the point of decision making.

5. The mental health service is provided in a physical environment which supports the delivery of high quality, safe, reliable service provision and protects the health and welfare of service users, staff and visitors.

6. The effectiveness of mental health care outcomes is systematically monitored, evaluated and continuously improved.

7. Service users' health and well-being is supported by the mental health service's policies and procedures for medication management.

Theme 3 : Safe Care and Support

Aims

1. The mental health service takes all reasonable measures to protect service users, staff and others from the risk of harm associated with the design and delivery of mental health services.

2. The mental health service gathers, monitors, and learns from information relevant to the provision of safe services and actively promotes learning both internally and externally.

3. The mental health service effectively identifies, manages, responds to and reports on service user safety incidents.

4. The mental health service ensures all reasonable measures are taken to protect service users from all forms of abuse.

5. Effective Fire Safety Management Systems are in place and in accordance with legislative requirements including Fire Services Acts, 1981 & 2003; Safety, Health and Welfare at Work Act, 2005 and Building Control Acts 1990 & 2007 and other relevant legislation.

Theme 4 : Leadership, Governance and Management

Aims

1. The mental health service has clear accountability arrangements in place to achieve the delivery of high quality, safe and reliable services.

2. The mental health service has formalised governance arrangements for assuring the planning and delivery of high quality, recovery oriented, safe and reliable services.

3. Each mental health service/ team maintains a publicly available Statement of Purpose that accurately describes the services provided, including how and where they are provided. The statement of purpose is communicated in an accessible format to all stakeholders, including service users.

4. The mental health service has systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of mental health services, which are in compliance with relevant legislation, national standards, best practice and any service level arrangements.

5. The mental health service has effective management arrangements to support and promote the delivery of high quality, safe, reliable and recovery oriented services.

6. Managers at all levels in the mental health service promote and strengthen a culture of quality and safety throughout the service.

Theme 5 : Workforce
Aims

1. The mental health service plans, organises and manages its workforce to achieve its objectives for high quality, recovery oriented, safe and reliable services.

2. The mental health service recruits staff with the required competencies to provide high quality, recovery oriented, safe and reliable services.

3. The mental health service ensures that its workforce has the competencies and capabilities required to deliver high quality, recovery oriented, safe and reliable services.

4. The mental health service supports its workforce in delivering high quality, recovery oriented, safe and reliable services.

SELF ASSESSMENT

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Why Self Assessment?

Self assessment contributes to continuous improvement by providing a structured opportunity to assess performance and identify improvements. Self assessment helps to answer the question *"How well are we doing?"* as well as other questions that follow on from it: *"How do we know?"* and *"How can we do better?"*. Self assessment allows each mental health service to examine its everyday activities and assess them against the Best Practice Guidance. It facilitates an examination of where the service has been, where it is now, and where it will need to go next. The process also allows teams and services to realise what they do well and the areas they need to improve upon. It also helps in terms of ownership of the process and its outcomes, thereby strengthening accountability and responsibility for acting on the findings.

Preparation for Self Assessment

In order to comprehensively self assess a service, a self assessment team must be established by the management team. The membership of the self assessment team should reflect the multidisciplinary members providing integrated care within the service. Membership should be reflective of staff knowledge and experience, not necessarily the position they hold within the team/organisation.

Multi-disciplinary self assessment teams may include front line direct and indirect care/service providers and professionals, organisation leaders, management, service users, family and carers, community partners, volunteers etc. Direct and indirect care/services may include such areas as healthcare assistant staff, nursing, psychiatry, psychology, pharmacy, dietician, pastoral care, speech/ language therapy, social work, occupational therapy, household, catering, security and administration.

Self Assessment Teams

Assessing against the Best Practice Guidance provides an opportunity for mental health services to get a shared understanding of the quality of care being provided within their services and in particular, those areas that need greater focus and action. This can be achieved by assessing the indicators as a multidisciplinary team. This team based approach supports the generation of discussion around the quality of service being delivered as well as the capacity and capability within the service to support the delivery.

Identifying a designated lead within the self assessment team is an essential step, as this person will be the overall named lead person for both the coordination of the assessment process and arranging the collation of the services assessment information. The designated lead should be a senior staff member who has strong leadership and coordinating skills and have an understanding of the quality assessment and improvement process. The lead will engage with all relevant staff, ensuring broad participation throughout the process. The lead person will also be the key link between their service, the management team (through the agreed internal channels identified) and the National Mental Health QSUS team.

Membership of the team is dependant on the size of the service, but it is advisable to have between 6-8 members per self assessment team. The team should consist of:

- One Consultant Psychiatrist

- One Service User or Carer or Family Member

- One Senior Nurse Manager

- Two to four Health & Social Care Professionals – depending on the service

- One Site Manager (CNM 2 / CNM 3 / Team Coordinator)

- One Management / Administration staff member.

How to Self-Assess?

The self assessment process is carried out by the self assessment teams over an average period of 9 – 10 months. During this period the team meet on a regular basis. Frequency of team meetings may vary from once a week (for one to two hours), to teams meeting for half a day once a month.

Whatever structure is employed it is necessary for a self assessment team to follow some key steps in the process. These areas are outlined here and discussed further below.

1. Knowledge of the self assessment process and their own role

2. Discussion

3. Planning the schedule of self assessment

4. Gathering evidence / triangulation of multiple sources of evidence

5. Completing the Guidance Assessment Improvement Tool – GAIT

6. Onsite documentation to support self assessment

7. Level of Achievement and Risk Rating.

8. Developing and monitoring Quality Improvement Plans (QIP) / Corrective and Preventative Action Plans (CAPA's).

1. Knowledge

Before beginning self assessment, each team member should have a good understanding and knowledge of their own role, and the aims and objectives of the self assessment process. The Quality Service User Safety (QSUS) team will provide specific education sessions for nominated Quality Champions / Trained Trainers, in each of the CHO areas. The Quality Champions / Trained Trainers will provide training and mentoring to the self assessment teams within their area. Individual self assessment team members should read all the Guidance and the checklists and be familiar with their contents. This will enable team members to get a clear understanding of what each area covers. The indicators and features will assist in explaining each aim.

2. Discussion

The main points that will need to be discussed and agreed during the initial self assessment team meeting include:

• Assigning a designated lead for each self assessment team.

• Agreeing the membership of the self assessment team (a record of attendance should be kept by each Lead).

• Agreeing a schedule and the timelines for a completed assessment.

• Setting the dates, times and venues for the meetings.

• Agreeing who will facilitate each meeting and input information into the Guidance Assessment Improvement Tool (GAIT) during the meetings.

• Agreeing where the documentation identified by the self assessment teams during their assessment will be stored within the GAIT system, to enable easy uploading and retrieval on GAIT.

After the initial self assessment team meeting further meetings are facilitated by the lead and these are used to review the evidence and complete the GAIT.

3. Planning the schedule of Self Assessment

In view of the size of the task in assessing against 60 indicators it is proposed that each service sets out a realistic plan to undertake and complete the assessment against the Guidance. The following table provides a summary of the number of Themes, Aims and Indicators associated with the HSE Best Practice Guidance for mental health services.

	Theme	No of Aims	No of Indicators
Theme1	Recovery Oriented Care and Support	8	16
Theme 2	Effective Care and Support	7	16 plus 6 supportive Checklists
Theme 3	Safe Care and Support	5	8
Theme 4	Leadership, Governance and Management	6	12
Theme 5	Workforce	4	8
Total		30	60, plus 6 Checklists

Table 1: Number of Themes, Aims & Indicators.

Overview of Assessment Process
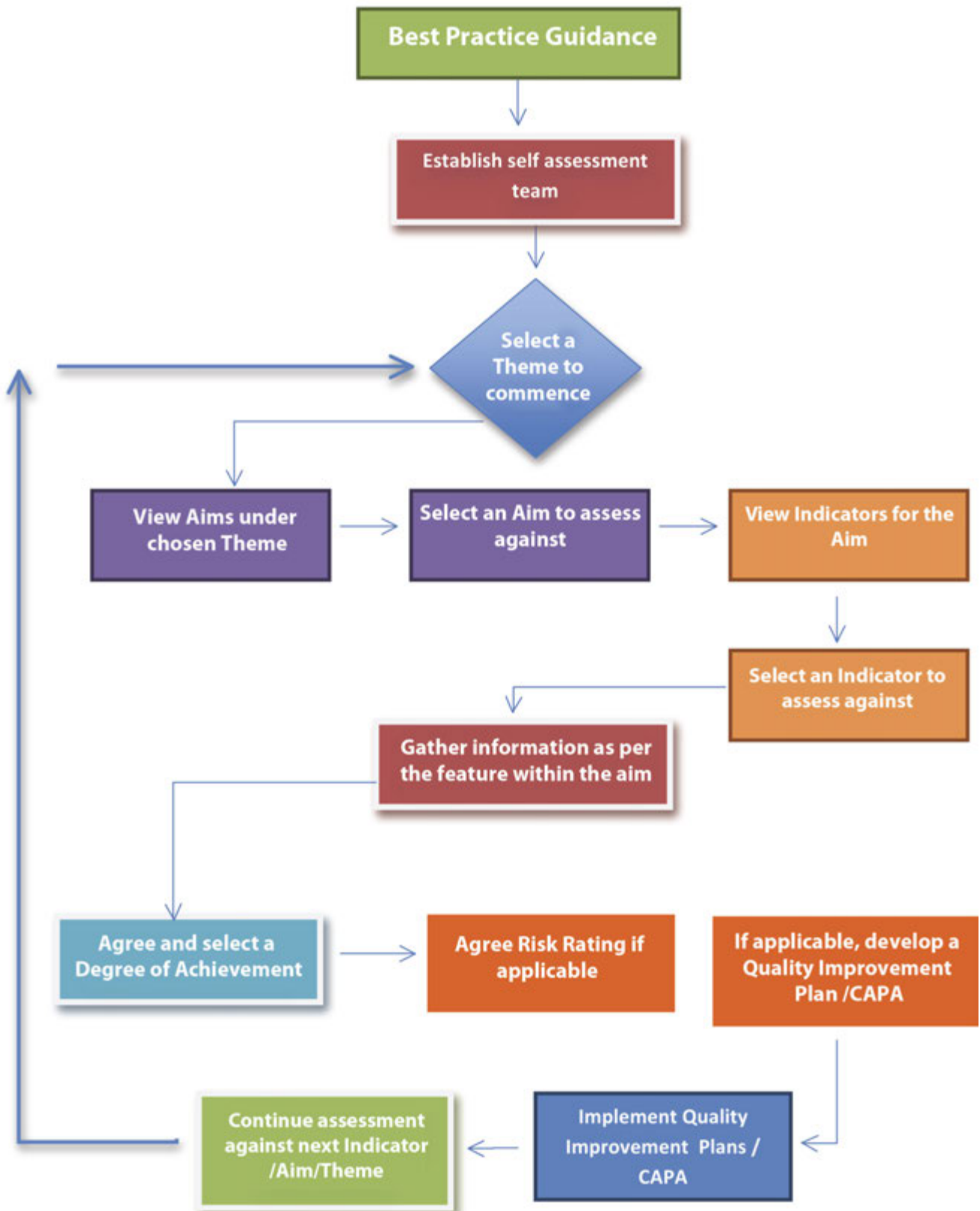
Figure 5: Overview of Assessment Process

4. Gathering evidence / triangulation of multiple sources of evidence

In conducting the self assessment, the team will make a determination of it's achievement with each of the indicators. In making a judgment on their level of achievement, the self assessment team will gather and analyse many sources of information to determine whether this judgement is supported by up to three separate sources of information, this process is known as triangulation. Sources of information can be a combination of available documentation, interviews and/or direct observation undertaken by the self assessment team. The key strengths in using triangulation are that multiple sources of information often give more information regarding the level of achievement.

On occasions where there is insufficient information available, a request for further information or clarification can be made to other members of the wider team or relevant service manager. Once it has been determined that there is enough information, the self assessment team agree the level of achievement.

Interview
➤ what is told to the self assessment team

Observation
➤ what is seen on site by the self assessment team

Documentation
➤ what is read

This means that the self assessment team triple check everything to see if what is observed, what is told to them, and what is documented links together. This is a process known as triangulation of evidence.
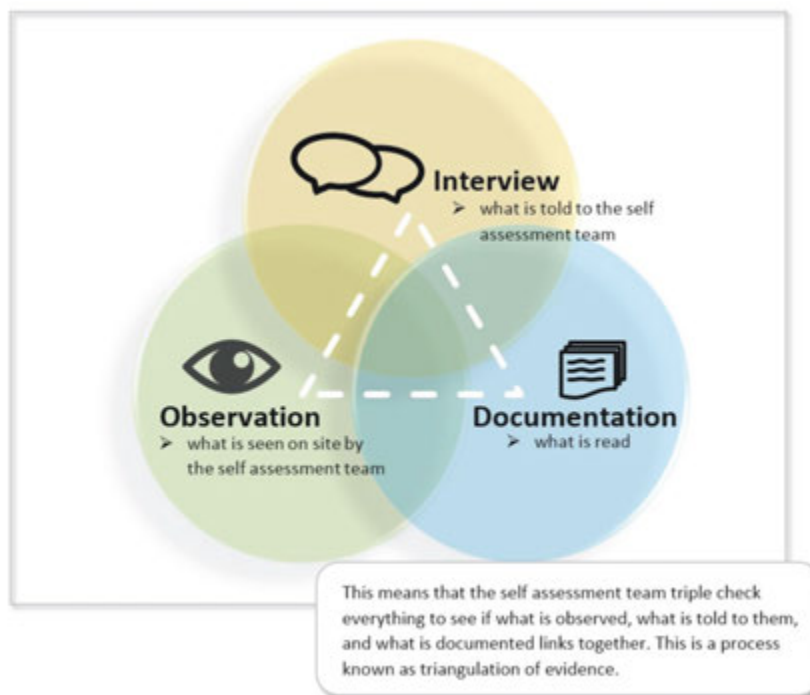
5. Completing the Guidance Assessment Improvement Tool – GAIT

To aid the introduction of the Best Practice Guidance, an information technology software framework has been developed by the QSUS office and the ICT projects office, to facilitate service self assessment. It is a web-enabled tool allowing each self–assessment team to record a rating against each indicator. The tool also supports the development and implementation of quality improvement plans and actions to address gaps identified during the assessment process. Each self assessment team records, maintains and monitors progress on the GAIT tool. This will help support regulatory compliance and the Mental Health Commission inspection process.

The tool will reflect the complete contents of the Best Practice Guidance along with all the accompanying checklists. It will enable discussion through management team meetings of each team's/service's level of completion and achievement, areas of good practice and opportunities for improvement. This will also support adhering to regulatory compliance and facilitate the Mental Health Inspection process.

6. Onsite documentation to support Self Assessment

Both during and upon completion of the self assessment process, each team will have access to the GAIT tool. This will enable teams to upload documentary evidence and to easily retrieve their evidence to support their level of achievement against the Guidance.

7. Level of Achievement and Risk Rating

The final stage of the self assessment process is the rating of the team's level of achievement and where applicable, the level of risk related to the indicator.

Rating Scale

The rating of an individual indicator is designed to assist self assessment teams and the service in general, to prioritise areas for improvement. To rate the degree of achievement against an indicator, the team must first ask itself what would constitute a 100% achievement of the indicator, i.e. what structures, processes and outcomes would have to exist for full achievement. The team must then determine what level of achievement they adhere to. The rating for the indicator can be determined based on the impact and the level of action that is required.

The self assessment team chooses a rating:

- Fully Achieved - **Green**
- Partially Achieved - **Yellow**
- Partially Achieved - **Amber**
- Not Achieved - **Red**

Assessment Rating Criteria:

Fully Achieved: Green
- The assessment demonstrates that the indicator is fully met.

Partially Achieved: Yellow
- The assessment demonstrates that some or most features of the indicator are met.
- The impact on people who use services, visitors or staff is low.
- The action required is minimal.

Partially Achieved: Amber
- The assessment demonstrates some or little of the indicator is met.
- The impact on people who use services, visitors or staff is medium.
- The action required is moderate.

Not Achieved: Red
- The assessment demonstrates that some or all of the indicator is not met.
- The impact on people who use services, visitors or staff is high.
- The action required is immediate.

Figure 6: Assessment Rating Criteria

Risk Assessment

Risk should be managed as an integrated part of the HSE's overall approach to quality improvement. The risk management process intertwines with the quality cycle in terms of risk assessment. Key to both quality improvement and risk management processes, are the identification of risks, agreeing improvement programmes to treat risks and on going monitoring and evaluation to manage the risks. Where a self assessment team has identified a level of achievement at **red**, it must consider the possibility of related risks with regard to the service user, staff or the service.

Where a self assessment team has identified a level of achievement at **amber**, the team may consider the possibility of related risks. To help identify these risks and prioritise those that are identified, the self assessment team carries out a risk rating.

Stage One involves making a determination of the impact of the event based on the failure to meet the indicator/s. To determine the impact of this harm should it occur, each risk area has been assigned descriptors over 5 levels ranging from negligible to extreme harm. In scoring impact, the anticipated outcome of the risk is grade from 1-5, with 5 indicating a more serious Impact.

The only area for self assessment teams to consider in relation to these risks within the risk impact table below is 'Compliance with Standards, statutory, clinical, professional and management).

	Negligible	Minor	Moderate	Major	Extreme
Injury	Adverse event leading to minor injury not requiring first aid. No impaired Psychosocial functioning	Minor injury or illness, first aid treatment required <3 days absence <3 days extended hospital stay Impaired psychosocial functioning greater than 3 days less than one month	Significant injury requiring medical treatment e.g. Fracture and/or counselling. Agency reportable, e.g. HSA, Gardaí (violent and aggressive acts). >3 Days absence 3-8 Days extended hospital Stay Impaired psychosocial functioning greater than one month less than six months	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling Impaired psychosocial functioning greater than six months	Incident leading to death or major permanent incapacity. Event which impacts on large number of patients or member of the public Permanent psychosocial functioning incapacity.
Service User Experience	Reduced quality of service user experience related to inadequate provision of information	Unsatisfactory service user experience related to less than optimal treatment and/or inadequate information, not being to talked to & treated as an equal; or not being treated with honesty, dignity & respect - readily resolvable	Unsatisfactory service user experience related to less than optimal treatment resulting in short term effects (less than 1 week)	Unsatisfactory service user experience related to poor treatment resulting in long term effects	Totally unsatisfactory service user outcome resulting in long term effects, or extremely poor experience of care provision
Compliance with Standards (Statutory, Clinical, Professional & Management)	Minor non compliance with internal standards. Small number of minor issues requiring improvement	Single failure to meet internal standards or follow protocol. Minor recommendations which can be easily addressed by local management	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards / Regulations (e.g. Mental Health, Child Care Act etc). Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.
Objectives/Projects	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over - run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Business Continuity	Interruption in a service which does not impact on the delivery of service user care or the ability to continue to provide service.	Short term disruption to service with minor impact on service user care.	Some disruption in service with unacceptable impact on service user care. Temporary loss of ability to provide service	Sustained loss of service which has serious impact on delivery of service user care or service resulting in major contingency plans being involved	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect.
Adverse publicity/ Reputation	Rumours, no media coverage. No public concerns voiced. Little effect on employees morale. No review/investigation necessary.	Local media coverage - short term. Some public concern. Minor effect on employees morale / public attitudes. Internal review necessary.	Local media – adverse publicity. Significant effect on employees morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/investigation necessary.	National media/ adverse publicity, less than 3 days. News stories & features in national papers. Local media – long term adverse publicity. Public confidence in the organisation undermined. HSE use of resources questioned. Minister may make comment. Possible questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken possible HSE review/investigation	National/International media/ adverse publicity, > than 3 days. Editorial follows days of news stories & features in National papers. Public confidence in the organisation undermined. HSE use of resources questioned. CEO's performance questioned. Calls for individual HSE officials to be sanctioned. Taoiseach/Minister forced to comment or intervene. Questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (independent) Inquiry.
Financial Loss (per local Context)	<€1k	€1k – €10k	€10k – €100k	€100k – €1m	>€1m
Environment	Nuisance Release.	On site release contained by organisation.	On site release contained by organisation.	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.)	Toxic release affecting off-site with detrimental effect requiring outside assistance.

Figure 7: HSE Risk Impact Table.

Stage Two of this process is to determine the likelihood of an event arising based on the failure to meet the indicator/s. The higher the likelihood score, the more urgent is the requirement for immediate action to be taken.

Rare/Remote (1)		Unlikely (2)		Possible (3)		Likely (4)		Almost Certain (5)	
Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability
Occurs every 5 years or more	1%	Occurs every 2-5 years	10%	Occurs every 1-2 years	50%	Bimonthly	75%	At least monthly	99%

Figure 8: HSE Risk Likelihood Table.

Stage Three involves plotting both the likelihood and impact scores on the Risk Matrix grid and to determine the rating of the risk being assessed in terms of a colour and a numerical score for the risk (e.g. a moderate impact 3 and a possible likelihood 3 will result in a rating of an amber 9).

- The high risks are scored between 15 and 25 and are coloured **Red**.

- Medium risk are scored between 6 and 12 and are coloured **Amber**.

- Low risks are scored between 1 and 5 and are coloured **Green**.

	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

Figure 9: HSE Risk Impact and Likelihood Table.

Stage Four requires the self assessment team to make decisions based on the outcome of the risk analysis regarding which risks require treatment and the priorities of that treatment. Depending on the risk rating and the adequacy of the current controls in place an evaluation is made whether to:

- accept the risk (A risk is called acceptable if it is not going to be treated) or

- treat the risk by: *i) Avoiding the risk,*

  ii) Transferring the risk or

  iii) Controlling the risk.

Criteria used to make decisions regarding accepting or treating the risk, should be consistent with the defined internal, external and risk management contexts and taking account of the service objectives and goals. The treatment of risks through a structured quality improvement process is a very powerful mechanism and one which is capable of targeting the quality programmes to areas of need in a prioritised way.

The self assessment team must enter the risk rating only into the GAIT.

8. Developing and monitoring Quality Improvement Plans / CAPAs

For service areas that have been identified as requiring improvement, it will be necessary for the self assessment team to develop a Quality Improvement Plan (QIP) / CAPA for the key areas that require improvement (as determined by the team) The QIP / CAPA document informs everyone in the service as to the direction, timeline, activities required and outcomes expected in addressing the quality deficit.

The steps involved in developing a QIP / CAPA action plan include:

- Firstly identifying areas for improvement in response to the self assessment

- Devising responsive action plans (Using the SMART methodology described below).

- Appointing a person to manage and monitor progress and follow-up on issues

- Setting a review date for evaluation/completion of the plan

- Recording and maintaining plans and responses monitored on the GAIT tool.

- Escalating outstanding QIPs to the management teams – detailing their level of completion.

In developing a quality improvement plan, the following SMART methodology should be considered.

S — **Specific goal** — What exactly is it you want to achieve?

M — **Measurable** — How you can measure and track the progress of the goal?

A — **Attainable** — Is it attainable in the given timeframe?

R — **Realistic** — Is the project small enough to finish it in the specified time frame? Is it something you want to do that will improve things for you?

T — **Time** — When will the action be completed? (an actual date is required).

A named person is identified with responsibility for the completion of each action.

Figure 10: SMART Methodology.

The Quality Cycle – developed by W. Edwards Deming in the 1950's

Tools such as the 'Plan, Do, Check, Act (PDCA)' cycle can be a useful resource in determining and implementing required actions from Quality Improvement Plans.

The Plan Do Check Act (PDCA) cycle or quality cycle is an important improvement model based on four stages which ensure a structured approach to the improvement of quality. The PDCA cycle can be used for every quality activity/initiative/ project that is undertaken to help ensure that the best possible results are achieved. The underlying principle of the cycle is that an activity is not complete until evaluation shows that it has been effective. Following in the spirit of continuous quality improvement, the process utilises this evaluation for even greater improvement.

Figure 11: Quality Cycle - PDCA

THE BEST PRACTICE GUIDANCE

3

THEME 1

RECOVERY ORIENTED CARE & SUPPORT

Theme 1
Recovery Oriented Care & Support

Aim 1

The planning, design and delivery of services are informed by service users' identified needs.

Indicator 1.1

Service users, family and carers are supported to be involved in the governance of mental health services.

These are the features you need to have in place to meet the indicator.

1. There are policies and procedures in place relating to engaging service users, family and carers in the governance of the mental health service *(HSE Code of Governance, 2015)*.

2. The policies and procedures relating to engaging service users, family and carers in the governance of the mental health service are implemented.

3. There are policies and procedures in place to actively involve service users, family and carers in planning, service delivery, evaluation at all levels (e.g. satisfaction surveys, interviews, focus groups, advocacy networks, service user participation in evaluation of services), including specific approaches to involve marginalised groups. All responses from service users, family and carers are kept confidential and the appropriate consent is obtained.

4. Terms of reference are in place, which describe the responsibilities of committees and boards for partnering with service users, family and carers.

5. Relevant documentation from committees and meetings reflect service user, family and carers' representation and involvement in governance activities. All responses from service users, family and carers are kept confidential and the appropriate consent is obtained.

6. An Area Lead for Service User, Family and Carer Engagement is appointed to the Area Mental Health Management Team in each Community Health Organisation (CHO) area.

7. An appropriate number of local fora are in place to involve service users, family and carers. The meetings should be at least every three months and the venue agreed.

8. Each service user, family and carer forum has clear terms of reference.

9. Minutes from service user, family and carer fora are provided to the Area Mental Health management team and responses and actions are documented with all documentation treated confidentially.

10. There is a process for analysing engagement with service users, family, and carers.

11. Financial and physical resources are provided to support service users, family and carers to participate and input at governance level, as per the payment scheme for reimbursement of service users, family members and carers, within the mental health division, as applicable.

12. Service users, family and carers have access to previously published Mental Health Commission inspection reports (Copies are available in the service area).

13. A dedicated time and location are made available to service users, family and carers to speak to the Mental Health Inspectorate while they are on inspection. There is a collaborative approach to this.

14. Where there are Peer Support Workers, these are employed in accordance with contracts of employment and job descriptions.

15. Training is available for those service users, family and carers involved in governance.

16. There is evidence of both local service management and the CHO senior management team meeting directly with service user, family and carer fora, where necessary.

17. There is evidence of communication of responses and actions by management from matters arising from any engagement with service users, family and carer fora.

Indicator 1.2

The service establishes mechanisms for engaging service users, family and carers in strategic and operational planning and design.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place which describe the role of service users, family and carers in strategic and operational planning and design.

2. The policies and procedures on the role of service users, family and carers in strategic and operational planning and design are implemented.

3. There is documented evidence of regular collaboration (minimum quarterly) between the Area Lead of Service User, Family and Carer Engagement and the Head of Mental Health Services.

4. There are policies and procedures in place in relation to working with families and carers, incorporating, confidentiality and consent.

5. These policies and procedures are implemented.

6. There is service user involvement in the co-production/co-designing any service design or reconfigurations:

   - Minutes of meetings reflect attendance and input into design meetings, planning, co-production of strategies and policy.

7. All documentation provided to service users, family and carers is in a clear and understandable format with glossaries provided as required.

8. Committee terms of reference, membership, selection criteria, papers and minutes demonstrate service user, family and carer engagement in strategic and operational planning.

9. Training is provided for service users, family and carers and staff participating in meaningful engagement.

Indicator 1.3

Service users, family and carers are partners in the planning of their treatment, including but not limited to, areas of consent[1], capacity, choice, rights and responsibilities.

These are the features you need to have in place to meet the indicator.

1. The human and legal rights of all service users are upheld.

2. The service user is involved in all aspects of his/her assessment, treatment, care and recovery planning, (e.g. Wellness Recovery Action Planning – (WRAP), Individual Care Planning (ICP), including discharge planning.

3. The best interest of the person should be the principal consideration with due regard given to the interests of other persons particularly where risk exists.

4. The mental health service, with the service user's informed consent[2] includes family and carers, other service providers and others nominated by the service users in their assessment.

5. Subject to service user consent, on-going information is provided to service users, family and carers about proposed treatment in a manner which meets the service users' assessed wishes.

6. Up to date written information is available regarding organisations that are present in the community to support the recovery process, as set out in the service users discharge plan. This includes information on advocacy services[3].

7. Where peer supports are available and appropriate the service user is informed and an appointment is offered to them to discuss their recovery plan.

8. Completed consent forms by service users demonstrate informed consent.

9. The views of service users, and the history of previous treatment is considered and documented prior to administration of new medication and/or other technologies.

10. The treatment and support provided, where applicable, is developed and evaluated collaboratively with the service users, family and carers. This is documented in the ICP.

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1. *Health Service Executive National Consent Policy, 2013*
2. *Same as above*
3. *Section 20(1)(d) Mental Health Act 2001 (Approved Centre) Regulations 2006*

11. Attendance at planning meetings and consultation is documented. (e.g. this is recorded in the service user experience forms). In the event that the service user cannot or refuses to attend a meeting, this is documented.

12. Feedback from service users, family and carers is used to improve the experience for service users.

13. Service user fora are regularly facilitated in the centre/service.

Aim 2

Admissions, transfers and discharges are timely and appropriate and based on service users' assessed needs.

Indicator 2.1

Admissions, transfers and discharges are in line with best available practice and where relevant, legislation, Regulations and Codes of Practice[4].

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place for admissions, transfers, discharge and temporary absence of service users. Where applicable, this is in accordance with the *Mental Health Commission Code of Practice on Admission, Transfer and Discharge* to and from an Approved Centre; *2010 with Regulation 28 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Transfer of Residents, and the Mental Health Commission Code of Practice relating to Admission of Children under the Mental Health Act 2001. HSE Policy on Transfer to and Admission to an Approved Centre S20,21&22 MHA, 2001.*

2. The policies and procedures are implemented.

3. The policies and procedures details the referral processes for the service, including the processes for planned, urgent and self-referrals.

4. Relevant staff have read and understand the policies and procedures on admissions, transfers and discharge.

5. Relevant staff can articulate the processes as set out in the policies.

6. The service is monitoring the implementation of the policies.

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4. Section 14 Mental Health Act, 2001; Section 21 Mental Health Act 2001; Section 22 Mental Health Act, 2001; Section 28 Mental Health Act 2001; Regulation 18 of (Approved Centres) Regulations 2006 (Transfer of Residents) Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

Mental Health Commission Code of Practice on Admission of Children under the Mental Health Act 2001

Admissions

7. Admissions[5] to the service are in accordance with the statement of purpose and the admissions policy and takes account of the legal provisions in the Mental Health Act, (2001).

8. No person under the age of 18 years is admitted to an adult service, or other adult service (save by order of the District Court or in exceptional circumstances).

9. In the exceptional circumstances where children are admitted to an adult unit, the rationale and action taken to locate an alternative arrangement is recorded. Daily input from the young adult or CAMHS team in the service users clinical file.

10. If, in exceptional circumstances, the admission of a person under the age of 18 years to an adult service occurs, the service submits a detailed report to the Mental Health Commission outlining why the admission has taken place, in accordance with the *Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act (2001)* (and completion of the associated clinical practice form within this section).

11. The admissions process[6] considers the wishes, needs and safety of the individual and the safety of other service users currently in the service.

12. If a child (any person under the age of 18, unless married)[7] has been admitted for care and treatment, consent[8] to the admission and treatment is documented.

13. The entry process for planned and unplanned admissions to the mental health service is a defined pathway with service specific entry points that meet the needs of the service user.

14. Admissions to the service are planned, in so far as is possible, through engagement with the service user and relevant stakeholders in a pre-admission process. This includes a pre-admission assessment and plan.

15. Family and carers are involved in the admission process, where appropriate. Families of service users who may require involuntary admission under the *Mental Health Act 2001*, are informed of the availability of Authorised Officers to complete the required forms.

16. On admission to the service, the service user[9] is provided with a written agreement of the terms on which they shall access the service. The agreement sets out the services to be provided and the fees to be included, if applicable. This agreement is reviewed regularly.

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5. *Section 14 Mental Health Act, 2001 (as amended)*
6. *Section 25 Mental Health Act, 2001 (as amended); Child Care Act, 1991 (as amended); Health Service Executive National Consent Policy; Mental Health Commission Code of Practice on Admission of Children under the Mental Health Act 2001*
7. *Child and Adolescent Mental Health Services (CAMHS) Standard Operating Procedure*
8. *Section 25 Mental Health Act, 2001 (as amended); Child Care Act, 1991 (as amended); Health Service Executive National Consent Policy*
9. *Mental Health Commission Statutory Forms*

17. Records show that admission[10] to the mental health service is efficient with minimised delay; in accordance with *the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre 2009; with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 18 Transfer of Residents, the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act (2001) and the Memorandum of Understanding between An Gardaí Síochána and the Health Service Executive.*

18. Assisted admissions[11] are in accordance with the service level agreement and HSE Policy on Assisted Admissions.

19. A key worker is assigned to each service user in accordance with Vision for Change (2006) and the *Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre 2009.*

20. Evidence of a physical examination is documented at the time of the admission.

Transfers

21. At a minimum, the policies and procedures in relation to the transfer of service users includes:

- The roles and responsibilities for to the service user transfer process, including the responsibility of the service's multi-disciplinary team and the service users' key worker.
- The planning and management of the service user transfer process in a safe and timely manner, including controls to ensure the continuity of care.
- The criteria for transfer.
- The process for making a decision to transfer to, or from, the service.
- The interagency involvement in transfer process.
- The communication requirements with the receiving facility including the provision of all relevant information about the service user.
- The service user assessment requirements prior to transfer from the service, including assessment of the service user risk.
- The process for managing service user medications during transfer from the service.
- The service user and/or their representative's involvement in, and consent to, the transfer process.
- The process for ensuring service user privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- The process for managing service user property during the transfer process.
- The process for managing the transfer of the service user when he/she is involuntarily detained under the MHA (2001), as amended.
- The process for emergency transfers.
- The processes for ensuring the safety of the service user and staff during the service user transfer process.
- The record keeping and documentation requirements for the service user transfer process.

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0. Section 14 Mental Health Act, 2001 (as amended)
11. Section 63 of the Health Miscellaneous Provisions Act 2009 (Assisted Admissions)

22. Documentation that supports verbal and written communication with the receiving facility is available, including agreement of service user receipt prior to transfer. Verbal communication and liaison takes place between the service and the receiving facility prior to the transfer taking place. These shall include a discussion of:

- the reasons for transfer;
- the service user care and treatment plan (including needs and risk); and
- if the service user requires accompaniment on transfer

23. Transfers are in accordance with the Statement of Purpose, the service admissions, transfers and discharge policy and takes into account the provisions in the Mental Health Act 2001.

24. Where a service user is transferred[12] (including emergency transfers), from a centre / service to or from another centre / service hospital or other place all relevant information is provided to the receiving centre / service, hospital or other place and records of this are maintained. This information is sent in advance[13], or at least accompanies the service user upon transfer, to a named individual.

25. The following information is issued (with copies retained) as part of the transfer of service user documentation;

- letter of referral, including a list of current medications;
- service user transfer form; and
- required medication for the service user during the transfer process.

26. In the case of an emergency transfer, communications between the service and the receiving facility are documented and followed up with a written referral in a timely period.

27. Checklists are completed by the service to ensure comprehensive service user records have been transferred to the receiving facility.

28. Copies of all records relevant to the service user transfer process are retained in the service user's clinical file.

29. A log of transfers is maintained and reviewed, to ensure relevant information is provided.

30. Systematic review and analysis is completed of each transfer to identify opportunities to improve information provision during transfers. This is documented.

31. An assessment of the service user is completed prior to the transfer including individual risk assessment relating to the transfer and the service user needs. This is documented and provided to the receiving facility/service[14].

32. The service where a person is transferred[15] to, is suitable in meeting the needs of the service user.

33. The decision to transfer the service user is discussed with the service user and with the receiving service prior to the transfer taking place.

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12. Section 22 Mental Health Act, 2001 (as amended)
13. Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (as amended) 2010
14. As above
15. Sections 20 – 22 of Mental Health Act, 2001 (as amended)

34. Documented consent of the service user to transfer is evident or a justification as to why consent was not received are recorded.

Discharge

35. The service user's discharge plan is commenced on admission and is included in their individual care plan upon transfer.

36. The discharge plan is developed in consultation with the service user and, where consent has been given, with their family and carer.

37. A comprehensive pre-discharge assessment is carried out by the multi-disciplinary team prior to discharge. This assessment is completed in conjunction with the service user.

38. General Practitioners/Primary Care Teams and/or community mental health services are informed of the discharge of a service user within 24 hours.

39. When a service user is discharged[16], a discharge summary is sent to the General Practitioner/Primary Care Team/community mental health services responsible for follow up care within 3 days of discharge.

40. If this is not practicable, a preliminary discharge summary (and prescription information) may be sent initially, followed by a comprehensive discharge summary within 14 days.

41. Discharge summaries are compiled in accordance with the Mental Health Commission Code of Practice on Admissions, Transfer and Discharge to and from a Service, (See Appendix 4).

42. Every effort should be made to identify the support needs of the family/carer, where appropriate, prior to discharge.

43. Comprehensive information is provided by the key-worker to the service user and his/her family/carer and/or chosen advocate, with the service users consent, in plain, understandable language upon discharge, which includes: contact details of community mental health services; details of how to access these services; contact details of other support services such as advocacy services; relevant voluntary organisations; relevant community groups and supported employment services; a crisis point of contact and details of how to re-access inpatient services (including during out of hours).

44. Services provide the service user and family, where appropriate with the consent of the service user, with a minimum of 2 days' notice of discharge. If this does not occur the reasons for it should be clearly documented in the service user clinical file.

45. A defined process is in place to return property to service users in accordance with the regulations.

46. A follow up appointment is made with the service user, post discharge based on the service user's needs and an assessment of risk by the supporting community mental health service team.

47. Delays to discharges are reviewed on at least a weekly basis.

48. A process is in place to monitor and manage delayed discharges.

17. Regulation 8 of Mental Health Act 2001 (Approved Centre) Regulations 2006, Residents Personal Property and Possessions.

Information is available from the service about how to access mental health care from a 24-hour/ seven days a week, public mental health service, or alternative mental health services.

These are the features you need to have in place to meet the indicator:

1.   The pathways for access to a 24-hour seven days a week, mental health service, are clearly defined.

2.   Brochures and posters including information about how to contact mental health services are available, in languages, as needed.

3.   Information is provided to the public, service users, family and carers on what services are available, how they work, and how to access them, especially in a crisis. This includes information for minority groups. This information is included on the mental health service website, with links to relevant options. (e.g. www.yourmentalhealth.ie)

4.   The mental health service promotes equality in accessing a service, regardless of the service user gender, marital status, family status, sexual orientation, religion, age, disability, ethnicity, membership of the traveller community or social class.

5.   There is an identified community team coordinator who is a contact for the General Practitioner.

6.   Information on the range of services are available such as:

    •   Liaison Psychiatry in the Emergency Department.
    •   Self harm liaison nurses in the Emergency Department, seven days a week, for extended hours.
    •   Suicide Crisis Assessment Nurses (SCAN), available to General Practitioners.
    •   Authorised Officers, available to families.

7.   There is a defined process for emergency admissions in place in accordance with the Mental Health Commission Code of Practice for Admission, Transfer and Discharge (2010).

8.   There are joint protocols for emergency admissions between adult and child services, demonstrating collaborative working, in accordance with HSE policy and CAMHS standard operating procedure.

9.   Data on waiting times to access the mental health service is analysed and strategies are developed and implemented to reduce the waiting times for service users and improve ease of access to services. All information is maintained confidentially and data is secured to prevent data breaches.

10.   Technology is used to improve access to services; this includes data bases, mobile phone text/email appointments, skype and video technologies in accordance with HSE Electronic Communications Policy and service user preferences.

11.   The mental health service analyses information and data to improve attendance, (including discharge metrics, and non-attendance data at clinics and appointments with any team member).

12. The service maintains a record of non-admissions and the reason for non-admissions, as well as the follow up action that was taken for those who were not admitted. This is maintained in accordance with the *HSE Records Retention Policy (2013) and Regulation 27 of Mental Health Act 2001 (Approved Centres) Regulations 2006.*

13. There are procedures in place to expedite service users through the Emergency Department, based on the service user's clinical assessed needs.

Indicator 2.3

The mental health service provides ease of physical access, with special attention given to those with physical disabilities and/or reliance on public transport[18], (in conjunction with Theme 2- effective care and support, indicator 5.1 - Premises)

These are the features you need to have in place to meet the indicator:

1. The mental health service is located in accessible premises, where applicable.

2. Part M Building Regulations (2000) "access for people with disabilities" are complied with. Other legislation including *Safety Health and Welfare at Work Act 1989/2005, the Employment Equality Act 1998/2004, the Equal Status Act 2000-2004, the Disability Act 2005* are complied with.

3. The four main dimensions of access are reviewed and evaluated and include:

- Physical access- for people requiring the use of wheelchairs or walking aids, the provision of handrails, ramps, lifts and lowered counters.

- Sensory access- for people with hearing and visual impairment, tactile markings, signs and labels, hearing augmentation listening systems, audio cues for lifts and lights.

- Communication access- for people who have difficulty with the written word, vision speech and language problems and those who do not speak English.

- Cognitive access- for people who have impaired awareness perception, reasoning and judgement.

4. The service consults with people from ethnic minority groups regarding cultural factors in the built environment, if appropriate.

5. The dementia specific care setting has a design and layout that encourages and aids independence, including appropriate signage, use of colours, sensory stimuli, own personalised space and lighting in accordance with best practice dementia care principles.

6. Service users with a disability are consulted about the design of new premises, if appropriate.

7. Available public transport options to access individual services and directions are detailed on the mental health service website and on notice boards in relevant areas.

18. *Regulation 22 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Premises*

Aim 3

Service users experience care which values them, respects his or her diversity and protects his or her rights

Indicator 3.1

The service ensures that service users are valued, his or her rights are protected and diversity is respected.

These are the features you need to have in place to meet the indicator:

1. The mental health services' values are clearly defined, articulated and reflected in practice.

2. The service user is consulted regarding their individual values and staff respond sensitively, as appropriate.

3. The service user has access to the HSE Charter of Rights. This is available and on display for the service user to access.

4. The service user is aware of the HSE Charter of Rights.

5. The service user has access to an advocacy service to support them to understand his or her rights and responsibilities.

6. The service user has access to an interpreter service, where necessary, to support them to understand his or her rights and responsibilities.

7. The involuntary service user is provided with information on the involuntary admission process and is supported to read and understand the contents at an appropriate time. This includes the information as specified by the Mental Health Commission, in accordance with *Section 16 Mental Health Act (2001)*.

8. Information is available to service users, family, carers, GP, Gardaí, etc. on the involuntary admission process, including the assisted admission process, if applicable.

9. Cultural awareness training is provided to staff, as necessary.

10. Accessible information about involuntary admission and rights is delivered in context, and is repeated as required, to service users, family and carers e.g. the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2009

11. Recovery approaches are encouraged to support service users to be involved in the assessment and management of risk, and to take positive and therapeutic risks within their day to day lives. This is in accordance with the HSE Risk Management in Mental Health Services Policy.

19. Regulation 20 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Provision of Information to Services Users
20. Section 16 Mental Health Act, 2001 (as amended)

Personal Property and Possessions[21]

12. There are written operational policies and procedures on service user's personal property and possessions, in accordance with of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 8 Residents Personal Property and Possessions.

13. At a minimum, the policies and procedures on personal property and possessions includes:

- The roles and responsibilities of the service to support service users to manage his or her personal property and possessions.
- The communications with the service user, and his or her representatives, regarding the service users' entitlement to bring personal property and possessions into the service at admission and on an ongoing basis.
- The process to record, secure and manage the personal property and possessions of the service user, including money.
- The process to allow a service user access to, and control over, his or her personal property and possessions, unless this poses a danger to the service user, or others, as indicated under an individual risk assessment and the service user's individual care plan.

14. Relevant staff are recorded as having read and understood the policies and procedures on service users' personal property and possessions.

15. Relevant staff can articulate the processes for service users' personal property and possessions as set out in the policy.

16. A record is maintained of each service users' personal property and possessions and is available to the service user in accordance with the service's written policy.

17. A signed property checklist is maintained of service user's property, detailing each service users personal property and possessions.

18. The property checklist is kept separate to the service user individual care plan, in accordance with of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 8 Residents Personal Property and Possessions.

19. Service users are provided with clothing[22] where they do not have an adequate supply. Night clothes are not worn during the day, unless this is specified in the care plan, in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 7 Clothing. (Such clothing should be individually labelled).

20. Service users retain control over their own personal property and possessions except under circumstances where this poses a danger to the service user or others, as indicated by the service users' individual care plan.

21. The service user's personal property and possessions are maintained safely when the centre assumes responsibility for it.

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21. Regulation 8 Mental Health Act 2001 (Approved Centres) Regulations 2006, Residents Personal Property and Possessions
22. Regulation 7 of the Mental Health Act 2001 (Approved Centre) Regulations 2006, Clothing

22. Secure facilities are provided for the safe-keeping of the service user's monies, valuables, personal property and possessions, as necessary.

23. The service user is entitled to bring personal possessions with him/her, the extent of which is agreed at admission.

24. The access to and use of service user monies is overseen by two members of staff and the service user or their representative.

25. Where any money belonging to the service user is handled by staff, signed records of the staff issuing the money is retained. Where possible, this is counter-signed by the service user or their representative.

26. Service users are supported to manage his or her own property, unless this poses a danger to the service user or others as indicated in their individual care plan.

27. Personal property logs are monitored.

28. Analysis is completed to identify opportunities to improve the processes for service users' personal property and possessions. This is documented.

Religion[23]

29. Service users are facilitated, in so far as is reasonably practicable, in the practice of their religion, in accordance with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 10 Religion*.

30. There is a policy and procedures on the practice of religion, and at a minimum the policy and procedures includes:

- Identifying the service user' religious beliefs.
- The roles and responsibilities in relation to the support of service user' religious practices.
- Facilitating service users in the practice of his or her religion, insofar as is practicable.
- Respecting religious beliefs during the provision of services, care and treatment.
- Respecting a service users' religious beliefs and values within the routines of daily living, including service user choice regarding his or her involvement in religious practice.

31. Relevant staff are recorded as having read and understood the policies and procedures on religion.

32. Relevant staff can articulate the processes for facilitating service users in the practice of his or her religion as set out in the policies and in the service users' Integrated Care Plan.

33. The implementation of the policy and procedures to support service users' religious practices is reviewed to ensure it reflect the identified needs of the service user. This is documented.

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23. *Regulation 10 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Religion*

34. Implementation of the policies and procedures includes:

- Service users' rights to practice religion are facilitated within the service insofar as is practicable.

- There are facilities provided within the service for service users' religious practices, insofar as is practicable.

- Service users have access to their nominated spiritual representative (e.g. a Cleric. Imam, Minister, Pastor, Priest, Rabbi or other).

- Service users have access to local religious services and are supported to attend, if deemed appropriate following a risk assessment.

- Care and services that are provided within the service are respectful of the service users' religious beliefs and values.

- Any specific religious requirements relating to the provision of services, care and treatment are clearly documented.

- The service user is facilitated to observe or abstain from religious practice in accordance with his/her wishes.

Searches[24]

35. There are written operational policies and procedures in place on the searching of a service user, his or her belongings and the environment in which he/she is accommodated and with the consent of the service user, in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 13, Searches.

36. At a minimum, the policies and procedures includes:

- The management and application of searches of a service user, his or her belongings and the environment in which he or she is accommodated.

- The consent requirements of a service user regarding searches and the process for carrying out searches in the absence of consent.

- The process following the finding of illicit substances during a search, including as appropriate Garda liaison and /or assistance.

- The roles and responsibilities in relation to the implementation of service user searches.

- The application of individual risk assessment in relation to service user searches.

- The processes for communicating the service's search policies and procedures to service users and staff.

- The processes for informing the service user being searched of what is happening and why.

- The considerations to be provided to the service user in relation to his or her dignity, privacy and gender during searches.

- The requirement to record searches, including the reason for the search and the outcome of the search.

24. *Regulation 13 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Searches*

37. Consent is sought prior to all searches. The request for consent and the received consent is documented for every search of a service user and every property search.

38. General written consent may be sought on admission for routine environmental searches.

39. Where consent has not been received, this is documented and the policies and procedures relating to searches without consent are implemented.

40. The policies and procedures on searching are implemented. An audit is carried on a six-monthly basis to ensure that the policies and procedure is adhered to.

41. Relevant staff have read and understand the policies and procedure on searches. This is documented.

42. Relevant staff can articulate the searching process as set out in the policy.

43. Service users are aware of the policies and procedures on searching. This is communicated to all service users.

44. There is a minimum of two appropriately qualified staff in attendance when searches are being conducted.

45. Searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the service user and staff and following a risk assessment.

46. Risk is assessed prior to a search of a service users, their property or the environment, appropriate to the type of search being undertaken.

47. Where a service user is required to be searched, he /she is informed of what is happening and why.

48. All searches are undertaken with due regard to the service users' dignity, privacy and gender. At least one of the staff members conducting the search is the same gender as the service user being searched.

49. A written record is maintained of each search carried out (including property searches) and includes the reason for the search and the names of both staff members who undertook the search and details of who was in attendance for the search.

50. Each search record is systematically reviewed to ensure the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 13 Searches have been complied with. Analysis is completed to identify opportunities for improvement of search processes. This is documented.

51. A log of searches is maintained and a systematic review of the data is undertaken to ensure the requirements of the regulation on searches is complied with. An analysis is conducted and documented to identify opportunities for learning and improvement.

52. The centre has written operational policies and procedures in relation to the finding of illicit substances and procedures for Garda involvement, if appropriate. This is implemented, as required. Staff have read and understood the policy and this is recorded.

Systems are in place to support service users who are at risk of not understanding their rights

These are the features you need to have in place to meet the indicator:

1.   A register of interpreters and support services are available to the workforce, service users, family and carers, in accordance with of *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 20 (d), Details of Relevant Advocacy and Voluntary Agencies are Provided.*

2.   The services user is supported and encouraged to contact advocacy services.

3.   A copy of the Mental Health Commission "Your Guide to the Mental Health Act 2001" is available to the service user, in an understandable form and language.

4.   The service user is informed as to how information is shared about them.

5.   The service user's right to privacy is respected and the duty of confidentiality upheld.

6.   Personal information regarding the service user is not communicated to a third party e.g. family, carer, advocate, health professional in another health care setting or outside agency, without the service user's consent, unless the service user poses a significant risk of harm to themselves, another person or society and duty of care requires this information to be shared.

7.   The service user's clinical records reflect assessment of need including risk and the interventions and support provided.

Indicator 3.3

Service users, family and carers have the right to independently determine who will represent their views to the Mental Health Service.

These are the features you need to have in place to meet the indicator:

1.   Written information about access to a range of independent advocacy services is available in brochures and on posters throughout the service, in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 20, (d) details of relevant advocacy and voluntary agencies is provided.

2.   Service users are able to access peer support workers, if employed in the relevant area.

3.   Job descriptions are in place for peer support workers outlining accountabilities and confidentiality requirements to service users and to the mental health service.

4.   The service user's records demonstrate that he/she has independently determined who will represent his/her views.

5.   The mental health service has properly informed the Mental Health Commission of service users who have been involuntarily detained.

6.   The Mental Health Commission has appointed a lawyer for the service user if involuntarily detained under the Mental Health Act (2001).

Indicator 3.4

Mental Health Services cooperate fully with Mental Health Tribunals[25] (Adult Services only)

These are the features you need to have in place to meet the indicator:

1. There are written policies and procedures available in relation to the facilitation of Mental Health Tribunals.

2. At a minimum, the policies and procedures includes:

> • The roles and responsibilities in relation to Mental Health Tribunals relevant to the service.
>
> • The relevant legislative requirements in relation to Tribunals.
>
> • The provision of information to the service user regarding the Mental Health Tribunals.
>
> • The communication processes between the service and external parties involved in the Mental Health Tribunals.
>
> • The resources and facilities provided by the service to support service users attending a Mental Health Tribunal, including the availability of staff to attend a Tribunal, as necessary.

3. Relevant staff have read and understood the policies and procedures relating to Mental Health Tribunals and this is documented.

4. Relevant staff can articulate the policies and procedures for facilitating Mental Health Tribunals.

5. The implementation of the policies and procedures in relation to facilitating Mental Health Tribunals is monitored, to ensure that the rights and needs of the service user are appropriately supported.

6. Analysis is completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.

7. The service provides private facilities to support the Mental Health Tribunal process.

8. The service provides adequate resources to support the local Mental Health Tribunal process.

9. Staff attend Mental Health Tribunals and provide assistance, as necessary, when the service user requires assistance to attend or participate in the process.

10. Staff provide support to the service user after the tribunal outcome is known.

25. Section 18 of Mental Health Act, 2001 (as amended)
Regulation 30 of Mental Health Act 2001 (Approved Centres) Regulations 2006, Mental Health Tribunals

The mental health service supports and promotes opportunities to enhance service users' positive social connections[26] with family, children, friends and their community.

These are the features you need to have in place to meet the indicator:

1. There is a mission statement which identifies recovery processes and outcomes, which is developed in consultation with service users, family, carers, and staff.

2. There is access to inpatient and community fora, peer support groups, family and carer member peer groups. Information from interactions with service users is maintained confidentially.

3. Multi-disciplinary teams encourage referrals and access to peer support workers and peer support services, where available.

4. Information is provided to staff, service users, family and carers about the range of support networks that are available in the community (e.g. peer support services, services outside mainstream mental health services, local day services and educational institution and recovery colleges).

5. The service user's care plan includes actions to increase social inclusion and participation in local and community groups. This includes mainstream social inclusion activities and supports.

6. Appropriate arrangements are made for service users to receive visitors, in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 11 Visits, having regard to:

   • The nature and purpose of the visit.

   • The needs of the service user.

   • Reasonable times are identified during which a service user may receive visits.

   • All reasonable steps to ensure the safety of service users and visitors.

   • The freedom of a service user to receive visits and the privacy of a service user during visits are respected, in so far as is practicable, unless indicated otherwise in the service user's individual care plan.

   • Appropriate arrangements and facilities are in place for children visiting a service user.

   • Ensuring that children visiting are always accompanied, to ensure their safety and ensuring that this is communicated publicly.

7. Written operational policies and procedures are available in relation to visits.

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26. Regulation 11 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 , Visits

8. At a minimum, the policies and procedures include:

> • The process for restricting visitors is based on a service user's request, an identified risk to service users, an identified risk to others or an identified health and safety risk.
>
> • The availability of appropriate locations for service user visits.
>
> • The arrangements and appropriate facilities for children visiting a service user
>
> • The required visitor identification methods.

9. Relevant staff have read and understood the policies and procedures on visits and this is documented.

10. Relevant staff can articulate the policies and procedures for visits.

11. The implementation of the policy on visits is reviewed to ensure it is appropriate to the identified needs of service user.

12. Restrictions on service user's rights to receive visitors is monitored and reviewed on an ongoing basis.

13. Analysis is completed to identify opportunities to improve visiting processes.

14. Visiting times are appropriate and reasonable and are publicly displayed.

15. Justifications for visiting restrictions are documented in the service user's clinical file.

16. The clinical file documents the names of the visitors the service user does not wish to see and those who pose a risk to the service user.

17. A separate visitor's room or visiting area is provided where service users can meet with visitors in private (unless there is an identified risk to the service user, an identified risk to other or a health and safety risk.)

18. Appropriate steps are taken to ensure the safety of service users and visitors during visits.

Aim 4

Service users are enabled to participate[27] in making informed decisions about their care.

Indicator 4.1

Mechanisms are in place to provide information to service users and to align the information provided to service users with their capacity to understand.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place within the service that provide ongoing information to service users.

2. At a minimum, the policies and procedures include:

   - The roles and responsibilities for the provision of information to service users.

   - The information provided to service users at admission.

   - The information provided to service users on an ongoing basis.

   - The process for identifying the service users' preferred ways of receiving and giving information. The methods for providing information to service users with specific communication needs.

   - The interpreter and translation services available within the service.

   - The process in place to manage the provision of information to service user representatives, family and next-of-kin, as appropriate.

   - The advocacy arrangements.

3. The policies and procedures on providing ongoing information to service users are implemented.

4. All staff have read and understand the policy on the provision of information to service users. This is documented.

5. All staff can articulate the processes for providing information to service users, as set out in the policy.

6. The service user's communication needs are assessed on admission and documented in their individual care plan.

7. Information is provided in a manner which meets each service user's assessed needs.

8. Relevant documentation from committees and meetings demonstrates service user involvement in developing service user information resources.

27. Regulation 12 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Communication Regulation 20 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Provision of Information to Service Users

9. A database of interpreter and other advocacy and support services (including voluntary agencies) is made available to the workforce, service users, family and carers. This includes peer and self-advocacy.

10. The Provision of information to service users, is in accordance with Regulation 20 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 -, and is in an accessible, booklet format, provided at admission and includes at a minimum:

    • Details of the service user's multidisciplinary team.

    • Verbal and written information on the service user's diagnosis.

    • Suitable written information relevant to the service user's diagnosis unless in the service user's psychiatrist view the provision of such information might be prejudicial to the physical and/or mental health, well-being or emotional condition of the service user.

    • Housekeeping practices, including arrangements for personal property.

    • Mealtimes.

    • Visiting times and visiting arrangements.

    • Service Users' rights.

    • Complaints policy and procedure[28].

    • Details of advocacy

    • Service user information is offered in formats that is appropriate and supports his/ her individual needs.

11. Information is provided on relevant care practices appropriate to the service user's needs, (e.g. use of medication, diagnosis, recovery pathways, general and mental health, roles and responsibilities of team members).

12. Service users are provided with written and verbal information regarding their diagnosis unless the service users' psychiatrist considers that the provision of such information might be prejudicial to the service users' physical or mental health, well-being or emotional condition. The justification for restricting information regarding a service users' diagnosis is documented in their clinical file.

13. Each service user has access to information resources available. (e.g. pamphlets, DVD, education resources, ICT programmes) to support their needs and to help them to make informed decision about their care.

14. Information is provided to the service user as to any potential effects of treatments, including the risks and possible side effects.

15. Medication information sheets, as well as verbal information, are provided in a format that is appropriate to the service user's needs. effects.

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28. Section 45 Health Act 2004 (as amended

16. The content of the medication information sheets include information on indications for use of all medications to be administered to the service user, including any possible side-effects.

17. The information in the documents provided by, or within, the service is evidence-based.

18. Information documents provided by, or within, the service are appropriately reviewed and approved prior to use.

19. Service Users have access to interpretation and translation services as required.

20. The implementation of the policy on the provision of information to service users is monitored and continuously improved.

21. The provision of information to service users is monitored on an ongoing basis to ensure the information is appropriate and accurate, particularly where information changes occur e.g. information on medication and housekeeping practices.

22. Review and analysis is completed to identify opportunities to improve the processes for providing information to service users. The findings and the lessons learned from this process are shared and documented.

Indicator 4.2

Service users, family and carers are supported to document clear advance care directives for physical and mental health and Do Not Attempt Resuscitation orders (DNAR) (only applicable for Voluntary Service Users).

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures on advance care directives and Do Not Attempt Resuscitation orders (DNARs), in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 14, Care of the Dying and HSE Policy.

2. The policies and procedures on advance care and directives and DNARs are implemented.

3. Staff have read and understood the policies and procedures, and this is documented.

4. Staff training is provided on the policies and procedures regarding Advance Care Directives and DNAR's.

5. The service user receives timely and appropriate assistance to discuss a plan for his or her end of life care, if required- including documentation relating to Advance Care Directives. There is support from advocacy if necessary.

6. Each service user has an opportunity to obtain relevant information and participate in discussions regarding end of life care planning including;

    • His or her preferences regarding decision making and communication.

    • His or her wishes in relation to end of life care, including symptom control and nutrition and hydration.

7.   The service user's preferences in relation to end of life care, including advance care directives and DNAR are documented in his or her care plan reflective of the HSE National Consent Policy (2013) Part 4 DNAR.

8.   If the service user has difficulty in expressing his or her wishes and preferences or lacks functional capacity, all reasonable steps are taken to maximise his or her ability to participate in the decision-making process.

9.   Advance Care Directives relating to end of life care as well as DNAR orders and associated documentation are clearly evidenced in the service user's clinical file.

10.   There are systems in place to manage the DNAR in accordance with the service policy.

11.   All consultation with the service user, family and carers regarding a (DNAR) decision are detailed in their clinical file. This is subject to the consent of the service user, where possible.

12.   The service user is provided with the agreed end of life care, as set out in his or her care plan.

13.   Staff can articulate the processes for advance care directives and DNAR's.

Aim 5

Service users' informed consent[29] to care and treatment is obtained in accordance with legislation and best available evidence.

Indicator 5.1

All care delivered is subject to the informed consent of the voluntary service user, in accordance with their will and preferences, or by the involuntary service user, in accordance with legislative requirements.

These are the features you need to have in place to meet the indicator:

1.   There are policies and procedures on obtaining and acting in accordance with the informed consent of service users in line with the *HSE National Consent Policy and the Mental Health Act (2001)*.

2.   The Policies and procedures on obtaining and acting in accordance with the informed consent is referenced with the *Mental Health Act (2001)* which addresses the arrangements that protect the best interest of children[30] and service users who lack capacity under the legislation and vulnerable adults.

3.   The HSE National Consent policy (2014) is implemented.

4.   Staff receive training on the policies and procedures, the *Mental Health Act (2001)* and Assisted Decision (Capacity) Legislation (2015) as appropriate.

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29. *Health Service Executive National Consent Policy; Mental Health Commission Guidance Document - Part 4 Mental Health Act 2001 Consent to Treatment*
30. *Child and Adolescent Mental Health Service (CAMHS) Standard Operating Procedure 2015*

5. The mental health service has arrangements in place to support the service user in making valid and informed consent to treatment and care and the provision of confidential information. These arrangements are in accordance with the provisions of the *Mental Health Act (2001)*, where appropriate, Mental Health Commission Statutory Form describing the assistance provided to the patient i.e. Form 17.

6. In the absence of service user consent to treatment, the provision of sections *59 (Electro-convulsive therapy), 60 (Administration of medicine) and 61 (Administration of medicine to a child) of the Mental Health Act (2001)* (as amended)[31] must be complied with regards to detained service users.

7. In the case of a child, informed consent is obtained from either parent or the legal guardian or the courts. The view of the child is taken into consideration.

8. Service users confirm that they understand decisions about their consent, treatment and care, where possible. This is provided through discussion with service users.

Aim 6

Service users' dignity, privacy[32] and autonomy are respected and promoted at all times.

Indicator 6.1

Each service user receives the care that respects their confidentiality, privacy, dignity and autonomy.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place in relation to service user dignity and privacy and autonomy, in accordance with the Mental Health Act (2001), (Approved Centres Regulations 2006, Regulation 21 Privacy.

2. At a minimum the policies and procedures on service users' dignity, privacy and autonomy include:

- The roles and responsibilities for to the provision of service user privacy and dignity.

- The method for identifying and ensuring, where possible, the service user's privacy and dignity expectations and preferences.

- The layout and furnishing requirements to support service user privacy and dignity within the practice setting.

- The mental health service 's process to be applied where service user's privacy and dignity is not respected by staff.

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31. *Mental Health Commission Memorandum on the Mental Health (Amendment) Act 2015 (03.02.16)*
32. *Regulation 21 of the Mental Health Act 2001 (Approved Centre) Regulations 2006, Privacy*

3. The policies and procedures in relation to service user dignity, privacy and autonomy are implemented.

4. All staff have read and understand the policies and procedures relating to dignity, privacy and autonomy, and this is documented.

5. All staff can articulate the processes for ensuring service users' dignity, privacy and autonomy as set out in the policies.

6. An annual review is undertaken to check that the policies are being implemented, and that the premises and facilities in the service are conducive to service users' privacy. This is documented.

7. Review and analysis is completed to identify opportunities to improve the processes relating to service users' privacy and dignity. The findings and lessons learned are shared and documented.

8. The service user's privacy and dignity is respected at all times.

9. The recovery approach informs every level of service provision so that each service user is facilitated to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks and pursue their goals.

10. Information is provided on mental health and the recovery approach in a language appropriate to the service user's health, literacy and language.

11. Each service user's recovery pathway includes partnership, listening, hope, choice and social inclusion.

12. The service user's treatment, care and recovery plans reflects his or her involvement, while incorporating family and carer insight, where agreed with the service user.

Communication[33]

13. Written operational policies and procedures are available within the service in relation to service user communication.

14. At a minimum, the policies and procedures in relation to service user communication includes:

- The roles and responsibilities for service user communication processes.
- The communication services available to the service user (including: mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods).
- The assessment of service users communication needs.
- The circumstances in which service users personal communications may be examined by a senior member of staff.
- The individual risk assessment requirements in relation to limiting service users communication activities.

33. Regulation 12 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Communications

15. Relevant staff have read and understood the policies and procedures on communication. This is documented.

16. Relevant staff can articulate the policies and procedures for communication as set out in the policy.

17. Service user communication needs and restrictions on communication are monitored on an ongoing basis.

18. Analysis is completed to identify opportunities to improve communication processes. This is documented.

19. Individual risk assessments are completed for service users as deemed appropriate in relation to any risks associated with their external communication and documented in the individual care plan.

20. The Clinical Director or a senior member of staff designated by the Clinical Director may only examine incoming or outgoing communication if there is reasonable cause to believe that the communication may result in harm to the service user or to others. In line with Regulation 12 of Mental Health Act 2001 (Approved Centres) Regulations 2006, Communication.

21. The service user is free to communicate at all times, and has access to mail, fax, email, internet (where available), telephone or any device for the purposes of sending or receiving messages or goods unless otherwise risk assessed with due regard to the service users' wellbeing, safety and health.

Privacy[34]

22. All bathrooms, showers and toilet and single bedrooms have locks on the inside of the door, unless there is an identified risk to a service user. Locks should have an override function.

23. Where the service user shares a room, the bed screening ensures that their privacy is not compromised.

24. All observation panels on doors of treatment rooms and bedrooms have blinds, curtains or opaque glass.

25. Rooms are not overlooked by public areas. If so, the windows have opaque glass.

26. Noticeboards do not detail the service user's name or other identifiable information.

27. The creation and storage of records ensures confidentiality and respect. In situations where disclosure of information is required, by law or advisable from an ethical perspective, the rationale for sharing such information should be documented and the service user informed and where applicable consent sought. This is in accordance with *Data Protection Acts 1988 – 2003; HSE Records Management Policy; Criminal Justice Act 2011; Criminal Justice (Withholding of Information of Offences Against Children and Vulnerable Persons) Act, 2012 ; Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2016).*

34. Regulation 21 of the Mental Health Act 2001 (Approved Centres) Regulations 2006

28. Service users are facilitated to make private phone calls.

29. The Health Service Executive Mobile Phone Device Policy on the use of staff mobile phones is complied with.

30. Service users are called by their preferred name and title.

31. Staff are observed to interact with service users in a respectful and dignified manner (evidenced through the demeanour of staff, the appearance and dress of staff and staff interactions with service users, seeking permission before entering bedrooms or areas where intimate care is provided).

32. Staff ensure that no ageist, racist, sexist or other inappropriate comments, 'banter' or 'jokes' are made.

33. Staff are discreet when discussing the service user's care and treatment needs.

Clothing[35]

34. There are written policies and procedures available in relation to service user' clothing in accordance with of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 7, Clothing.

35. At a minimum, the policies and procedures in relation to clothing includes:

- Responsibility for providing clothing to service users where necessary, with consideration of the service users' preferences, dignity, bodily integrity, religious and cultural practices.
- The appropriate use of night and day clothes.
- Recording the use of night clothes worn during the day in the service user's individual care plan

36. Relevant staff have read and understood the policies and procedures on service users' clothing. This is documented.

37. Relevant staff can articulate the policies and procedures for service users' clothing.

38. The implementation of the policies and procedures relating to service user clothing will be reviewed and updated in response to identified service user needs.

39. Service users are provided with emergency personal clothing that is appropriate to the service user and considers the services user's preferences, dignity, bodily integrity, religious and cultural practices.

40. The availability of an emergency supply of clothing for service users is monitored on an ongoing basis. This is documented.

41. The service user wears clothing of his or her personal choice that respects their privacy and dignity, e.g. no soiled clothing, inappropriate size or type of emergency clothing.

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35. Regulation 7 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Clothing2006

42. Service user clothing is clean and appropriate to the service user' needs.

43. Night clothes are not worn by the service user during the day unless specified in their individual care plan. A record is maintained of service users who wear night clothes during the day. This is monitored.

Autonomy

44. Records demonstrate a focus on autonomy and the right of the person to self-determine unless a specific assessment of capacity has determined otherwise. This is outlined in the Individual Care Plan.

45. Clinical and support staff help service users regain and maintain their autonomy and sense of individual choice throughout all aspects of their care pathway.

46. Staff recognise the lived experience of the service user and support individual strengths and abilities.

Closed Circuit Television

47. Closed Circuit Television used for the observation of service users is managed in accordance with the Mental Health Act 2001(Approved Centres) Regulations 2006, Regulation 25 Use of Closed Circuit Television notably: -

- CCTV is used solely for the purpose of observing a service user by a healthcare professional.
- CCTV is used solely for the purpose of ensuring the health and welfare of the service user.
- Clear signs in prominent positions where CCTV cameras or other monitoring systems are located throughout the service.
- There are clear written policy and procedures in place, re CCTV.
- CCTV is incapable of recording or storing a service users image on a tape, disc, hard drive, or 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 service user.
- CCTV must not be used if a service user acts in any way which compromises their dignity.
- Use of CCTV is disclosed to the service user / their representative and the Mental Health Commission Inspectorate.

48. Policies and procedures are available within the service in relation to the use of CCTV or other monitoring equipment.

36. Regulation 25 of the Mental Health Act 2001 (Approved Regulations) 2006, Use of Closed Circuit Television
Data Protection Act 1988 - 2003

49. At a minimum, the policy and procedure includes:

- The roles and responsibilities for the use of CCTV within the service.
- The purpose and function of using CCTV for observing service users in the service.
- The measures used to ensure the privacy and dignity of service users where the service uses CCTV cameras or other monitoring equipment.
- The maintenance of CCTV cameras by the service.
- The disclosure of the existence and usage of CCTV or other monitoring devices to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the service or at any time on request.
- Ensuring the use of CCTV in the service is overt and clearly identifiable using signage and communication with service users and/or their representatives.
- The process to cease monitoring a service user using CCTV in certain circumstances.

50. Relevant staff have read and understand the policy and procedure on CCTV and this is documented.

51. Relevant staff can articulate the processes on the use of CCTV.

52. The quality of CCTV images is checked regularly to ensure they are operating appropriately. This is documented.

53. Review and analysis is completed to identify opportunities for improvement of the use of CCTV with the findings and lessons learned shared and documented.

Aim 7

Service users' complaints[37] are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Indicator 7.1

Processes are in place to support the recognition, reporting and management of complaints.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place that describe the processes for making, handling and investigating complaints from any person about any aspect of the service, care and treatment provided in or on behalf of the service. This is in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 31, Complaints Procedures.

2. At a minimum, the policies and procedures include:

   - The roles and responsibilities associated with the management of complaints within the service, including a nominated person responsible to deal with all complaints.
   - The process for the management of complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in, or on behalf of, the service.
   - The communication of the complaints policy and procedure with service users, their representatives, family and next-of-kin, as well as visitors.
   - The methods available to all persons to make complaints regarding the service, care or treatment by the service.
   - The confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.
   - The timeframes for complaint management, including the timeframe for the service to respond to the complaint, and for the complaint to be resolved.
   - The documentation of complaints including the maintenance of a complaints log by the nominated person.
   - Communication with the complainant during the complaint process.
   - The process to escalate complaints that cannot be addressed by the nominated person.
   - The appeal process available where the complainant is dissatisfied with the outcome of the complaint investigation.

3. The complaints policies and procedures are implemented.

4. The details of the complaints procedure and the nominated person for dealing with complaints are on display in a prominent position within the service.

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37. Regulation 31 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 Your Service Your Say; Part 9 Health Act 2004 (as amended)

5. If the nominated person for complaints is not based in the mental health service, their contact details are publicly displayed.

6. Relevant staff are trained on the complaints management processes (including the nominated person for dealing with complaints, and other staff involved in screening, investigating and managing complaints).

7. All staff are recorded as having read and understood the policies and procedures relating to complaints.

8. All staff can articulate the policies and procedures for making, handling and investigating complaints, as set out in the policy. They can differentiate between the processes for managing a complaint that is raised informally and a formal written complaint.

9. Complaint forms are available for the service user to complete.

10. Service users have a secure comments, compliments and complaints box. Compliments forms and complaint forms and pens are present in a prominent and publicly accessible place.

11. The service user is made aware of the complaints procedure, and all methods by which a complaint can be made, as soon as practicable after admission to the mental health service.

12. The service user is supported to make a complaint where they wish to make one.

13. A consistent and standardised approach is implemented for the management of all complaints.

14. The methods for the persons, service user, and their representatives, to make a complaint are detailed within the complaints policy and procedure, which may include:

    • Verbal
    • Written
    • Electronically by email
    • Telephone
    • Through complaint, feedback or suggestions forms.

15. The service ensures access, insofar as practicable, to advocates to facilitate the participation of the service user and his or her representative in the complaints process.

16. The service's management of complaints processes is well publicised and accessible to service users and their representatives.

17. All complaints and the results of any investigations into the matters complained, and any actions taken on foot of a complaint, and whether the service user was satisfied, are fully and properly recorded. Such records are in addition to and distinct from the service user's individual care plan.

18. The nominated person for dealing with complaints maintains an up-dated complaints log.

19. All records relating to complaints are stored confidentially in accordance with legislation.

20. All complaints are investigated and managed promptly, in accordance with the time-frame for the management of complaints, as set out in the mental health service policy and in line with national policy. This is documented.

   Timeframes are provided for:

   - Responding to the complainant following the initial receipt of the complaint.
   - The investigation period for complaints.
   - The required resolution of complaints.
   - Where timeframes are not achieved, or further investigation time is required in relation to the complaint, this is communicated to the complainant.
   - The complainant is informed promptly of the outcome of the complaint investigation and details of the appeals process. This is documented.

21. A method for addressing minor complaints within the service is provided. Minor complaints must be documented.

22. Where minor complaints cannot be addressed locally the nominated person must deal with the complaint.

23. All complaints (that are not minor complaints) are dealt with by the nominated person, who is available to the service and recorded in the complaints log.

24. Where complaints cannot be addressed by the nominated person they are escalated in accordance with the service's policy. This is documented in the complaints log.

25. The registered proprietor ensures that the quality of the service, care and treatment of a service user is not adversely affected by reason of the complaint being made.

26. The service user is informed promptly of the outcome of their complaint and details of the appeals process (in line with policy time-frames).

27. Information on how to contact the Office of the Ombudsman is provided to service users and others, making complaints on behalf of the service user.

28. Where services, care or treatment are provided on behalf of the service by an external party, the nominated person is responsible for the full implementation of the services's complaints management process, including the investigation process and communication requirements with the complainant.

29. All information obtained through the course of the management of the complaint, and the associated investigation process, is treated in a confidential manner and meets the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 2014.

30. The service has a system in place to analyse complaints data and identify trends from the complaints received. Details of this analysis are considered by senior management. Required actions are identified and implemented to ensure continuous improvement of the complaints management process and the quality of the service. (See Theme 4, Leadership, Governance and Management, Aim 4, indicator 4.1)

31. Audits of the complaints log and related records are completed, the audits are documented and the findings are acted upon.

Aim 8

Mental health service users are supported in maintaining and improving their own health and well-being[38].

Indicator 8.1

The general health and well-being of each person is promoted with an emphasis on self-help where at all possible.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place on general health and well-being, in accordance with *Mental Health Act 2001 (Approved Centres) Regulations 2006*, *Regulation 19 General Health* and in accordance with Health Service Executive policies. These policies are available to service users.

2. There are policies and procedures in place on responding to emergencies, in accordance with the *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 19, General Health* and in accordance with health service policies.

3. At a minimum, the policies and procedures on general health includes:

    - The roles and responsibilities for the provision of general health services to service users.
    - Service user access to a Registered Medical Practitioner.
    - The ongoing assessment of service users' general health needs.
    - The resource requirements for general health services, including equipment needs.
    - The protection of service user's privacy and dignity during general health assessments.
    - The incorporation of general health needs into the service users' individual care plan.
    - The referral process for general health needs of service users.
    - The documentation requirements in relation to general health assessments.
    - Access to national screening programmes available for service users through the service.

4. At a minimum, the policies and procedures on responding to emergencies include:

    - The roles and responsibilities in relation to responding to medical emergencies.
    - The management, response and documentation of a medical emergency, including cardiac arrest.
    - The staff training requirements in relation to Basic Life Support (BLS).
    - The management of emergency response equipment, including resuscitation trolley and Automated External Defibrillator (AED)

5. The policies and procedures on general health are implemented.

6. All clinical staff are documented as having read and understood the policies and procedures relating to general health and well-being and responding to emergencies.

38. Regulation 19 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, General Health

7. The implementation of the policies on the provision of general health services and responding to medical emergencies is monitored and continuously improved

8. A systematic review is undertaken to ensure six-monthly reviews of general health needs take place.

9. Review and analysis is completed to identify opportunities to improve general health processes. The findings are implemented.

10. All clinical staff can articulate the processes for the provision of general health services and for responding to medical emergencies as set out in the policies.

11. The service develops and delivers initiatives to promote general health and well-being, in accordance with the services objectives and in consultation with people who access the service.

12. The service cooperates with other service providers and other statutory and non-statutory agencies to promote the health and development of the service user.

13. Staff have the necessary competencies and skills to support health promotion initiatives.

14. Records are available demonstrating the services users completed general health checks and the associated results, including records of any clinical testing, e.g. Lab results.

15. The service user is provided with information and has access to screening, according to age and gender, early detection and the full range of universal health services including Breast check, Cervical screening, Retinal checks (for diabetics only) Bowel screening and Prostate screening. Take up of screening is recorded and monitored, where applicable.

16. The service user has access to general health services, and for referral to other health services as required, in accordance with *Regulation 19 of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 19, General Health*.

17. The service user's health care needs are assessed regularly as per their individual care plan, at least every six months, in line with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 19, General Health*.

18. There is a documented review to ensure all service users have a six-monthly review.

19. Each service user is supported to live healthily and take responsibility for his or her own health.

20. The service user is offered appropriate health information, education and interventions, both within the service and in the community.

21. Information is provided to service users regarding the national screening programmes available through the service and the service user is enabled to register for such programmes.

22. This includes information on the following:

- Mental well-being.

- Mental health recovery.

- Healthy eating.

- Recreation, interests and activities.

- Smoking, alcohol and drug consumption.

- Physical activity.

- General Anxiety Disorders.

- Relationships and sexual health.

23. Each service user has opportunities for new experiences, (e.g. social participation, recreation, education, training and employment as applicable.

Medical Emergencies:

24. The service has an emergency trolley and staff have access at all times to an AED.

25. Weekly checks are completed on the resuscitation trolley/tray and on the AED, if located in the service.

26. Records are available of any medical emergency that occurred within the service and the care implemented.

27. Protocols are in place to ensure effective and efficient emergency medical access for ambulance or crash teams to service users within the service.

THEME 2

EFFECTIVE CARE & SUPPORT

Theme 2
Effective Care & Support

Aim 1

Mental health care reflects national and international evidence of what is known to achieve best clinical outcomes for service users.

Indicator 1.1

Mental health care is based on current and best available practice supported by evidence-based policies, procedures and guidelines and the knowledge and experience of staff and service users.

Please read this indicator in accordance with Theme 4, indicator 2.2

These are the features you need to have in place to meet the indicator.

1. The policies, procedures and guidelines of the service incorporate relevant legislation[1], evidence-based best practice and clinical guidelines and national clinical programmes, in accordance with the *Mental Health Act 2001 (Approved Centres) Regulations 2006*[2], *Rules*[3] *and Codes of Practice*[4]*, and the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines, 2016.*

2. All national and CHO area policies and procedures are adopted and appropriate to the local service, the service user profile and guide the practice in place. Throughout this document, where a policy or procedure is referred to, the minimum requirements of the policy are included.

1. Primary Legislation –
Mental Health Act, 2001;
Mental Health Act 2008;
Mental Health (Amendment) Act 2015;
Mental Health Act 2001 (Authorised Officer) Regulations 2006 S.I. No 550 of 2006; and
Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No 551 of 2006
2. Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No S.I. No 551 of 2006
3. Mental Health Commission Rules:
Mental Health Commission Rules Governing the Use of Electro-Convulsive Therapy;
Mental Health Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Version 2)
Mental Health Commission Addendum to the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Version 2)
4. Mental Health Commission Codes of Practice:
Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre
Mental Health Commission Code of Practice on Admission of Children under the Mental Health Act 2001
Mental Health Commission Code of Practice on Notification of Deaths and Incident Reporting
Mental Health Commission Addendum to the Code of Practice on Notification of Deaths and Incident Reporting
Mental Health Commission Code of Practice on Guidance for Persons working in Mental Health Services for People with Intellectual Disabilities
Mental Health Commission Code of Practice on Use of Electro-Convulsive Therapy for Voluntary Patients
Mental Health Commission Code of Practice on Use of Physical Restraint in Approved Centres

3. The polices and procedures are developed in accordance with the seven stages of the National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPG 2016).

4. The following policies and procedures are in place and are in accordance with the legislation[5]:

    •   Regulation 8: Residents' Personal Property and Possessions.
    •   Regulation 11: Visits.
    •   Regulation 12: Communication.
    •   Regulation 13: Searches.
    •   Regulation 14: Care of the Dying.
    •   Regulation 18: Transfer of Residents.
    •   Regulation 19: General Health.
    •   Regulation 19: Medical Emergencies
    •   Regulation 20: Provision of Information to Residents.
    •   Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines.
    •   Regulation 24: Health and Safety.
    •   Regulation 25: Use of Closed Circuit Television (where applicable).
    •   Regulation 26: Staffing.
    •   Regulation 27: Maintenance of Records.
    •   Regulation 31: Complaints Procedures.
    •   Regulation 32: Risk Management Procedures.
    •   Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (and addendum).
    •   Rules governing the use of Electro-Convulsive Therapy (ECT).
    •   Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients.
    •   Code of Practice relating to Admission of Children under the Mental Health Act (2001) (and addendum).
    •   Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting.
    •   Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.
    •   Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities.
    •   Code of Practice on the use of Physical Restraint in Approved Centres.

5. National Clinical Guidelines and nationally agreed protocols, programmes and care pathways are in place.

6. Staff have read and understand all the policies and procedures and this is documented.

7. Staff are supported through journal clubs, and training, to access evidenced based information to deliver appropriate care.

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5. Mental Health Commission Quality and Safety Forms, Mental Health Commission Statutory Forms, Clinical Forms and Patient Information Forms

Service users are readily identifiable[6] by staff, when receiving medication, healthcare and other services.

These are the features you need to have in place to meet the indicator.

1. There are written policies and procedures in relation to the identification of service users in the service, in accordance with the *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 4 Identification of Residents*.

2. At a minimum the policies and procedures include:

    - The roles and responsibilities in relation to the identification of service users.
    - The required use of two service user identifiers prior to the administration of medications, medication investigations or other services.
    - The required use an appropriate service user identifier prior to the provision of therapeutic services and programmes.
    - The process of identification applied for same/similar name service users.

3. Relevant staff have read and understand the policies and procedures on identification of service user. This is documented.

4. Relevant staff can articulate the process for identifying service users as set out in the policies.

5. The policies and procedures are implemented throughout the service, including, but not limited to:

    - The need for a minimum of two service user's identifiers, appropriate to the service user profile and individual service users' needs. The identifiers are detailed within the service user's clinical file/plan. (e.g. photograph, wrist band, two staff who know the service user).
    - The identifiers used are person specific (e.g. do not include room number or physical location).
    - The identifiers used are appropriate to the service users' communication abilities.
    - Two appropriate identifiers are used when administering medication, before medical investigations and providing other healthcare services.
    - An appropriate service user identifier prior to the provision of therapeutic services and programmes.
    - Appropriate identifiers and alerts are used for same/similar name service users (e.g. 'warning same name' stickers)

6. An annual audit is undertaken to ensure there are appropriate service user identifiers on clinical files. Analysis is completed to identify and respond to issues identified.

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6. Regulation 4 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No 551 of 2006

All aspects of the Mental Health Commission, Rules on Seclusion[7] are complied with.

A Checklist is included *(Appendix 1)* to support services to determine if this indicator is being met.

These are the features you need to have in place to meet the indicator:

1. There is a written policy and procedures in place on the use of seclusion. This policy on the use of seclusion is in accordance with the *Mental Health Act 2001, Rules[8] Governing the Use of Seclusion (Mechanical Means of Bodily Restraint).*

2. The policy on the use of seclusion is implemented.

3. Staff have read and understand the policy and procedures on seclusion and records of this is documented.

4. Staff can articulate the policy and procedures on the use of seclusion.

5. Staff have received training on the use of seclusion.

6. Seclusion, where used, is strictly in accordance with the Rules Governing the Use of Seclusion.

7. There is a strategy in place to minimise the risk of return to seclusion which is discussed with the service user.

8. There is a multi-disciplinary strategy in place to reduce the use of seclusion in the service.

9. An annual report on the use of seclusion is provided to the Mental Health Commission [9].

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7. Seclusion: -
Section 69 Mental Health Act, 2001 (as amended)
Mental Health Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Version 2)
Mental Health Commission Addendum to Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Version 2)
Mental Health Commission What You Need to Know About the Rules on Seclusion
Mental Health Commission Seclusion and Restraint Reduction Strategy
Mental Health Commission Memo – Key Revisions to Seclusion Mechanical Restraint Rules (14.10.09)
Mental Health Commission Review of Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint and Review of Code of Practice on the Use of Physical Restraint in Approved Centres
8. See Footnote Above
9. Rule 10(4) of Mental Health Commission

Indicator 1.4

All aspects of the Mental Health Commission Rules[10] and Code of Practice[11] Governing the use of Electro-Convulsive Therapy (ECT)[12] are complied with.

A Checklist is included *(Appendix 2)* to support services to determine if this indicator is being met.

These are the features you need to have in place to meet the aim:

1. There is a written policy and procedure in place on the use of ECT. This policy on the use of ECT is in accordance with the Mental Health Commission Rules and Code of Practice on ECT[13].

2. The policy and procedures on the use of ECT are implemented.

3. Staff have read and understand the policy and procedures on ECT and records of this are documented.

4. Staff can articulate the policy and processes on the use of ECT.

5. Staff have received training on the use of ECT.

6. ECT, where used, is strictly in accordance with the Rules and Code of Practice.

7. Services are in receipt of accreditation by an approved body to enable the safe provision of ECT.

8. Where ECT is used, an annual report is completed on its use[14]. This report is submitted to the Head of Mental Health in the CHO.

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9. *Rule 10(4) of Mental Health Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Version 2)*
10. *Electro-Convulsive Therapy, Section 59 of Mental Health Act 2001 (as amended)*
Mental Health Commission Rules Governing Use of ECT (Version 3)
11. *Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients (15.02.16)*
12. *Mental Health Commission Memorandum on the ECT Rules (03.02.16); Mental Health Commission Memorandum on the Mental Health (Amendment) Act 2001 (03.02.16)*
13. *See Footnotes Above*
14. *Rule 11 Mental Health Commission Rules Governing Use of ECT (Version 3)*

Indicator 1.5

All aspects of the Mental Health Commission Rules governing the use of Mechanical Means of Bodily Restraint[15] and the Code of Practice on Physical Restraint are complied with.

A Checklist is included (Appendix 3) to support services to determine if this indicator is being met.

These are the features you need to have in place to meet the indicator:

1. There are written policies and procedures in place on the use of restraint (physical and/or mechanical). This policies and procedures on the use of restraint are in accordance with the Mental Health Commission Rules Governing the Use of Mechanical Means of Bodily Restraint and the Code of Practice on Physical Restraint.

2. Staff have read and understand the policies and procedures on restraint and this is documented.

3. Staff can articulate the policies and procedures on the use of restraint.

4. The policies and procedures on the use of restraint are implemented.

5. Nominated staff have received training in the use of restraint.

6. Mechanical and/or physical restraint, where used, is used strictly in accordance with the Rules and Code of Practice.

15. *Mechanical / Physical Restraint*
Section 69 Mental Health Act 2001 (as amended)
Mental Health Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Version 2)
Mental Health Commission Addendum to Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (Version 2)
Mental Health Commission Seclusion and Restraint Reduction Strategy
Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres (Version 2)
Mental Health Commission What You Need to Know about the Code of Practice on the Use of Physical Restraint
Mental Health Commission Key Revisions Contained in the Code of Practice on the Use of Physical Restraint
Mental Health Commission Review of Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint and Review of Code of Practice on the Use of Physical Restraint in Approved Centres

Indicator 1.6

Practice is in accordance with the Mental Health Commission Code of Practice / Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities [16] (2010).

These are the features you need to have in place to meet the indicator:

1. There are written policies and procedures in place to support staff working with people with intellectual disabilities who use Mental Health Services, which is in accordance with the *Code of Practice / Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities*; with emphasis on:

   - The development of person-centred care planning.
   - Identification of service user's communication needs and the supports required.
   - Supporting the service user in the process for obtaining informed consent[17].
   - How the least restrictive approaches to managing behaviours of concern are developed.

2. The policies and procedures are in accordance with the Mental Health Commission Code of Practice / Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities.

3. Staff have read and understand the policies and procedures and this is documented.

4. Staff can articulate the policies and procedures on working in Mental Health Services with People with Intellectual Disabilities.

5. The policies and procedures are implemented and practice is in accordance with the Code of Practice on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

6. Relevant staff have received training.

7. Communication tools are utilised, where appropriate, as per the Code of Practice and these are integrated into the Individual Care Plan.

8. Mental health services link with outside agencies to ensure service user needs are met.

17. Mental Health Commission Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities 2010

16. Consent
Mental Health Commission Guidance Document - Part 4 Mental Health Act 2001 Consent to Treatment
Health Service Executive National Consent Policy 2014

Aim 2

Care is planned and delivered to meet the individual service user's initial and on-going assessed mental healthcare needs, while taking account of the needs of other service users.

Indicator 2.1.

Each service user has an individual care and treatment plan (ICP) that describes the levels of support and treatment required in accordance with his/her needs and is co-ordinated by an identified team.

These are the features you need to have in place to meet the indicator:

1. There policies and procedures in place on the development, use and review of the ICP in accordance with the Mental Health Commission Guidance on ICP 2012 and with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 15 ICP.

2. At a minimum, the policy includes:

   - The roles and responsibilities relating to the individual care planning.
   - The comprehensive assessment of service users at admission and on an ongoing basis.
   - The required content in the set of documentation making up the individual care plan.
   - The implementation of individual care plan reviews and updates.
   - The required service users involvement in individual care planning, where practicable.
   - The timeframes for assessment planning, implementation and evaluation of the individual care plan.
   - Clarity in relation to service user access to his or her individual care plan

3. The policy and procedures on ICP is implemented.

4. All clinical staff have read and understand the policy and procedures on ICP and a record of this is documented.

5. All clinical staff can articulate the policy and procedures on ICPs.

6. All Multi-disciplinary team members are trained on ICPs.

7. A key worker is identified for each service user to ensure continuity in the implementation of a service user's ICP.

8. A pre-admission assessment is carried out where appropriate to identify the assessed needs of the service user and to ensure his or her assessed needs can be met.

18. Individual Care Plan
Regulations3, 5, 7, 8, 11, 15, 16, 17, 19 and 31 of Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No 551 of 2006
Mental Health Commission Document on Individual Care Planning Mental Health Services (April 2012)
Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre
Mental Health Commission Quality Framework Standard 1.1.

9. Each service user is initially assessed at admission. An initial care plan is completed by the admitting clinician to address the immediate needs of the service user, Where agreed by the service user, this is carried out in consultation with the service user, family and carer.

10. Registered Medical Practitioners assess service users' general health needs at admission and on an ongoing basis as part of the service's provision of care.

11. Service users receive appropriate general health care interventions in accordance with his or her individual care plans.

12. Records are available demonstrating the service users' completed general health checks and the associated results, including records of any clinical testing, for example laboratory results.

13. The comprehensive assessment completed on admission may include, but is not limited to, the following:

   • Views, wishes and preferences of the service user.
   • Medical, psychiatric and psychosocial history.
   • Medication history and current medications.
   • Current physical health assessment.
   • Nutritional assessment.
   • Detailed risk assessment.
   • Social, interpersonal and physical wellbeing related issues including resilience and strengths.
   • Communication abilities.
   • Educational, occupational and vocational history.

14. Evidence-based assessments are consistently completed by appropriately trained staff with the required skills.

15. An integrated ICP is developed by the MDT or the service user's support team, with the service user, where practicable, following a comprehensive assessment and any immediate interventions required, as soon as possible, but within seven days of admission.

16. The individual care plan (ICP), identifies the service user's assessed needs.

17. The individual care plan is discussed, agreed where practicable and drawn up with the participation of the service users and, his or her representative, family and next-of-kin, as appropriate with consent.

18. There is documented evidence where the service user refuses involvement in the individual care planning process.

19. Appropriate outcome goals are clearly defined in planning care for individual service users. These goals are:

   • Based on the service user's assessed needs.
   • Agreed between the service user and the identified lead healthcare professional.
   • Regularly reviewed and revised to ensure effectiveness.
   • Regularly reviewed and revised to ensure they reflect the service user's changing needs and preferences.

20. The ICP identifies the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.

21. The ICP of a child service user must include his or her educational requirements, in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 15 & 17, Individual Care Plan & Children's Education.

22. The ICP has a relapse prevention focus.

23. The ICP has a recovery focus.

24. The ICP has a strengths based focus.

25. The ICP identifies the resources required to provide the care and treatment identified.

26. The ICP includes an individual risk and safety management plan.

27. The ICP includes a preliminary discharge plan where deemed appropriate.

28. The ICP is implemented and monitored by the key worker, and other relevant staff.

29. The ICP including the risk assessments and management plans are reviewed and updated in accordance with regulatory and best practice requirements, and review dates are set in the care plan. (Weekly review within an approved centre for an acute admission and at least every 6 months for the service user in a continuing care facility, or in accordance with the service user's changing needs, condition, circumstances and goals).

30. The ICP is reviewed by the MDT in consultation with the service user, as far as is practicable. The service user has access to the ICP and is involved with and informed of any changes. It is updated as indicated by the service user's changing needs and communicated to relevant staff as appropriate.

31. The service user is offered a copy of his or her ICP, including any reviews; this is documented.

32. When a service user declines or refuses a copy of their individual care plan, this is recorded, including the reason, if given.

33. The ICP must be recorded in one composite set of documents, i.e. the service user's clinical file.

34. The ICP is not amalgamated with progress notes. It should be identifiable and uninterrupted.

35. If the needs of a service user cannot be met within the scope of the service there is evidence that the service user is informed and that the necessary arrangements for transfer of care to the appropriate service are made, in consultation with the service user.

36. Audits of ICPs are carried out on a quarterly basis and improvements required are documented and implemented.

Indicator 2.2

Each service user who is a child is provided with appropriate educational services[19] in accordance with his or her needs and age as indicated by his or her individual care plan [20] (applicable to Approved Centre only)

These are the features you need to have in place to meet the indicator:

1. Written policies and procedures are available in relation to the provision of education to child service users in the service.

2. At a minimum, the policy and procedures includes:

- The roles and responsibilities relating to the provision of educational services for child service users by the approved centre.
- The planning, provision, documentation and review of educational provisions to child service users.
- The assessment of the educational needs of child service users.
- The information provided to child service users, and their representatives, on the educational services available.
- The facilities and resources available to support education of child service users. This considers facilities and support for education provided by the service and support for child service users that access external educational services.
- The methods of assessment of child service users' progress within the educational provisions of the service.
- The management of the transition of child service users between educational services.

3. Relevant staff are trained on the policy relating to children's education and its implementation throughout the service.

4. Individual providers of educational services on behalf of the service are appropriately qualified in accordance with their role and responsibilities.

5. All staff are trained in legislation relating to working

6. The implementation of the children's education policy within the approved centre is monitored and continuously improved.

7. Monitoring requirements include, but are not limited to:

- A record is kept of attendance at internal and external educational services and of other educational services availed of.
- Child service users are assessed regarding his or her individual educational requirements with consideration of his or her individual needs and age on admission.

8. Where appropriate, the service links with The Department of Education, local authorities and local education providers to ensure that each child service user is appropriately assessed in relation to education needs.

19. *Regulation 17 of the Mental Health Act 2001 (Approved Centre) Regulation 2006 S.I. No 551 of 2006 (Children's Education)*
20. *Regulation 15 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No 551 of 2006 (Individual Care Plan)*

9. Where appropriate to the needs, ability and age of the child service user, the education provided by the approved centre is reflective of the required educational curriculum.

10. Appropriate facilities are available for the provision of education to child service users within the approved centre.

11. Sufficient personnel resources are available for the provision of education to child service users within the approved centre.

12. Sufficient personnel and resources are available to support child servicer users to access external educational services.

13. The educational provisions available within the approved centre are effectively communicated to child service users and his or her representatives.

14. A daily activity timetable for schooling is available for each child service user receiving educational services within the approved centre.

15. Attendance by child service users at the educational services of the service is documented.

16. Attendance by child service users at external educational services is documented.

17. The service maintains comprehensive records of each child service user's educational history for example, schools attended, reports obtained, certificates awarded, assessment reports and any remedial assistance provided including reasons for non-attendance.

18. Where child service users are managing a transition, such as changing school or entering a higher level of education, they are given additional support and appropriate assistance by the service, if appropriate.

Indicator 2.3

Each service user has access to an appropriate range of therapeutic services and Programmes[21] and recreational activities[22], in accordance with his or her ICP.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place, relating to the provision of therapeutic services and programmes, and recreational activities in accordance with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 16 Therapeutic Services and Programmes and Regulation 9 of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 9 Recreational Activities.*

2. At a minimum, the policies in relation to the provision of recreational includes:

    - The roles and responsibilities relating to the provision of recreational activities within the service.
    - Determining service user needs likes and dislikes in relation to activities.
    - The process applied to risk assess service users for recreational activities, including outdoor activities.
    - The process applied for the development of recreational activity programmes.
    - The methods of communicating recreational activities and individual activities programmes with the service user.
    - The facilities available for recreational activities, including identification of suitable locations for recreational activities within and external to the approved centre.
    - The process to support service user involvement in planning and reviewing recreational activities.

3. At a minimum, the policies in relation to the provision of therapeutic services and programmes includes:

    - The roles and responsibilities in relation to the provision of therapeutic services and programmes.
    - The planning and provision of therapeutic services and programmes within the Service.
    - The provision of therapeutic services and programmes by external providers in external locations.
    - The resource requirements of the therapeutic services and programmes.
    - The recording requirements for therapeutic services and programmes.
    - The review and evaluation of therapeutic services and programmes.
    - Assessing service users as to the appropriateness of services and programmes (including risk).
    - The facilities for the provision of therapeutic services and programmes

4. The policies and procedures relating to the provision of therapeutic services and programmes, and recreational activities are implemented.

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21. *Regulation 16 of the Mental Health Act, 2001 (Approved Centres) Regulations S.I. No 551 of 2006*
22. *Regulation 9 of the Mental Health Act, 2001 (Approved Centres) Regulations S.I. No 551 of 2006*

5. All relevant/clinical staff have read and understand the policies and procedures on the provision of therapeutic services and programmes, and recreational activities and a record of this is documented.

6. All relevant/clinical staff can articulate the policies and processes on the provision of therapeutic services and programmes, and recreational activities.

7. Therapeutic services and programmes and recreational activities provided are appropriate and meet the assessed needs of the service users and the service user group profile, as documented in the service user's ICP and in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 16, Therapeutic Services and Programmes and Regulation 9, Recreational Activities.

8. Recreational activities and therapeutic services and programmes are developed, implemented and maintained for service users, with service user involvement.

9. Where recreational activities are provided they are adequately and appropriately resourced.

10. The therapeutic services, programmes and recreational activities provided are specific, targeted and evidence-based, developed in conjunction with the service user and directed towards restoring and maintain optimum levels of physical and psychosocial functioning of the service user.

11. A list of all therapeutic services and programmes and recreational activities provided within the service is available to service users, in an accessible format. The information includes the types and frequency of appropriate, recreational activities available.

12. Where a service user requires a therapeutic service or programme that is not provided internally by the mental health service, the service arranges for the programme and or activity to be provided by an approved, qualified professional in an appropriate location.

13. Therapeutic services and programmes are provided in a separate dedicated area, containing facilities and space for individual and group therapies. Both indoor and outdoor activities are provided, where practicable.

14. Records of participation, engagement and outcomes achieved in therapeutic services and programmes or recreational activities are maintained within the service user's ICP or clinical file. Where the service user refuses to attend, this is documented. Service user decisions to participate, or not, in activities is respected.

15. There is access to recreational activities on weekdays and during the weekend.

16. Individual risk assessments are completed for service users, where deemed appropriate, in relation to the selection of appropriate activities.

17. There is ongoing monitoring of the range of therapeutic services and programmes, and recreational activities provided, to ensure they meet the assessed needs of service users.

18. Analysis is completed to identify opportunities for improvement.

Indicator 2.4

Service users are provided with food and drink in quantities and quality adequate for his or her needs.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures in place in relation to the provision of appropriate food and nutrition to all service users.

2. At a minimum, the policies and procedures include:

    •   The roles and responsibilities for food and nutrition within the service.
    •   The management of food and nutrition for each service user within the service.
    •   Assessing the dietary and nutritional needs of service users.
    •   Monitoring food and water intake.

3. The policy and procedure on the provision of appropriate food and nutrition to service users is implemented.

4. Relevant staff have read and understand the policy and procedure and can articulate the process and this is recorded.

5. Food is properly prepared, wholesome and nutritious, takes account of any special dietary requirements and is consistent with each service user's ICP.

6. Food is presented in a manner which is attractive and appealing in order to maintain appetite and the nutritional status of the service user.

7. Weight and growth charts are implemented, monitored for variances and appropriate action is taken where indicated.

8. Service users are offered a daily menu with a choice of main meal that reflects his or her preferences and dietary requirements. The menu varies regularly and takes into account feedback from service users, and includes a hot meal daily. There are a variety of wholesome and nutritious food choices.

9. Menus are approved by a nutritionist / dietician to ensure nutritional adequacy in accordance with service users' needs.

10. Each service user's cultural needs are met via appropriate food provision to the service location, (for example, consider the Food and Nutritional Care in Hospitals, DoHC, 2009).

11. There are facilities for service users to make his or her own hot and cold drinks unless actual individual risk prohibits this and this is reflected in accordance with their ICP.

12. There is a source of safe, fresh drinking water[12] available at all times, in easily accessible locations. Hot and cold drinks are offered regularly to service users.

13. There is appropriate staff observation and engagement at meal times.

23. *Duties in Relation to Water on Premised - Section 6 European Union (Drinking Water) Regulations 2014 S.I. No 122 of 2014*

For service users with special dietary requirements – (eg. Malnutrition, eating disorder, etc.)

1. Special dietary needs are documented and catered for e.g. diabetic, coeliac disease, allergies. This information is stored confidentially.

2. Staff are appropriately trained on how best to meet the nutritional needs of the service users in their specific area.

3. Dietary preferences in relation to cultural or religious beliefs are being identified and are catered for.

4. Modified consistency diets are presented in a manner that is attractive and appealing in terms of texture, flavour and appearance, in order to maintain appetite and nutrition. Appropriate links are maintained with Speech and Language Therapy for service users on modified texture diets.

5. Service users, their representatives, family and next-of-kin are educated about the service users' diets, where appropriate, specifically in relation to any contraindications with medication.

6. The needs of service users identified as having special nutritional requirements are regularly reviewed by a dietician.

7. Intake and output charts are maintained and monitored for service users, where appropriate.

8. An evidence-based nutrition assessment tool is used, where appropriate. (MUST, MNA)

9. Weight charts in graph format are implemented, monitored and acted upon for service users, where appropriate.

10. Nutritional and dietary needs are assessed, where necessary, and addressed in the service user's ICP.

11. Analysis is completed to identify opportunities to improve the processes for food and nutrition. This is documented.

Areas of food preparation, handling, storage, distribution and disposal are appropriately managed to ensure safety[24] and compliance with relevant legislation and best available practice.

These are the features you need to have in place to meet the indicator:

1. There are written policies and procedures available in relation to food safety in the service, in accordance with the *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 6, Food Safety.*

2. At a minimum, the policies and procedures include:

    - The roles and responsibilities in relation to food safety within the service.
    - Food preparation, handling, storage, distribution and disposal controls.
    - Adhering to the relevant food safety legislative requirements.
    - The management of catering and food safety equipment.

3. The policies and procedures in relation to food safety are implemented.

4. Relevant staff have read and understand the policies and procedures and this is documented.

5. Relevant staff can articulate the process for food safety as set out in the policy.

6. Appropriate hand-washing areas are provided for catering services.

7. Appropriate Protective Equipment (including Personal Protective Equipment (PPE), where required, is used during the catering process.

8. Suitable and sufficient catering equipment, crockery and cutlery are in place and provided to service users which meets his or her needs.

9. Proper facilities for the refrigeration, storage, preparation, cooking and serving of food are in place.

10. Hygiene is maintained to support food safety requirements, in relation to food preparation, storage and disposal. In line with Regulation 6 of the Mental Health Act 2001 (Approved Centre) Regulations 2006, Regulation 6 Food Safety.

11. Catering areas, and associated catering and food safety equipment, are appropriately cleaned.

12. Food is prepared in a manner that reduces risk of contamination, spoilage, and infection.

13. Staff handling food have up to date accredited training in HACCP requirements. The training is documented and the certificates maintained on file.

14. Food temperatures are recorded in accordance with food safety recommendations. A log sheet of this is maintained and monitored.

15. Food safety audits occur periodically.

16. Analysis is completed to identify opportunities to improve food safety processes and this is documented.

24. *Regulation 6 of the Mental Health Act 2001 (Approved Centres) Regulations 2006*

Aim 3

Service users receive integrated care[25] which is coordinated effectively within and between services.

Indicator 3.1

Mental health services are coordinated and integrated to meet the full range of social, psychological and physical care needs of individuals with mental illness.

These are the features you need to have in place to meet the indicator.

1.	Documented policies and procedures are in place to support the co-ordination of care within and between teams, services, hospitals and settings. This includes the process for transfer, admission and discharge[26].

2.	The policies and procedures are implemented.

3.	Staff have read and understand the policies and procedures and this is documented.

4.	Staff can articulate the processes.

5.	There is collaboration between the service and relevant external service providers/individuals. (e.g. Primary care services, acute hospitals, advocacy, voluntary and statutory agencies, Gardaí, external agencies, homeless agencies, etc).

25. Regulation 19 of the Mental Health Act 2001 (Approved Centres) Regulations 2006
Health Act 1947 (as amended)
26. Mental Health Act, 2001 (as amended); Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre; Mental Health Commission Code of Practice on Admission of Children under the Mental Health Act 2001

Indicator 3.2

Each service user continues to receive care at the end of his or her life[27] which respects his or her dignity and autonomy and meets his or her physical, emotional psychological, social and spiritual needs.

These are the features you need to have in place to meet the indicator:

1. There is a policy and procedure in place regarding care of the dying, in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 14 Care of the Dying.

2. At a minimum, the policy and procedure includes:

- The roles and responsibilities in relation to care of the dying.
- The identification and implementation of the service user's physical, emotional, social, psychological, spiritual and pain management needs in relation to end of life care.
- Advance directives in relation to end of life care, Do Not Attempt Resuscitation orders (DNARs), and service user' religious and cultural end of life preferences, in accordance with HSE National Consent Policy Part 4.
- The privacy, propriety and dignity requirements of service users to be implemented as part of care of the dying.
- The required communication with the service user and their representatives, family, next-of-kin and friends during end of life care.
- The involvement and accommodation and support of service user representatives, family, next-of-kin and friends during the end of life care of a service user, in so far as is practicable.
- The process for managing the sudden death of a service user.
- The supports available to other service users and staff following a service user's death.
- The process and the responsibility for reporting the death of a service user to the required external bodies.
- The process for the notification to the Mental Health Commission of the death of a service user within 48 hours.
- The process for ensuring that the service is informed in the event of the death of a service user who has been transferred elsewhere.

3. The policy and procedures on end of life care are implemented.

4. Relevant staff have read and understand the policy and procedures on end of life care and this is documented.

5. Relevant staff can articulate the processes for end of life care as set out in the policy.

6. The Service user's religious, spiritual and cultural practices at the end of his or her life and the extent to which their family is involved in the decision-making processes are recorded and respected where possible.

27. *Regulation 14 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 10 of the Mental Health 2001 (Approved Centres) Regulations 2006 Care of the Dying*
Mental Health Commission Code of Practice on Notification of Deaths and Incident Reporting; Mental Health Commission Addendum to the Code of Practice on Notification of Deaths and Incident Reporting; Section 18 Coroners Act 1962 (Notification);

7. The service user is provided with appropriate care and comfort to address his / her physical, emotional, psychological, social and spiritual needs. This is documented in the ICP.

8. Pain is prioritised and managed during end of life care.

9. Every effort is made to ensure that the service user's choice as to the place of death, including the option of a single room or returning home, is identified and is respected as far as is practicable.

10. In accordance with the service users assessed needs and consent; referrals are made to specialist palliative care services so that an integrated MDT approach to end of life care is provided.

11. Staff are provided with accredited training and guidance in end- of-life care as appropriate to their role.

12. The mental health service has facilities in place to support end of life care so that a service user is not unnecessarily transferred[28] from a continuing care facility to an acute setting, except for specific medical reasons and in accordance with his or her wishes.

13. The privacy and dignity of service users is protected, for example this may include the provision of a single room within the centre during the provision of end of life care.

14. As far as is practicable, overnight facilities are available to family, friends and carers in accordance with the service users wishes. Time and privacy are allowed and support is provided to family, friends and carers upon the death of a service user.

15. The service user's death is managed with dignity and propriety.

16. When a sudden death of a service user occurs religious and cultural practices are respected.

17. The sudden death of a service user is managed in accordance with legal requirements.

18. Support is given to other service users and staff following a services users' death.

19. As far as is practicable the service user family, next of kin, friends and carers are accommodated.

20. There is a written procedure for staff to follow after the death of a service user in relation to the verification and certification of death, in accordance with the Coroners Act (1962).

21. The service user's body is treated with dignity and respect in accordance with his or her wishes, the service users' cultural and religious beliefs and evidenced – based practice.

22. The Mental Health Commission is notified in writing of the death of any service user of the approved centre, including the death of any service user transferred to a general hospital for care and treatment, as soon as is practicable, but no later than 48 hours of the death occurring.

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28. *Section 22 of the Mental Health Act, 2001; Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*
Mental Health Commission Code of Practice on Admission of Children under the Mental Health Act 2001

23. End of life care provided to the service user is systematically reviewed to ensure that the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 14; Care of the Dying is complied with.

24. A systems analysis is undertaken if applicable, in line HSE Safety Incident Management Policy 2014, in the event of a sudden or unexpected death within the service.

25. The implementation of the care of the dying policy and procedures are monitored and continuously improved. This is documented, for example, review of deaths, audits, systems analysis and investigation reports. Documentation confirms that analysis is completed to identify opportunities to improve the processes for the care of the dying.

Indicator 3.3

Handover[30] of clinical information is timely, concise, accurate and appropriate..

These are the features you need to have in place to meet the indicator.

1. There is a policy and procedure in place on structured clinical handover.

2. The policy and procedures on clinical handover is implemented.

3. Staff have read and understand the policy and procedures and this is documented.

4. Staff can articulate the processes on structured handover as outlined in the policy.

5. Agreed communication tools are in use for handover including handover checklists with minimum data sets.

6. Tools and resources for a structured clinical handover process, are available to the workforce. Examples include ISOBAR (Identify–Situation–Observations– Background– Agreed plan–Read back) and SHARED (Situation–History–Assessment– Risk– Expectation–Documentation).

7. Handovers are timely, accurate, concise and appropriate.

8. Documentation in relation to structured handover is maintained safely.

9. Handovers are reviewed to determine effectiveness and to identify areas for improvement.

10. Information on handover is routinely reported to and reviewed by management.

11. Records show that effective handover has occurred, (e.g. service user care plans, clinical file, discharge summary, e-referrals).

30 Regulation 18 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Section 14 Mental Health Act, 2001; Section 21 Mental Health Act 2001; Section 22 Mental Health Act, 2001; Section 28 Mental Health Acts 2001; Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre Mental Health Commission Code of Practice on Admission of Children under the Mental Health Act 2001

Aim 4

All information necessary[31] to support the provision of effective care, including information provided by the service user, is available at the point of decision making.

Indicator 4.1

Accurate, integrated and readily accessible service user records are developed in accordance with best available practice/legislation, and are available to the workforce at the point of care.

These are the features you need to have in place to meet the indicator:

1. There are policies and procedures for the creation, access, retention of and destruction of records in place and are in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 27 Maintenance of Records and HSE Standards and Recommended Practices for Healthcare Records Management (2011).

2. At a minimum, the policies and procedures for the creation, access, retention of and destruction of records includes:

> - The roles and responsibilities for the creation of, access to, retention of and destruction of records.
> - The required service user record creation and content.
> - Those authorised to access and make entries in the service users' records.
> - Privacy and confidentiality of service user record and content.
> - Service users'' access to service user records.
> - Record retention periods, see Health Service Policy Record Retention Periods (2013)
> - The destruction of records.
> - Record review requirements.
> - The relevant legislative requirements relating to record maintenance; the implementation of the Data Protection Act 1988 (as amended).
> - Acts, Freedom of Information Acts and associated controls for records.
> - How entries in the service user'' records are made, corrected and overwritten.
> - The process for making a retrospective entry in service users' records.
> - General safety and security measures in relation to records (stored in locked room or press).
> - Retention of inspection reports relating to food safety, health and safety and fire inspections.

3. The policies and procedures for the creation, access, retention of and destruction are implemented.

4. All clinical staff and other relevant staff have read and understand the policies and procedures and this is documented.

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31. *Regulation 27 of the Mental Health Act 2001 (Approved Centre) Regulations 2006*
32. *Health Services Regulations 1971 S.I. No 105/1971*

5. All clinical staff and other relevant staff can articulate the policies and procedures.

6. Staff are trained in best practice record keeping.

7. The service user's record is maintained using two appropriate service user identifiers which are unique to the service user.

8. All relevant records are available at the point of decision making.

9. Technology is available to ensure staff can access service users clinical records whether attending out patients department, day hospital, emergency department , etc. to assist in focused care planning.

10. All relevant staff working with the service user have read the service user's records to ensure they are knowledgeable, with the appropriate service user's consent.

11. Where a service user requires support in providing information for records this is facilitated. (e.g. peer advocate, family member or nurse/staff member).

12. Records are developed in accordance with legislative and best available practice guidelines.

13. Records and reports are maintained in a manner to ensure completeness, accuracy and ease of retrieval.

14. The following requirements are in place regarding records:

   • Records are kept up-to date.
   • Records are maintained in good order and in logical sequence and are accessible to authorised staff only.
   • Only authorised staff make entries in service users records or specific sections therein.
   • Records are maintained in a safe and secure place, in accordance with Mental Health Act 2001 (Approved Centre) Regulations 2006, Regulation 27 Maintenance of Records.
   • Records are written legibly in black ink and are readable when photocopied.
   • Records are factual, consistent, accurate and do not contain jargon, unapproved abbreviations or meaningless phrases (e.g. observations – "service user kept a low profile").
   • Each entry includes the date and the time using the 24-hour clock.
   • Each entry is followed by a signature and the signatures discipline.
   • The service also maintains a record (signature bank) of all signatures used in the service user's record.
   • All entries made by student nurses/clinical training staff are counter-signed by a registered nurse/clinical supervisor.
   • Where an error is made, this is scored out with a single line and the correction written alongside with date, time and initials.
   • Correction fluid is not used on clinical records.
   • The service user's name and date of birth is detailed on all documentation and is transcribed correctly.
   • Where a member of staff makes a referral to, or consults with another member of the healthcare team, this person is clearly identified by their full name and title. (Seen by doctor' or 'doctor informed' is not acceptable).

15. Where information or advice is given over the telephone, this is documented as such by the member of staff who took the call and the person giving the information or advice is clearly identified.

16. Records are appropriately secured throughout the service/centre from loss or destruction and tampering and unauthorised access or use.

17. All service users' records are physically stored together, where possible

18. A record is initiated for every service user assessed or provided with care and/or services by the service.

19. Service user records are reflective of the service users' current status and the care and treatment being provided.

20. Documentation on inspections of food safety, health and safety and fire safety is maintained in the service.

21. Records are retained and destroyed in accordance with legislative requirements, the policy and procedure of the service, and the HSE Policy on Record Retention Periods (2013).

22. Computer access to electronic records is available to the clinical workforce in clinical areas including access to multidisciplinary team records (for example laboratory reports).

23. Audits are conducted into compliance with legislation to ensure completeness, accuracy and ease of retrieval (e.g. Data Protection Act, FOI Act 2014). This is documented. The records of transferred or discharged service users are included in the audit, as far as is practicable.

24. Analysis is completed to identify opportunities to improve the maintenance of records processes.

Aim 5

The mental health service is provided in a physical environment[33] which supports the delivery of high quality, safe, reliable service provision and protects the health and welfare of service users, staff and visitors.

Indicator 5.1

The premises and facilities comply with relevant legislative requirements and best available practice.

A Checklist is included *(Appendix 4)* **to support services to determine if this indicator is being met.**

These are the features you need to have in place to meet the indicator:

1.   There are policies and procedures in place, relating to the premises.

2.   At a minimum, the policies and procedures include:

- The roles and responsibilities for the maintenance of the premises and related processes.
- The legislative requirements to which the premises must conform.
- The premises maintenance programme.
- The premises cleaning programme.
- The premises utility controls and requirements.
- Identifying hazards and ligature points in the premises.
- The provision of adequate and suitable furnishings in the premises.

3.   The policies and procedures relating to premises are implemented.

4.   Relevant staff have read and understand the premises policies and procedures and this is documented.

5.   Relevant staff can articulate the policies and procedures relating to the maintenance of the premises.

6.   Premises are clean and maintained in good structural and decorative condition.

7.   Premises are adequately lit, heated and ventilated.

8.   A programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programmes are maintained.

9.   The service has adequate and suitable furnishings, having regard to the number and mix of service users.

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33. *Regulation 22 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 Premises*

9.   The service has adequate and suitable furnishings, having regard to the number and mix of service users.

10. The condition of the physical structure and the overall environment is developed and maintained with due regard to the specific needs of service users and the safety, well-being, privacy and dignity of service users, staff and visitors.

11. In approved centres, any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of the 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, and accessible to persons with disabilities.

12. The design of the physical environment offers maximum opportunity to maintain and improve mental and general health, in so far as is practicable.

13. Structures and systems, physical and human resources are in place to plan and implement effective infection prevention and control programmes, including but not restricted to hand hygiene, C. diff, MRSA, Norovirus and the management of an infectious outbreak. (See and use Appendix 5, Self Assessment Infection Control Checklist)

14. There is a system to audit the premises, including ligature audit and hygiene audit; and action is taken to address any improvements required.

15. Analysis is completed to identify opportunities to improve the premises.
     This is documented.

Aim 6

The effectiveness of mental health care outcomes is systematically monitored, evaluated and continuously improved.

Indicator 6.1

There is a structured approach to quality improvement which involves service users, family, carers and staff.

These are the features you need to have in place to meet the indicator:

1. The service evaluates and monitors the quality and safety of the care provided and the outcomes for service users. Mechanisms for this include:

    - Performance indicators and benchmarks (e.g. waiting times, use of restrictive practice, service user information, service user experience, ICP, medications, environment).

2. National Care metrics are in use. These are collected and reviewed monthly and include: service user identification, complaints information, provision of information, rights and discharge planning, medication storage and custody, medication administration.

3. The service has an audit schedule which includes but is not limited to:

    - Identification of service users.
    - Food safety.
    - ICP.
    - Hygiene and infection control.
    - Ligature audit.
    - Medication management (including quarterly audits of prescription and administration records).
    - Service user records.
    - Operating policies and procedures.
    - Complaints log.
    - Risk register.

4. The schedule includes self-assessment / audit against this Best Practice Guidance for Mental Health Services.

5. The records of audits / self-assessments include quality improvement plans, any action taken, trending and learning.

6. Governance arrangement are in place to ensure that findings from audits / self-assessments, incident reports and complaints are effectively managed, monitored and disseminated to staff and service users and anonymised where appropriate

7. Minutes of health and safety committees, quality and safety committees demonstrate that mental health care is being monitored, evaluated and improved.

8. Service users and staff are involved in the quality improvement process, (e.g. executive quality improvement walk around and service users' committees) and receive training as required.

9. Clear written language is used in core processes and documentation.

Aim 7

Service users' health and well-being is supported by the mental health service's policies and procedures for medication management[34].

Indicator 7.1

Medication Management policies & procedures are in place and implemented effectively in accordance with regulations and best available practice.

A Checklist is included *(Appendix 6)* to support services to determine if this indicator is being met.

These are the features you need to have in place to meet the indicator:

1. There are written operational policies and procedures relating to the ordering, prescribing, storing and administration, recording, monitoring review, self administration, crushing, covert administration, withholding, refusal, reconciliation, and disposal of medicines are in place. The policy also includes the processes for medication management at admission, transfer, and discharge. Roles and responsibilities are defined in the policy.

2. The process for the management of medication errors and/or adverse effects, including external reporting requirements.

3. These policies and procedures are developed in accordance with NMBI guidelines; in accordance with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines; and in accordance with the Misuse of Drugs (Amendment) Regulations 1993, 1999, 2006, 2007, 2009, (No. 2) 2009, 2010, (No.2) 2010, 2011, 2014, (No.2) 2014; and the Misuse of Drugs Regulations 1988 (as amended).*

4. The policies and procedures are implemented.

5. The practices regarding ordering, prescribing, storing, administering, recording and disposal of medications are in accordance with the policies and procedures.

6. All nursing and medical staff as well as pharmacy staff, where applicable have read and understand the policies and procedures for medication management and this is documented.

7. All nursing and medical staff as well as pharmacy staff, where applicable can articulate the processes as set out in the policies and procedures.

8. Staff have access to comprehensive, up-to-date information on all aspects of medication management.

9. All nursing and medical staff as well as pharmacy staff, where applicable staff receive training on the importance of reporting medication incidents, errors or near misses. This is documented.

34. Section 60 Mental Health Act, 2001; Regulation 23 Mental Health Act 2001 (Approved Centres) Regulations 2006 (Ordering, Prescribing, Storing and Administration of Medicines)

10. Service users are encouraged to take responsibility for his or her own medication, in accordance with his or her age, capacity and wishes.

11. The service user's choice to self-administer medication is facilitated, where the risks have been assessed and the competence of the service user to self-administer is confirmed, and is referred to in the ICP.

12. A record of all prescribers' Medical Council Registration number is maintained for medical staff and the Nursing and Midwifery Board of Ireland (NMBI) Registration Number is maintained for Nurse Prescribers within the Nurse Prescriber Division.

13. Each service user, family and carer is advised, as appropriate, about the side effects of prescribed medicines and is given access to information leaflets and where necessary training, regarding medication.

14. Each service user is afforded the opportunity to consult the pharmacist, prescriber or other appropriate healthcare professional about medicines prescribed.

15. Medication is monitored and reviewed according to evidence-based practice. Medication is reviewed at regular specified intervals and the findings of this review are documented in the service user's ICP / healthcare record.

16. All medication incidents (including near misses), and suspected adverse reactions are recorded, reported and analysed within an open culture of reporting. The lessons learned are used to improve each service user's safety and to prevent recurrence.

17. The service operates evidence-based practice in medication safety, including medication reconciliation, on transfers within the service and between acute, community and continuing care services.

18. Medication processes are in place to review medication practices, (e.g. minutes of Drugs and Therapeutics Committees, Adverse Incident Report forms relating to medication errors and adverse drug reactions, Health Product Regulatory Authority notifications).

19. Quarterly audits of medication prescription and administration records are undertaken to determine compliance with the policies and procedures and with the applicable legislation and guidelines.

20. An inventory of medications is conducted monthly.

21. Incident reports are recorded for medication incidents, errors and near misses.

22. Analysis is completed to identify opportunities for improvement of medication management processes.

23. Quality Improvement Plans/CAPA's are in place relating to improving medication management processes.

THEME 3

SAFE CARE & SUPPORT

Theme 3
Safe Care & Support

Aim 1

The mental health service takes all reasonable measures to protect service users, staff and others[1] from the risk of harm associated with the design and delivery of mental health services[2].

Indicator 1.1

There are mechanisms in place for identification and assessment of risk for all service users and stakeholders throughout the mental health service. The measures and actions to control the risks, including safety planning are identified and implemented.

These are the features you need to have in place to meet the indicator.

Risk Management

1.   There is a comprehensive written risk management policy and procedures in place, in accordance with the Mental Health Act 2001 (Approved Centres) Regulation 32 2006, Risk Management Procedures, , HSE Guidance Document on Risk Management in Mental Health Services, HSE Integrated Risk Management Policy and HSE Best Practices Principles for Risk Assessment and Safety Planning for Nurses working in Mental Health Services.

2.   At a minimum the risk management policy includes the following:

> - The roles and responsibilities for risk assessment and management and the implementation of the risk management policy within the service.
> - The person with overall responsibility for risk management.
> - The responsibilities of the registered proprietor.
> - The responsibilities of the multi-disciplinary team members.
> - The person responsible for the completion of six-monthly incident summary reports. A defined quality and safety oversight and review structure as part of the governance process for managing risk.
> - The processes for the identification, assessment, treatment, reporting, reviewing and monitoring of risks throughout the services, including:
> - Organisational risks.
> - Structural risks, including ligature points.
> - Capacity risks relating to the number of service user in the service.
> - Health and safety risks to the residents, staff, visitors and others.
> - Risks to the service user group during the provision of general care and services.

1. *Regulation 11 of the Mental Health Act 2001 (Approved Centres) Regulations 2006*
2. *Safety Health and Welfare at Work Act, 2005 (and associated Regulations)*

- Risks to individual service user during the delivery of individualised care.
- The process for rating identified risks.
- The precautions and systems in place to control risks.
- Documenting, reporting, recording, investigating, learning from serious or untoward incidents or adverse incidents involving service users and others.
- The process for escalating risks within the organisation.
- Arrangements for responding to emergencies.
- Reference to the arrangements for the protection of children and vulnerable adults from abuse.
- The process in place for quality and safety notifications to the Mental Health Commission.
- The process for maintaining and reviewing the risk register .
- The record keeping requirements for risk management
- The policy also details the precautions in place to control the following specified risks:
  - Service user absent without leave.
  - Vulnerable adults and children.
  - Suicide and self-harm.
  - Assault.
  - Accidental injury to service users or staff.
  - The process for responding to specific emergencies:
  - including the role and responsibilities of key staff,
  - the sequence of required actions,
  - the process for communication,
  - escalating emergencies to management.

3. This policy and procedures relating to risk are implemented throughout the service.

4. All staff have read and understand the policy and procedures and this is documented.

5. All staff can articulate the processes.

6. Relevant staff have received training in the risk management policy and procedures and their implementation throughout the service.

The training includes:

- The identification, assessment and management of clinical and non-clinical risk.
- Health and safety risk management (including occupational health).
- Clinical staff are trained in individual clinical risk management processes.
- Management staff are trained in organisational risk management.
- All staff receive training on incident reporting, documentation and review.

3. Child Care Act, 1991; Children First ; HSE Child Protection and Welfare Policy 2016; Section 7 Health Act 2004; Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures;
4. Regulation 32(3) of the Mental Health Act 2001 (Approved Centres) Regulations 2006; MHC Quality and Safety Notification under the Mental Health Act 2001 (Revised July 2016)
5. Regulation 32(3) of the Mental Health Act 2001 (Approved Centres) Regulations 2006
6. Section 27 Mental Health Act 2001

7. Clinical risks are identified, assessed, treated, reported and monitored. Clinical risks are documented in the risk register, as appropriate.

8. Health and safety risks (Non-clinical) are identified, assessed, treated, reported and monitored and escalated where appropriate by the service. Health and safety risks are documented within the risk register, as appropriate.

9. Responsibilities are allocated at management level and throughout the service to ensure that the risk management policy is implemented. While the registered provider has ultimate responsibility for risk management, there is an identified person responsible for risk management in the service area and this person is known to staff.

10. There is a nominated person with responsibility for risk management reviews incidents for any trends or patterns occurring in the services.

11. Strategic and operational (corporate) risks are identified, assessed, treated, reported and monitored by the service.

12. Strategic and operational (corporate) risks are documented in the risk register.

13. There is an identified person responsible for the completion of six-monthly incident summary reports[7].

Health and Safety

14. There are policies and procedures pertaining to the health and safety of residents, staff and visitors, in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 24, Health and Safety. (e.g, safety statements and associated policies).

15. At a minimum the policies and procedures/safety statement pertaining to the health and safety of service users, staff and visitors includes:

- The roles and responsibilities for ensuring the health and safety of staff, service users and others.

- Specific roles are allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

- Safety representative roles are allocated and documented.

- The services compliance with health and safety legislation including the reporting requirements and process for escalating risks.

- The content of the Health and Safety Statement[8].

- The health and safety risk management process.

- The fire management plan.

7. MHC Quality and Safety Notification under the Mental Health Act 2001 (Revised July 2016)
8. Section 20 Safety, Health and Welfare at Work Act, 2005 (as amended)

Infection control measures, including:

- Provision and required use of Personal Protective Equipment (PPE).

- Safe handling and disposal of healthcare risk waste.

- Management of spillages.

- Raising awareness of residents and their visitors to infection control measures.

- Hand washing.

- Linen handling.

- Covering of cuts and abrasions.

- Response to sharps or needle stick injuries.

- Availability of staff vaccinations and immunisations.

- Management and reporting of an infection outbreak.

- Support provided to staff following exposure to infectious diseases.

- Specific infection control measures in relation to infection types, e.g. C.diff, MRSA, Norovirus.

- First aid response requirements.

- Falls prevention initiatives.

- Vehicle controls.

- The staff training requirements in relation to health and safety.

- The monitoring and continuous improvement requirements implemented for the health and safety processes.

16. All staff have read and understand the policies and procedures and safety statement and associated risk assessments and this is documented.

17. The policies and procedures/ safety statement clearly outlines the measures in place to manage safety issues (e.g., falls, infection control, sharps, vehicles, first aid, cuts and abrasions, needle-stick injuries, visual display units and manual handling), of Safety, in accordance with Section 20 of the Safety Health and Welfare at Work Act 2005 (as amended).

18. All staff can articulate the processes relating to health and safety as set out in the policies/safety statement.

19. The health and safety policies/safety statement are monitored in accordance with the Mental Health Act 2001 (Approved Centres) Regulation 29.

20. Roles and responsibilities with regard to ensuring the health and safety of staff, service users and visitors are clearly defined.

21. Safety representative roles are allocated and documented and staff are aware of these.

22. The service complies with health and safety legislation and all relevant statutory obligations under the Mental Health Act 2001.

23. Relevant staff have received training in the controls and any safe work practices are in place to manage risks in which they are likely to be exposed.

24. This regulation is only assessed against the written policies and procedures and does not assess health and safety practices with the service.

Individual Risk and safety Planning:

25. Risk and safety planning is delivered in line with evidenced based practice. A comprehensive risk assessment and safety plan process is in place, as outlined in the overall mental health assessment and recovery plan, this includes:

- A sense of connection between the service user and staff member.

- Non-judgemental and positive attitude towards the service user.

- Possible options and solutions for positive risk taking/ risk enablement.

- A focus on service user strengths.

- Identification of protective factors.

- Empirically validated assessment tools, where relevant.

- Risk categories, i.e. risk to self, risk to others, risk by others or risks caused by the service.

26. Risk assessment and safety planning is carried out on an ongoing basis, with multi-disciplinary involvement (rather than as a static or once-off event). Risk assessment should be considered for all areas required by legislation and the following:
(This is not an exhaustive list of risk assessments), in particular the following areas;

- Resident seclusion.

- Physical restraint.

- Mechanical restraint.

- Specialised treatments, e.g. ECT.

- At admission to identify individual risk factors, including general health risks, risk of absconsion, risk of self-harm, vulnerable adult etc.

- Service user transfer.

- Service user discharge

- In conjunction with medication requirements or administration

27. When a risk incident has been resolved, a proactive safety plan for the future is developed, when required.

28. The proactive safety plan contains a summary of the risks identified including warning signs, factors that may escalate the risks and strategies to be taken by staff and the service user in response to the risk identified.

29. The safety plan contains a clear statement of who is responsible for carrying out specific tasks and the timeframe for completion.

30. Service users have a copy of the safety plan and are asked to indicate his or her agreement with the plan as far as is practicable.

Indicator 1.2

There are mechanisms to identify and manage risks, including clinical and non –clinical risks.

These are the features you need to have in place to meet this indicator:

1. There are systems in place to assess and manage the following risks. (Best Practice Principles for This is not an exhaustive list:

   As per the obligation under Section 4, Mental Health Act (2001) (the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made).

Risk to self	Risk to Others
• Deliberate or unintentional harm to self -suicide, self-harm (including repetitive self-injury), self-neglect and substance misuse.	• Violence, aggression, verbal or physical assault.
• Loss of social and financial status arising from mental health status such as loss of employment, loss of accommodation, loss of supports (family/friends/other relationships); loss of custody of children, loss of reputation.	• Sexual assault or abuse, harassment, stalking or predatory intent. • Property damage including arson. • Neglect or abuse of children or adults for who care is being provided.
• Risk to physical, psychological and sexual health as a result of engaging in risk behaviours, such as substance misuse, sexual risk behaviours.	• Behaviour that could be thought of as reckless or high risk to others, such as drink driving.

Risk from others	Risk from the mental health service
• Physical, sexual and emotional abuse by others. • Financial abuse or neglect by others. • Victimization and harassment (in own home and public: name calling, having objects thrown, having offensive graffiti written on the walls, social media abuse/ humiliation). • Being treated unfairly in the workplace. • Losing accommodation or having difficulty getting accommodation	Risk to the person from engaging with the mental health service may be associated with: • Diagnosis and labelling. • Erosion of identity and self-esteem; loss of autonomy and voice, institutionalisation. • Stigma and discrimination. • Accommodation capacity risk relating to the number of residents in the approved centre. • Structural risks, including ligature points. • Emotional trauma associated with detention, seclusion, restraint. • Negative, paternalistic attitudes and controlling behaviours of staff. • Violation of human rights. • Health problems associated with side effects of medication. • Experiencing harassment within the service.

Higgins, A; Morrissey, J; Doyle, L; Bailey, J Gill, A (2015) Best Practice Principles for Risk Assessment and Safety Planning: a guide for mental health nursing. Dublin: Health Service Executive

2. There is a Risk Register[9] in place, which is audited on at least on a quarterly basis and in accordance with HSE National Risk Management Policy requirements.

3. The terms of reference are written and minutes of executive management team, clinical governance and risk management meetings demonstrate effective mechanisms to identify and manage risk.

4. Safety statements[10] are in place and include risk assessments.

5. The service adheres to the Mental Health Commission Quality and Safety Notifications under the Mental Health Act (2001) and the Mental Health Commission Code of Practice on the Notification of Deaths and Incident Reporting.

9. *Regulation 32(3) of the Mental Health (Approved Centre) Regulations 2006*
10. *Section 20 Safety, Health and Welfare at Work Act, 2005 (as amended) and associated Regulations*

6.   There is an emergency plan in place, which includes a process for responding to specific emergencies, including the role and responsibilities of key staff and the sequence if required actions and the process for communication and escalating emergencies to senior management. The process for securing alternative accommodation (contingency plan) is included.

7.   Staff are aware of the emergency plan, which includes emergencies, such as fire, flood, and cardiac arrest.

Indicator 1.3

The selection, procurement, management, maintenance and replacement of equipment including medical devices, is in accordance with legislative requirements, national standards, national policy & guidelines.

These are the features you need to have in place to meet this indicator:

1.   There are policies and procedure in place on the selection, procurement, management, maintenance and replacement of equipment including medical devices, in accordance with the HSE Health Business Service - Procurement Policy and the HSE Medical Devices / Equipment Management Policy (2009)

2.   The policies and procedures on the selection, procurement, management, maintenance and replacement of equipment is implemented.

3.   There is an identified person within the service with responsibility for medical devices and equipment management, including staff training and safety assurance.

4.   Procurement is carried out in accordance with national policy.

5.   Records demonstrate that specialist medical devices and equipment are identified, prescribed and made available to meet the service users' needs, in accordance with his or her individual care plan.

6.   Documentation e.g. prescriptions, care plan, correspondence demonstrates the involvement of Allied Health Professionals (e.g. Occupational Therapy/Physiotherapy) in recommending and advising on the selection of medical devices to meet the service user needs.

7.   There is an inventory of medical devices available and kept up to date.

8.   Equipment including medical devices maintenance records are available to demonstrate that maintenance is in line with manufacturer's standards.

9.   There is guidance available to staff on the operation of equipment and medical devices to ensure they are operated in line with manufacturer's instructions and good practice.

10.   There is a system of governance and dissemination available in relation to Health Products Regulatory Authority notices relating to the safety and/or quality of medical devices.

11.   Reports from the National Incident Management System (NIMS) demonstrate frequency and severity of incidents associated with use of equipment and medical devices. These are reviewed and improved the practice.

Aim 2

The Mental Health Service gathers, monitors and learns from information relevant to the provision of safe services and actively promote learning both internally and externally.

Indicator 2.1

The mental health service has a system in place which ensures monitoring and reporting on the quality and safety of care delivered and supports improvement and learning.

These are the features you need to have in place to meet this indicator:

1. There is an agreed system in place to collect, monitor and evaluate data relevant to provision of safe services.

2. Data collected is used to measure performance and improve efficiency of mental health services (e.g. audits, analysis, trending, variances, complaints and balanced score card), National Incident Management System reports, including six- monthly anonymised Mental Health Commission Summary Report, are available and accessible in accordance with the Mental Health Commission Code of Practice on the Notification of Deaths and Incident Reporting and the Mental Health Commission Quality and Safety Notifications under the Mental Health Act, (2001)

3. Quality and Safety Improvement plans are in place arising from data analysis and evidence of the improvements made as a result of the analysis.

4. Minutes of team, management and executive team meetings demonstrate that reports from the information management system are discussed at all appropriate levels of the organisation and actively inform change.

5. There is a system in place for monitoring of corrective action and preventative action plans (CAPA) or quality improvement plans (QIP) and quality profiles.

6. There is evidence of the use of forums and approaches to share learning, (e.g. notice boards, journal clubs, suggestion box, survey focus group, sharing learning days, Newsletter, Service User Stories, ARI, HSE Land, Enhancing Team Work initiative).

7. Learning notices and memos are circulated to share learning from systems analysis investigation, audit, complaints management, safety pause etc.

8. Quality and safety Information and learning is used and shared, within and between services/agencies to inform continuous improvement and the provision of safe services.

9. There is a system in place to ensure that the voice of Service users, families and carers is reflected in the analysis of information[11] towards the improvement of services. This is in accordance with the Data Protection Acts (1988 – 2003); Freedom of Information Act (2014).

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11. Consent to release of sharing of information; Cognisance of Data Protection Acts 1988 – 2003; Freedom of Information Act 2014

Aim 3

The mental health service effectively identifies, manages, responds to and reports on service user-safety incidents.

Indicator 3.1

There are arrangements for the identification, recording, and review, reporting and learning from adverse incidents.

These are the features you need to have in place to meet this indicator:

1. The National Safety Incident Management Policy and the National Safety Incident Management Framework (2014) is in place and is available to all staff.

2. The National Safety Incident Management Policy/Framework is implemented.

3. All incidents are recorded and the impact is rated in accordance with the policy/framework.

4. Incident report/NIMS forms are completed, signed and dated, contain agreed minimum data set and reflect the WHO taxonomy.

5. Clinical Incidents and subsequent interventions are recorded in the clinical records.

6. Nominated staff have received incident management training, including incident investigation.

7. Senior team managers are aware of safety incidents and records are maintained to demonstrate this.

8. NIMS reports are available, discussed and acted on. All clinical incidents are reviewed by the multi-disciplinary team at their regular meeting. A record is maintained of this review.

9. Key Performance Indicators related to incident management are met.

10. Records are maintained of systems analysis reviews, the recommendations, actions taken and the learning implemented.

11. Service user, family and carers are involved in accordance with Safety Incident Management Policy/framework.

12. The Safety Incident Management team have the necessary competencies and skills to oversee the management of a review/investigation. Teams have the necessary competencies, skills and support to conduct and complete a review/investigations.

13. The requirements of the National Standards in terms of oversight of the review process are implemented.

Aim 4

The mental health service ensure all reasonable measures are taken to protect service users from all forms of abuse.

Indicator 4.1

Service users are protected from all forms of abuse.

These are the features you need to have in place to meet this indicator:

1. There are protection of children and vulnerable adults[12] from abuse policies and supporting procedures for ensuring that each person is protected from all forms of abuse (e.g, safeguarding, financial management policies, and searches). In accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 32(2) (f) Risk Management Procedures, Children's First, Trust in Care Policy and the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures.

2. The policies and procedures for the protection of children and vulnerable adults from abuse are implemented.

3. At a minimum the policies and procedures for the protection of children and vulnerable adults include the following:

- The processes for safeguarding children and adults

- Staff training

- Appointment of designated officers

- Appointment of designated liaison persons

- Responsibilities of all staff and management, including designated officers and designated liaison persons

- All staff receive HSE approved training on the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures, 2014

- Reporting concerns, suspicions and allegations

- The management of reported concerns, suspicions and allegations, including notifications, preliminary screening, safeguarding plans, investigations.

- The process for interagency and inter-division communication.

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12. *Regulation 32(2)(f) of the Mental Health Act 2001 (Approved Centres) Regulations 2006*
Section 7 Health Act 2004
HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures
Child Care Act, 1991; Children First ; HSE Child Protection and Welfare Policy 2016; Section 7 Health Act 2004;
Section 19 Criminal Justice Act 2011 (Reporting Obligations)
Protections For Persons Reporting Child Abuse Act, 1998
Data Protection Acts 1988- 2003
HSE Trust in Care Policy, 2004
HSE Child Protection and Welfare Policy 2016

4. All staff are aware of and have an understanding of the HSE policies and the relevant legislation which are in place to protect children and persons at risk of abuse including but not restricted to the following:

- The HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures, 2014HSE Child Protection and Welfare Policy 2016

- Assisted Decision Making (Capacity) Act, 2015.

- Section 19 Criminal Justice Act 2011 (Reporting Obligations)

- Children First Act 2015

- Regulation 32(2)(f) Mental Health Act 2001 (Approved Centres) Regulations 2006
  - Section 7 Health Act 2004

- HSE Policies guiding the Practices of the Mental Health Services, including:
  - HSE National Consent Policy
  - Financial Management Policies
  - Search Policies
  - Seclusion Policies
  - Intimate Care Policy

- 'Trust in Care': the HSE policy guiding procedures when an allegation has been made that a staff member has abused or neglected a Service User.

- HSE Policy on Domestic, Sexual and Gender Based Violence, 2011

- HSE Practice Guide on Domestic, Sexual and Gender Based Violence, 2012

5. All staff receive training in Children's First, National Guidelines For The Protection And Welfare Of Children.

6. Staff demonstrate their understanding of the different types of abuse and know what to do in the event an allegation, suspicion or disclosure of abuse including who to report any incident to.

7. Staff are appropriately recruited, selected, trained and supervised in accordance with their role and policy.

8. Service Users have access to an advocate or advocacy services. For example, there are notices on display detailing the advocacy service available and contact details.

9. Service users receive training/information where necessary and are assisted and supported to protect themselves against abuse.

10. Service users are aware of the complaints process and the persons to whom they can raise concerns / allegations.

11. Staff members treat service users with respect and dignity at all times.

12. There is an up to date confidential register maintained in each CHO area in accordance with the HSE Child Protection and Welfare Policy 2016 officer.

13. The safeguarding system is monitored to protect service users.

14. Service users confirm that they feel safe within the service.
This is achieved through regular multidisciplinary reviews.

Aim 5

Effective Fire Safety Management Systems are in place and in accordance with legislative requirements including Fire Services Acts, 1981 & 2003; Safety, Health and Welfare at Work Act, 2005 and Building Control Acts 1990 & 2007 and other relevant legislation.

Indicator 5.1

There are adequate precautions in place against the risk of fire.

These are the features you need to have in place to meet this indicator:

Complete either Section A or B

<u>A. For New and Proposed facilities:</u>

1. A copy of the relevant Fire Safety Certificate (if applicable) received with respect to each premises identified for its intended usage. All documents submitted to the Local Fire Safety Authority as part of the process should also be made available.

2. A copy of the Certificate of Compliance issued by either an Architect or suitably qualified Chartered Engineer i.e. must have specific Fire Safety Qualifications, evidence that the plans for which the Fire Safety Certificate was issued for have been adhered to and that the building is fire safe.

3. Copies of the relevant Certificates of Design, Installation, Commissioning of the Fire Detection and Alarm System. This certificate must confirm alarm type and compliance with the relevant IS 3218 Standard.

4. Copies of the relevant Certificates of Design, Installation, Commissioning of the Emergency Lighting System. This certificate must confirm compliance with the relevant IS 3217 Standard.

5. A copy of the certificate for the Electrical Condition of the building and confirming it complies with ETCI Rules.

B. For Existing Facilities:

1. Copies of Current Fire Safety Management Policy and Safety Statement complete with relevant records

    *   Relevant Fire Safety Notices
    *   Fire Safety Risk Assessments
    *   Maintenance contracts for:
        i.   Hand Held Fire Fighting Equipment
        ii.   Fire Detection and Alarm Systems
        iii.   Emergency Lighting Systems
        iv.   Automatic suppression systems if relevant.
    *   Site specific Evacuation Plans including PEEP's where necessary.
    *   Records of all associated Fire Safety Training:
        v.   Fire Extinguisher Training
        vi.   General Fire Safety Lecture
        vii.   Site Specific Evacuation Training
    *   Fire Door schedule and Maintenance program.

2. Adequate arrangements in place for:
    *   Detecting, containing and Extinguishing a Fire
    *   Giving warning of a fire
    *   Means for notifying the Fire Services
    *   Means of containing a fire
    *   Limit the development and spread of fire
    *   Adequate means of Escape
    *   Adequate signage
    *   The provision of access to facilities for the Fire Services
    *   Use of Oxygen and Medical gases if relevant

3.   The Fire Safety Register is up to date and maintained

4. All relevant people are aware of their individual responsibilities in
        a.   The prevention of Fires and
        b.   In the event of an outbreak of fire in their area of responsibility.

5. That the Fire Safety Management Plan and Fire Safety Register are updated to reflect any changes to the facility.

Indicator 5.2

There are appropriate and safe systems in place with regards to tobacco management[13] within a mental health setting.

These are the features you need to have in place to meet this indicator:

1. There is a policy in place towards a smoke free environment, in accordance with legislation and the HSE Best Practice Guideline for Tobacco Management in the Mental Health Setting (2008).

2. The policy on a smoke free environment is implemented.

3. The smoking-cessation support services and programmes are adhered to.

4. There are individual smoking risk assessments completed and appropriate risk management plan in place.

5. The facility is smoke free and where possible, there is a strategy to move towards a smoke free environment in line with national policy.

6. There is a designated smoking area if applicable, which is well maintained.

7. There are records of inspections of smoking areas and action taken to address issues raised.

8. There are appropriate supervision arrangements for smokers where it is agreed in his or her integrated care plan.

9. There is accessible, effective and appropriate fire safety equipment and devices in place, e.g. fire blankets, fire aprons, fire extinguishers, smoke alarms.

10. Bedding and furnishings are fire safe and maintained in a condition to mitigate fire risk.

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13. *Public Health (Tobacco) Act 2002 (as amended)*

THEME 4

LEADERSHIP, GOVERNANCE AND MANAGEMENT

Theme 4
Leadership, Governance and Management

Aim 1

The mental health service has clear accountability arrangements in place to achieve the delivery of high quality, safe and reliable services.

Indicator 1.1

The mental health service identifies clear lines of accountability, responsibility and authority to oversee quality and safety.

These are the features that you need to have in place to meet this indicator:

1. There is an organisational chart in place, which demonstrates accountability arrangements at all levels of the mental health service.

2. The mental health service identifies clear lines of accountability, responsibility and authority to oversee quality and safety within the service.

3. Staff at all levels have a clear understanding of their accountability, responsibility and authority for quality and safety.

4. The persons identified have such responsibilities, authority and accountability identified in their job descriptions.

5. The persons who have responsibility authority and accountability for quality and safety demonstrate their awareness of their responsibilities for quality and safety.

6. Job descriptions outline responsibilities and accountabilities of all staff regarding the delivery of high quality, safe and reliable mental health service.

7. Staff are aware of their roles and responsibilities regarding quality and safety.

Aim 2

The mental health service has formalised governance arrangements for assuring the planning and delivery of high quality, recovery oriented, safe and reliable services.

Indicator 2.1

There are integrated corporate and clinical governance arrangements, throughout the service for assuring quality, risk and safety. These reflect the CHO operational plan, the national service plan and the mental health division operational plan.

These are the features that you need to have in place to meet this indicator:

1. The Community Health Organisation operational plan reflects the national service and mental health division operational plan, where applicable.

2. The CHO operational Plan reflects Department of Health and Health Service Executive policies and strategic directions.

3. There is consultation between managers and clinicians in the development of the CHO operational plan in a timely manner.

4. Managers and staff are aware of the CHO operational plan.

5. There is a clear management structure which includes corporate and clinical governance responsibilities and reporting relationships.

6. There is a local quality and safety committee in place, in line with the HSE (2016) Quality and Safety Committee Guidance and Resource document. This committee reports to the local management team and the service quality and safety committee, which in turn reports to the CHO quality and safety committee.

7. Quality and safety is an agenda item on every relevant meeting at all levels of the service

8. Minutes of meetings at all levels of the service show that discussion on quality, risk and safety taken place.

9. The minutes of all quality and safety committees' meetings demonstrate effective working of the committee and implementation of agreed actions, from meeting to meeting.

10. There are reports produced and circulated to the management team on quality, risk and safety indicators and outcomes.

11. This HSE Best Practice Guidance for Mental Health Services is actively implemented.

12. There is an escalation policy and system to ensure that quality and safety issues are escalated and dealt with at the appropriate level.

13. Quality and safety is considered in matters concerning finance. This is illustrated in the minutes of various management meetings.

14. The interests of service users and results of audits are taken into consideration when decisions are made about the planning, design and delivery of services.

15. The impact on service user safety and quality of care is a high priority in business decision-making. This is demonstrated within the minutes of management meetings.

16. A mechanism exits to support the constitution of committees and groups in the service, this includes, sponsorship, terms of reference, agendas and minutes for all meetings in the service. These are reviewed annually.

17. Management team meeting minutes are present and demonstrate consideration of progress against operational plan objectives and targets.

Indicator 2.2

An Integrated system to govern the development, dissemination, approval, implementation, monitoring and review of policies, is set, in accordance with regulations and best practice requirements.

Please read this indicator in conjunction with Theme 2- effective care and support, indicator 1.1.

These are the features that you need to have in place to meet this indicator:

1. There are policies in place to meet statutory and best available practice requirements.

2. All healthcare staff, service users, family and carers and other stakeholders are involved, as appropriate, in the development of Policies.

3. All operational policies and procedures are reviewed at least every three years or earlier if required from a legislative/service perspective, having regard to any recommendations made by the Mental Health Commission and in accordance with the *Mental Health Act 2001 (Approved Centres) Regulation 29 Regulations 2006, Operating Policies and Procedures.*

4. There are policies and procedures which sets out the development, dissemination, approval, implementation, monitoring and review, in accordance with the HSE national framework for developing policies, procedures and guidelines, (2016) and the Mental Health Act 2001 (Approved Centres) Regulation 29, Regulations 2006 Operating Policies and Procedures.

5. At a minimum, this policy includes:

- The roles and responsibilities for the development, management and review of operating policies and procedures.

- The processes for the development of the operating policies and procedures required by the Regulations.

- The processes for the approval of operating policies and procedures the process for dissemination operating policies and procedures either in an electronic or hard copy.

- The process for, reviewing and updating of policies and procedures at least every three years

- The processes for making obsolete and retaining previous versions of policies and procedures.

- The processes for training of staff including training following the release of a new or updated policy and procedure.

- The processes for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.

- The standard operating policy and procedure template and layout used by the service.

6. Each PPPG has a signature sheet which indicates that all staff have read and understand each operating policies, procedures, protocols and guidance.

7. Relevant staff can articulate the processes for the development and review of operating policies and procedures.

8. All policies and procedures are communicated and implemented.

9. Relevant staff have read and understood the policies and procedures on developing and reviewing operational policies, as set out in the policy. This is documented.

10. Obsolete versions of operating policies and procedures are retained but removed from possible access by staff.

11. The format of policies and procedures is standardised and is in accordance with the national framework for developing policies, procedures and guidelines, (PPPG 2016). This includes at a minimum:

- Title of the policy and procedure
- Reference number and revision of the policy and procedure
- Document owner
- Approvers
- Reviewers, where applicable
- Scope of the policy and procedure
- Date from which the policy will be implemented (effective from)
- The implementation plan
- The procedure (s)
- Scheduled review date - the document is re-dated after each review
- Total number of pages in the policy and procedure.
- Audit tool specific to the adoption of the PPPG in practice.

12. Any generic policies used are appropriate to the service and the service user' group profile

13. Where generic policies (e.g. dealing with complaints, recruitment of staff, etc.) are used, the service has a written statement, adopting the generic policy, which is reviewed at least every three years.

14. Each policy includes an audit tool to support audit of implementation.

15. There is an annual audit completed to determine compliance with policy and procedure review times. Analysis is completed to identify opportunities to improve the processes of developing and reviewing the policies.

Aim 3

Each mental health service/team maintains a publicly available Statement of Purpose that accurately describes the services provided, including how and where they are provided. The statement of purpose is communicated in an accessible format to all stakeholders, including service users.

Indicator 3.1

A Statement of Purpose is in place for each mental health service.

These are the features that you need to have in place to meet this indicator:

1. There is an up to date statement of purpose in place, which includes the:

   • Aims and objectives of the service including how resources are aligned to deliver these objectives.

   • Description of services provided.

   • Intended service-user population.

   • Inclusion/ exclusion criterion.

   • Models of service delivery and allocated resources.

   • Location or locations of service delivery.

2. The Statement of Purpose is signed off/approved by the CHO senior mental health management team in consultation with the mental health service team/local management team.

3. The service delivered reflects the approved statement of purpose.

4. The statement of purpose is communicated in an accessible format and is available publicly.

5. The statement of purpose is reviewed on an annual basis or sooner if there are any proposed service changes to ensure the statement of purpose reflects what will be delivered safely, sustainably and within available resources.

6. Notification of any changes is provided in a timely manner that allows stakeholders appropriate time to respond to proposed changes. Any necessary approval is sought before changes to the statement of purpose are made.

Aim 4

The mental health service has systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of mental health services, which are in compliance with relevant legislation, national standards, best practice, and any service level arrangements[2].

Indicator 4.1

There are systematic monitoring arrangements for identifying internal and external opportunities to improve quality and safety.

These are the features that you need to have in place to meet this indicator:

1. Data is collected from quality, risk and safety systems and used to measure and improve the service (e.g. audits, analysis, trending, complaints, risk register, safety notices, incidents, HSE nursing and midwifery metrics).

2. Information is used and shared as appropriate within and between services/agencies to inform continuous improvement and the provision of safe services; (e.g. quality and safety committees, and other areas including notice boards, journal clubs, suggestion box, survey, focus groups, sharing learning days, newsletter and conferences).

3. There are proactive measures and mechanisms in place to elicit and respond to feedback from service users, families and carers.

4. Opportunities are sought for local and national benchmarking and sharing good practice initiatives.

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2. *Section 38 Health Act, 2004 (as amended); Section 39 Health Act, 2004 (as amended)*

Indicator 4.2

The quality and safety of mental health services provided on behalf of healthcare service providers are monitored through formalised agreements, (Applicable only to services that have service level arrangements / agreements[3] with the funding body (HSE) or with external recruitment agencies[4] / contractors).

These are the features that you need to have in place to meet this indicator:

1.   A formalised, signed service level agreement is in place and is available in accordance with the national template.

2.   The service level agreement specifies:

   •   Scope of service provided.
   •   Required standards.
   •   Resources required.
   •   Quality assurance, monitoring and governance arrangements for the quality and safety of services delivered, including compliance with relevant standards.

3.   There is written evidence of monitoring of the agreement, in accordance with the requirements set out in the service level agreement.

4.   Any non-compliance with the service level agreement are acted on and appropriate action is taken to address the non-compliances.

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3. *Section 38 Health Act, 2004 (as amended); Part 2 of Service Arrangements with non-statutory agencies funded under Section 38 Health Act, 2004, Section 39 Health Act, 2004, Section 10 Child Care Act, 1991, and Commercial / For Profit*
4. *Public Service Management Recruitment and Appointments Act 2004 (as amended)*

An up-to-date register5 (Approved Centre only) is established and maintained in relation to every service user as required by legislation. The certificate of registration is managed in accordance with Mental Health Act 2001 (Approved Centres) Regulation 34

These are the features that you need to have in place to meet this indicator:

1. The register of service users is in a format determined by the Mental Health Commission and the service makes available such information to the Mental Health Commission as and when requested by the Commission.

2. A documented register (electronic or hard copy) of all service users admitted to the Approved Centre is available, with accurate and current information. The register of service users contains at a minimum the following information in accordance to the *Mental Health Act 2001 (Approved Centres) Regulations 2006), 28, Schedule 1.*

     A.   Full name.
     B.   Address.
     C.   PPSN.
     D.   Gender.
     E.   Date of birth.
     F.   Country of birth.
     G.   Ethnic or cultural background.

     White
          Irish.
          Irish Traveller.
          Roma.
          Any other white background.

     Black or Black Irish
          African.
          Any other Black background.

     Asian or Asian Irish.
          Chinese.
          Any other Asian background.
     Other, including mixed background
     Other, write in description

     H.   Next of Kin/Representative(s).
     I.   Admission date.
     J.   Discharge date.
     K.   Diagnosis on admission.
     L.   Diagnosis on discharge
     M.   Patient Status, i.e. voluntary or involuntary

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5. Regulation 28 Mental Health Act 2001 (Approved Centres) Regulations 2006

3.   The register of service users is up to date.

4.   There is a process in place to support the following, in relation to the register of service users in the approved centre:

- The roles and responsibilities for the maintenance and access to the register.
- A standard and agreed practice to be applied in updating and maintaining the register (to include informing relevant staff of the process for updating and maintaining the register).
- The method to maintain the register in the format determined by the Mental Health Commission.

5.   Relevant staff are informed of the processes relating to the updating and maintenance of the register.

6.   The registered proprietor is responsible for ensuring that the register of service users contains up-to-date and accurate information (certification of registrations)

7.   The current approved centres certificate of registration issued pursuant to section 64(3)(c) of the Act[6], including any conditions of registration, is displayed in a prominent position in the approved centre, in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 34, Certificate of Registration.

8.   Where changes have arisen in relation to the information detailed within the certificate of registration, this has been communicated to the Mental Health Commission.

9.   Defined processes are available to support the following in relation to the certificate of registration.

- The roles and responsibilities in relation to the management and display of the certificate of registration.

- The process to review the certificate of registration and communicate with the Mental Health Commission should a change be required to the content (e.g. the number of registered beds).

10.   Relevant staff are aware of the processes relating to the approved centre's certificate of registration.

11.   The registered proprietor monitors the approved centre's certificate of registration.

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6. *Section 64 Mental Health Act 2001 (as amended)*

Aim 5

The mental health service has effective management arrangements to support and promote the delivery of high quality, safe, reliable and recovery oriented services.

Indicator 5.1

Management arrangements are in place to effectively and efficiently achieve planned objectives.

These are the features that you need to have in place to meet this indicator:

1. The mental health service reviews management arrangements and identifies gaps and acts to address these gaps.

2. Effective and efficient management arrangements include the use and review of the following structures, processes and systems:

A. Workforce management
- Workforce planning is based on a documented process, in line with the assessed needs of service users, projected and actual service demand and the resources available.
- Processes for addressing issues with rosters / staff deficits.
- Attendance and absence records, policy and processes.
- Records of back to work interviews.
- Employee assistance system.
- System of agreement on annual leave and records of planned annual leave.
- Records of allocations of staff.
- System for professional development planning and review.
- System for the use and review of agency and contracted staff.
- Appropriate means of measuring demand based on acuity and activity.
- System for managing changes in demand (resource allocation, contingency plans, gate keeping policies).
- Robust Information system which facilitates workforce management.
- Exit interviews for staff.

B. Communication Management
- Terms of reference, agendas and minutes of all meetings.
- Minutes available to all relevant stakeholders.
- Clinical Handover records.
- Communication fora to improve communication (e. g. huddles, information share, broadcast, safety pause, memos).
- ICT infrastructure to support communications.
- Media management systems, Health Service Executive (HSE Land).
  Detailed terms of reference for project groups, to include how they are commissioned, established, operated and terminated.

C. Information management

- Information Governance policy.
- ICT systems
- Data Protection and Freedom of Information policy.
- Safe storage of data in line with policy.
- Consent policy.
- Confidentiality agreements included in employment contracts.
- Audit of records.
- Systems to integrate service user information.
- System to actively manage information (record retention policy, healthcare records management).
- Data protection breaches reported investigated and communicated in line with policy.

D. Environment and physical infrastructure management

- Records indicating management of estates / infrastructure and environment; Compliance with Regulation 22, Mental Health Act 2001, (Approved Centres) Regulation 2006.
- Maintenance records.
- Health and Safety statement.
- Minutes of health and safety committee and infection control meetings.
- Maintenance records of portable appliance testing.
- Records of equipment testing and servicing.
- Records of environmental assessment and relevant tests (e.g. legionella testing).
- Fire register / fire safety records.
- Records of assessing, adaptation and customising the environment to meet service user's needs (e.g. safety considerations, ligature points, accessibility needs, compartmentation).
- Quality improvement and audit results being implemented.

E. Financial and resource management

- Financial and resource management system in accordance with HSE National financial regulations.
- Financial control regulation processes complied with (E.G staff above grade eight sign annual declaration)
- Committee meeting records (including audit and finance sub-committees where in place).
- Policy, system and safeguards on service user finance are aligned to national financial regulations.
- Agreed budgetary allocation in place.
- Agreed budget is appropriated managed to deliver operational plan.
- Service level arrangement and records of monitoring and compliance with these.
- Internal and external audit records.
- Evidence of implementation of actions from audits.
- Records of theft and fraud preventative measures.

E. Financial and resource management

- Financial and resource management system in accordance with HSE National financial regulations.
- Financial control regulation processes complied with (E.G staff above grade eight sign annual declaration)
- Committee meeting records (including audit and finance sub-committees where in place).
- Policy, system and safeguards on service user finance are aligned to national financial regulations.
- Agreed budgetary allocation in place.
- Agreed budget is appropriated managed to deliver operational plan.
- Service level arrangement and records of monitoring and compliance with these.
- Internal and external audit records.
- Evidence of implementation of actions from audits.
- Records of theft and fraud preventative measures.

F. Regulatory management

- System of notification to Regulatory Authorities and other agencies.
- Analysis of the system of notifications.
- Nominated person allocated responsibility for
  1) Notification of Incidents in accordance with MHC and other regulatory requirements and
  2) Maintenance of records in accordance with HSE Standards and recommended practices for Healthcare records management 2011.
- Compliance with Mental Health Commission Codes of Practice and Guidance & Rules and Regulations.
- Clear tracking of regulatory activity and responses taken to address breaches/conditions/recommendations/immediate action notices.
- Professional registration requirements adhered to.

Indicator 5.2

The mental health service is adequately insured[7] against accidents and injury to service users, staff, relevant others and to the service itself.

These are the features that you need to have in place to meet this indicator:

1. The service insurance is comprehensive and covers accidents or injury to service users, staff and others, loss or damage to the assets of the service user, any services provided and the building and its contents.

2. There are defined policies and procedures in place regarding insurance and they include:

- The roles and responsibilities in relation to the sourcing, scope and payment of insurance.
- Process for ensuring insurance is in place and up to date.
- The process for required approval to renew the insurance annually, or as appropriate.
- The process for the provision of evidence of insurance to relevant individuals or bodies, including the Mental Health Commission.
- The process to be applied in the event of a claim being submitted by a service user, visitor or staff member

3. The policies and procedures are implemented

4. The policies and procedures cover the following:

- Public liability;
- Employers' liability;
- Clinical indemnity; and
- Property

5. Relevant staff are aware of the processes relating to the approved centre's insurance cover.

6. There is a process for an annual claims review with the insurance provider.

7. Insurance is in place for the number of service users in the service / centre and on the capacity of the service.

8. The Insurance certificates are available and up to date.

9. There is a review of the scope of insurance cover in accordance with any increase in the risk of injury to service users, staff, visitors or others.

10. An audit is completed of the notification to the state claims agency and to insurers for potential claims.

11. There is an indemnity scheme statement available for inspection or on request by the Mental Health Commission as provided by the HSE insurers.

12. Confirmation of insurance is available in documentary form and in date on inspection and on request by the Mental Health Commission.

7. *Regulation 33 Mental Health Act 2001 (Approved Centres) Regulations 2006*

Aim 6

Managers at all levels in the mental health service promote and strengthen a culture of quality and safety throughout the service.

Indicator 6.1

Managers at all levels demonstrate a clear commitment to promote and strengthen a culture of quality and safety.

These are the features that you need to have in place to meet this indicator:

1. The HSE mission statement, are in place and displayed.

2. The Health Service Executive Code of Governance (October 2015) is adhered to and includes the code of conduct and management of conflict of interest. Management staff are aware of this code.

3. Resources are allocated and training is provided to promote quality and safety.

4. Quality and safety processes are developed and evaluated.

5. The HSE open disclosure policy is implemented.

6. The Managers promote and facilitate service user feedback.

7. There is external input to improve the quality and safety of services.

8. There are management and training opportunities for staff to support quality and safety.

9. Management walkabouts and visibility of leadership occur.

10. Quality and safety issues are prioritised and included as an agenda item in all meetings.

11. There is senior management presence on quality committees and initiatives.

12. Managers sponsor specific quality initiatives.

THEME 5

WORKFORCE

Theme 5
Workforce

Aim 1

The mental health services plans, organises and manages its workforce to achieve its objectives for high quality, recovery oriented, safe and reliable services.

Indicator 1.1

There are appropriate numbers and skill mix of staff and these are effectively managed to meet the assessed needs of the service users and the size and layout of the service.

These are the features that you need to have in place to meet this indicator:

1. There are written policies and procedures in place for services in relation to the recruitment, selection and vetting of staff.

2. At a minimum, the policies and procedures on staffing include:

- The roles and responsibilities for the recruitment, selection, vetting and appointment processes for all staff within the mental health service.
- The recruitment, selection and appointment process of the service, including the Garda vetting requirements.
- The roles and responsibilities in relation to staffing processes.
- The roles and responsibilities in relation to staff training processes within the approved centre.
- The organisational structure of the approved centre, including lines of responsibility.
- The job description requirements.
- The staff planning requirements to address the number and skill mix of staff appropriate to the assessed needs of service users as well as the size and layout of the approved centre.
- The staff rota details and the methods applied for its communication to staff.
- The orientation and induction training for all new staff.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications and accreditation of training personnel.
- The evaluation of training programmes.
- The staff performance and evaluation requirements.
- The use of agency staff

3. Relevant staff have read and understood the staffing policies and procedures. This is documented.

4. Relevant staff can articulate the processes relating to staffing as set out in the policies and procedures.

5. There are sufficient staff with the appropriate qualifications to do their job; to meet the number and assessed needs of the service users, the size and layout of the service and the statement of purpose; and in accordance with the, *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 26, (2), Staffing*.

6. There is a written staffing plan for the mental health service which takes into consideration the following:

   - The skill mix, competencies, number and qualifications of staff
   - The assessed needs of the service user group profile of the service through the following:
     - The size and layout of the centre.
     - The level of acuity of psychiatric illness.
     - The age profile of service users.
     - The length of stay of service users.
     - The physical and psychological care needs of service users.
     - Behaviours of concern exhibited by service users.
     - The level of dependency and need for supervision of the service users.
     - The number of beds available.

7. There is a planned and actual roster in place showing staff on duty during the day and night. Records of changes are tracked, identified and reviewed.

8. There is a documented process for reassignment of staff in response to changing needs and staff shortages.

9. There is a required number of staff on duty at all times to ensure safety of service users in the event of a fire or other emergency.

10. There is a documented process in place for transferring responsibility of care from one staff member to another, e.g. change of shift, inter-agency transfer.

11. There is continuity of care and support provided to service users, particularly where staff are employed on less than a full-time basis.

12. There are sufficient staffing levels to avoid an over-dependency on the use of temporary and agency staff.

13. There is an appropriately qualified and experienced staff member on duty and in charge at all times. This is documented.

14. Strategies for the retention of staff are in place (e.g. provision of additional training, professional development and in-house promotion opportunities).

15. Senior management arrange for additional staff to cover shifts in an emergency (e.g. serious incident, outbreak of infectious disease and in the event of evacuation).

16. There is ongoing workforce planning in the mental health service to avoid gaps in service delivery.

17. The number and skill mix of staff is reviewed against the level recorded in each approved centre's registration.

18. Review and analysis is completed within the mental health service to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of service users. The findings and lessons learned are shared and documented.

Aim 2

The mental health service recruits staff with the required competencies to provide high quality, recovery oriented, safe and reliable services.

Indicator 2.1

A rigorous recruitment process is in place in the service.

These are the features that you need to have in place to meet this indicator:

1. There are written policies and procedures relating to the recruitment, selection, vetting and appointment of staff, based on Irish and European legislation, and in *accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 26, (1) Staffing*.

2. The policies and procedures relating to recruitment, selection, vetting and appointment are implemented.

3. The service site management team have read and understand the policies and procedures, and this is documented.

4. The service site management staff can articulate the processes relating to staffing as set out in the policies.

5. Service users, family and carers are involved in the recruitment process, where appropriate.

6. Those involved in recruitment and selection receive relevant training.

7. Staff, including temporary, permanent, contract and volunteers are recruited in accordance with employment and equality legislation[1] and with the legislation governing public service appointments[2] and best practice.

8. Where a recruitment agency is used to recruit staff, only recruitments agencies that are approved by the Commission for Public Service Appointments as "listed recruitment agencies" may be used.

9. The service site manager/head of discipline and /or the National Recruitment Service (NRS) identify the skills, competencies and personal attributes required of staff and recruits accordingly.

10. Garda vetting is carried out on all staff, contractors, volunteers, students on placements and on work place experience, and all other relevant personnel in as required.

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1. *Employment Equality Acts 1998 to 2015*
2. *Public Service Management (Recruitment and Appointments) Acts 2004 as amended and the Codes of Practice published by the Commission on Public Service Appointments pursuant to that Act.*

11. Contractors on site are obliged to provide evidence of appropriate indemnity and insurance and appropriate records of such indemnity and insurance are maintained by the mental health service and appropriate records are kept of indemnity and insurance.

12. Three satisfactory written references are obtained and verified before staff start working in the service. These include one written reference from each employee's most recent line manager/employer.

13. Where employment records are maintained nationally, records are maintained locally for verification in accordance with the Data Protection Act 1998 – 2003.

14. All staff have a written contract of employment signed by the staff member and on behalf of the employer and a job description and a copy of their terms and conditions prior to taking up their post.

15. Where agency staff are used, there is a comprehensive contract that sets out the agency's responsibilities in relation to:

- Vetting of staff, including Garda vetting and references and vetting from other jurisdictions as appropriate.

- Confirmation of registration with relevant professional organisations/ validation of status (where applicable).

- Confirmation of attendance at mandatory training, as applicable to the service.

- Confirmation of identity.

- Confirmation of entitlement to work in the State, where necessary.

- Professional indemnity.

- Confirmation of staff training.

- Arrangements for responding to concerns and complaints.

- Indemnity for the mental health service in respect of wrong doing on behalf of the employment agency.

Aim 3

The mental health service ensures that its workforce has the competencies and capabilities required to deliver high quality, recovery oriented, safe and reliable services.

Indicator 3.1

Staff are supported in maintaining and developing their competencies.

These are the features that you need to have in place to meet this indicator:

1. Appropriate orientation, induction, probation and ongoing training programmes (including e-learning) are provided to the workforce, including agency staff.

2. A training needs analysis (TNA) is carried out annually on or on behalf of the service and this includes:

   • Circulation of TNA questionnaires

   • Feedback from staff, service managers, Multi Disciplinary Teams, service users and family and carers.

3. The TNA takes account of the following: -

   • Work force reviews.

   • Systems audits.

   • Review of incidents and other key indicators (e.g. complaints, safeguarding issues, safety issues, audit outcomes, changes to service user profiles and changing needs).

4. Training and development plans are reviewed on an annual basis.

5. Annual training and development plans are completed for all disciplines, to reflect the training needs analysis and the assessed needs of the service user group.

6. Staff have access to education and training resources, including local internet access, access to HSE Land, access to appropriate journal publications and HSE regional libraries.

7. Staff are trained to implement therapeutic and recovery based care and support for service users at each stage of his or her care pathway (including: during the assisted admission process; whenever all aspects of care and support are provided; before and during discharge). Training should consider the impact of involuntary admission on service users and their families and associated issues in developing and maintaining therapeutic engagement.

8. Staff training records and logs are maintained by line managers for all disciplines and these are available for review. Training provided is in accordance with professional development planning and linked to the skills required in the service area.

9. All education and training programmes delivered are evaluated and periodically reviewed, and records are maintained of this.

10. Staff are (where appropriate and within available resources) provided with protected time and financial support for education and training, to include academic study, continued professional development requirements for professional registration and research activity.

11. There are resources, facilities and equipment available for staff in-service education and training (whether didactic or through e-learning, demonstration work-based projects, etc.)

12. In-service training is provided by appropriately trained and competent individuals.

13. A copy of the *Mental Health Act (2001) and any Regulations, Rules and Codes of Practice* made thereunder are made available to all staff in the approved centre or on request. In accordance with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 26,(6) Staffing.*

14. All staff members are made aware of the provisions of the *Mental Health Act (2001)* and all Regulations, Rules and Codes of Practice made thereunder, commensurate with their role, *in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 26, (5), Staffing.*

15. Records are maintained of management training including supervision, which is provided to all managers who manage front-line staff.

16. Staff are provided with training to meet the assessed needs of service users, in accordance with their roles, responsibilities and areas of work.

17. All healthcare professionals and support staff are trained in the following, in accordance with legislation and best available practice, as pertinent to their role and any CPD requirements:

- Fire safety
- Basic Life Support
- First Aid
- Hazard Analysis Critical Control Points (HACCP)
- Management of violence and aggression (e.g. Therapeutic Crisis Intervention (TCI) /Professional Management of Aggression and Violence (PMAV)
- The Mental Health Act (2001)
- Children First
- Open disclosure
- Manual handling
- Medication management training as appropriate
- Recovery-centred approaches to mental healthcare and treatment, including individual rights
- Infection control and prevention (including sharps, hand hygiene techniques and use of PPE)
- Risk management – individual, organisational and care and treatment provision as appropriate to the staff role
- Incident reporting
- Documentation and record keeping
- Individual Care Planning
- Care of service users with an intellectual disability.

18. Training may also include, but is not restricted to the following:

- Safeguarding vulnerable persons / Adults at risk of abuse
- Dementia care
- End of life care

19. Relevant staff providing support to children are trained on the policy relating to children's education and its implementation.

20. Non-clinical staff receive training to develop an understanding of mental health and recovery.

21. There is oversight and governance of those who provide training to the services to ensure a competent, coordinated, evidenced based approach.

22. There is a collaborative approach to the development and delivery of all new mental health training programmes that are in keeping with a recovery orientated approach, including co-production, co-delivery and co-evaluation. This includes training on the involuntary admission process, including the assisted admission process.

23. Wherever possible staff education and training occurs within a multidisciplinary context.

Indicator 3.2

Regular formal and informal supervision is available to staff to ensure that they perform their job to the best of their ability. See also indicator 4.1 Professional Development Planning

These are the features that you need to have in place to meet this indicator:

1. There are guidelines to govern the implementation of supervision.

2. The guidelines are implemented.

3. There is a formalised written contract of supervision between the supervisor and supervisee.

4. Staff have access to individual, peer or group clinical supervision as per local guidelines.

5. There is a system to track supervision.

6. A written record is kept of any supervision meeting and a copy is given to the member of staff.

Aim 4

The mental health service supports its workforce in delivering high quality, recovery oriented safe and reliable services.

Indicator 4.1

The mental health service has arrangements to support staff in delivering high quality care.

These are the features that you need to have in place to meet this indicator:

1. There are policies and procedures on professional development planning.

2. The policies and procedures on professional development planning are implemented.

3. A documented professional development planning system is in place.

4. Individual professional development plans and system-wide tracking of staff participation are in place.

5. A written record is kept of each professional development planning meeting and a copy is given to the member of staff.

6. The record is signed by the line manager and staff member at the end of each meeting. These records are maintained confidentially.

7. Mechanisms are in place to support staff engagement, consultation and responding to staff feedback. Staff have access to health and safety programmes, employee assistance programmes and occupational health.

8. Staff receive debriefing in a timely manner after incidents or responding to people in crises.

9. There are measures in place to protect the work force by minimising the risk of violence, bullying and harassment by other members of the work force or people using the service.

Indicator 4.2

There is an effective performance management system in place which is collaborative.

These are the features that you need to have in place to meet this indicator:

1. There are policies and procedures on performance management in place, in accordance with HSE Guidance Document 2012.

2. The policies and procedures on performance management are implemented.

3. Team performance is measured and monitored and appropriate action taken to respond to underperforming teams. This includes indicators for each team and audit of each team's performance.

Indicator 4.3

The mental health service has a culture of openness and accountability.

These are the features that you need to have in place to meet this indicator:

1. Staff are supported to critically assess and reflect on their practice and to propose areas for improvement.

2. There is ongoing evaluation and response to feedback about the service from service users and staff.

3. A culture survey is completed on a two yearly basis by a member of senior management and action is taken to respond to issues raised.

4. Staff are aware of policies and are clear on their responsibilities relating to openness and transparency and there is evidence of implementation.

   These include:

   - Complaints Policy

   - Trust in Care Policy

   - Dignity at Work Policy

   - Safeguarding Vulnerable Persons at Risk of Abuse Policy

   - Open Disclosure Policy

   - Protected Disclosure Policy

5. Relevant information that is gleaned from the above policies, procedures are discussed with staff and relevant others and is used to improve the service.

6. Information and data on open disclosure is presented to the management and relevant committees, as appropriate.

7. Staff are appropriately supported if a complaint or concern has been expressed about them.

8. Staff who make a complaint or disclosure are appropriately supported.

Indicator 4.4

The service has formal processes to support and sustain multi-disciplinary teams.

These are the features that you need to have in place to meet this indicator:

1. There are multidisciplinary teams in place which include staff with the appropriate qualification, skills and experience to address the assessed needs of the population in a recovery oriented way, in accordance with *Advancing Community Mental Health Services in Ireland 2012 and Vision for Change 2006*.

2. Teams have clearly defined goals and robust governance structures as well as agreement regarding their model of clinical responsibility.

3. There is a communication protocol about how communication will take place within teams.

4. All team members are aware of their own team roles and target population.

5. All team members understand the roles of other relevant teams in the system.

6. The team co-ordinator is responsible for the coordination and integration of service user care.

7. Minutes are maintained of multidisciplinary team meetings, in accordance with *Advancing Community Mental Health Services in Ireland, 2012 Guidance Paper 5*.

8. Training programmes reflect the benefits of multi-disciplinary practice and strategies to improve this practice.

APPENDICES

4

HSE Mental Health Services

Self-Assessment Seclusion Checklist

Appendix 1

(Refer to: Theme 2 Effective Care & Support, Aim 1, Indicator 1.3)

Name of Centre / Service:	
Date of Self-Assessment:	
Name of person(s) carrying out the Self-Assessment:	
Signature (s) of person(s) carrying out the Self-Assessment:	

Seclusion Check-list

This check-list supports staff to self-assess against Aim 1 in Effective Care and Support. Those carrying out the self-assessment can use this check-list to help them to determine if Indicator 1.3 in particular, of that Aim is being met.

Indicator 1.3

All aspects of the *Mental Health Act (2001, Section 69(2), Rules on Seclusion* are complied with.

	Evidence that indicator is being met	Yes	No	Comment
1	The Seclusion register is present in the Approved Centre.			
2	A supply of Seclusion Observation Charts is present in the Approved Centre.			
3	For each episode of seclusion, the decision to seclude the patient is clearly recorded in the patient's clinical file.			
4	For each episode of seclusion, the decision to seclude is dated.			
5	For each episode of seclusion, the decision to seclude is timed.			
6	For each episode of seclusion, the decision to seclude is signed.			
7	There is documentary evidence that alternatives to seclusion were considered.			
8	There is documentary evidence that the patient has been assessed (including a risk assessment) before the seclusion order is signed.			
9	There is documentary evidence of a medical review of the patient in seclusion within 4 hours of the commencement of the seclusion episode.			
10	For each episode of seclusion, the seclusion register is fully completed within 24 hours.			
11	A copy of the completed seclusion register is in the patient's clinical file.			

	Evidence that indicator is being met	Yes	No	Comment
12	There is documentary evidence that the patient was/was not informed of the reason for seclusion.			
13	There is documentary evidence that the patient was/was not informed of the likely duration of the period of seclusion.			
14	There is documentary evidence that the patient was/was not informed of the likely duration & circumstances which will lead to discontinuation of seclusion.			
15	For adult patients - There is documentary evidence that the patient's next of kin or representative was informed of the patient's seclusion (except where the patient refuses to give consent for this).			
16	For child patients - There is documentary evidence that the patient's parent or guardian was informed of the patient's seclusion.			
17	In the event that the patient's next of kin was not informed, the reason is clearly documented in the patient's clinical file.			
18	There is documentary evidence that the patient's individual care and treatment plan is commenced and addresses the assessed needs of the patient in seclusion, with the goal of bringing seclusion to an end.			
19	There is documentary evidence that the seclusion observation chart is completed every 15 minutes.			

	Evidence that indicator is being met	Yes	No	Comment
20	This includes a record of the patient's level of distress and their behaviour.			
21	If the behaviour has abated, there is documentary evidence that the discontinuation of seclusion has been considered.			
22	There is documentary evidence that 2 staff (1 of whom must be a Registered Nurse) reviewed the patient every 2 hours (unless to do so would place the patient or staff at a high risk of injury - in which case the reason for this is clearly documented); and the review is documented in the patient's clinical file.			
23	There is documentary evidence that the 4-hourly medical review is conducted and documented.			
24	Where a patient was sleeping, and clinical judgement determined that the 4-hourly medical review was suspended due to this; this is clearly recorded.			
25	There is documentary evidence that the seclusion care plan is commenced.			
26	There is documentary evidence that the seclusion care plan is reviewed regularly.			
27	Seclusion of a patient with a known psycho-social/medical condition, in which close confinement would be contraindicated, is only used when all alternative options have been implemented and proven unsuccessful.			
28	Observation confirms that the clothing worn in seclusion respects the patient's dignity, bodily integrity and privacy.			

	Evidence that indicator is being met	Yes	No	Comment
29	If clothing is not worn, the reason is documented in the patient's individual care and treatment plan and there is evidence that all efforts **have** been made to preserve the patient's dignity and privacy.			
30	Where refractive clothing is worn, this complies with the patient's documented risk assessment and management plan.			
31	Observation confirms that patients in seclusion do not have access to hazardous objects.			
32	Where bodily searches take place, these respect the right of the patient to dignity, bodily integrity and privacy.			
33	Staff are aware of the rules that seclusion can be ended at any time; in accordance with the conditions set out in Rules 7.1 and 7.2.			
34	There is documentary evidence that the seclusion has discontinued and an end time recorded.			
35	There is evidence that the patient has been informed of the ending of an episode of seclusion.			
36	The reason for the ending of seclusion is recorded in the patient's clinical file.			
37	There is documentary evidence that the post seclusion care plan commenced.			
38	There is evidence that the patient was afforded the opportunity to discuss the episode of seclusion with members of the Multi-Disciplinary Team involved in their care and treatment; post episode.			

	Evidence that indicator is being met	Yes	No	Comment
39	There is documentary evidence that the episode of seclusion was reviewed by members of the Multi-Disciplinary Team; as soon as practicable as and in any event no later than 2 normal working days after the episode of seclusion.			
40	There is an annual report on the use of seclusion available, based on information gathered on the use of seclusion.			

41	Length of Seclusion Episodes for this approved centre
	Review all episodes of the use of seclusion in the last three months (for example at a minimum review the last five episodes). 0-8 hours 9-16 17-24 25-32 33-40 41-48 49-56 57-64 65-72 72 hours

		Yes	No	
42	There is documentary evidence that the Consultant Psychiatrist has seen and examined the patient after a continuous period of 24 hours seclusion.			
43	There is documentary evidence that the Consultant Psychiatrist has seen and examined the patient after a continuous period of 48 hours seclusion.			
44	There is documentary evidence that the Consultant Psychiatrist has seen and examined the patient after a continuous period of 72 hours seclusion.			
45	There is documentary evidence that the Consultant Psychiatrist has notified the MHC or Inspector of Mental Health Services (→72 hrs seclusion).			

HSE Mental Health Services

Self-Assessment – Electro Convulsive Therapy Checklist

Appendix 2

(Refer to: Theme 2 Effective Care & Support, Aim 1, Indicator 1.4)

Name of Centre / Service:	
Date of Self-Assessment:	
Name of person(s) carrying out the Self-Assessment:	
Signature (s) of person(s) carrying out the Self-Assessment:	

It is recommended that you review the use of ECT for the previous three months.

Electro Convulsive Therapy Check-list

Using this check-list supports staff to self-assess against Aim 1, to determine whether Indicator 1.4 is being met.

Please note that the Rules and Code of Practice are similar in all respects in terms of content, with two exceptions.

1. Part 2 (section 4) of the Rules, which relates to Absence of Consent; is not included in the Code of Practice, as the Code of Practice relates to voluntary patients and the administration of ECT. Therefore, if using this tool for voluntary patients, please exclude questions 19-22.

2. The auxiliary verb "must" is used in the rules. The auxiliary verb "should" is used in the code of practice.

Indicator 1.4

All aspects of the *Mental Health Act (2001, Section 59(2)* and the ***Mental Health Commission Rules and Code of Practice governing the use of Electro-Convulsive Therapy (ECT)* are complied with**.

	Information provided to Patient			
1.	The consultant psychiatrist responsible for the patient has provided information about ECT to the patient. The information included: a. The nature of the treatment of ECT b. A description of the process of ECT c. The purpose of treatment with ECT d. The intended benefit of the treatment with ECT e. The possible consequences of not having ECT f. Treatment alternatives to ECT g. Confirmation that the patient will be offered alternative treatment to ECT if he/she decides to withhold consent.			

	Evidence that indicator is being met	Yes	No	Comment
2.	Information on the likelihood of adverse effects of ECT, including risk of cognitive impairment, amnesia and other potential side effects, has been provided to the patient.			
3.	Information was provided both orally and in writing to the patient, in a clear and language format that the patient can understand.			
4.	Information was provided in languages other than English if necessary and access to an interpreter, including Irish sign language interpreter, was available if required.			
5.	The patient was given at least 24 hours to reflect on the information provided, subject to the urgency of the clinical circumstances.			
6.	The patient was informed that he/she could access an advocate of his/her choosing at any stage.			
7.	Opportunities were provided to the patient to ask questions at any time before, during or after the ECT programme and these questions were answered.			
8.	A record of discussions with the patient regarding the ECT programme was maintained in his/her file.			
	Consent	Yes	No	Comment
9.	The patient was considered capable to give informed consent to ECT and anaesthesia, unless there was evidence to the contrary.			

	Consent	Yes	No	Comment
10.	The responsible consultant psychiatrist was satisfied that the patient had the capability to give consent before he or she obtained consent from the patient for the programme of ECT and anaesthesia.			
11.	There is documentary confirmation that the patient's capacity to consent included an ability to: a. Understand the nature of ECT b. Understand why ECT is being proposed c. Understand the benefits, risks and alternatives to receiving ECT d. Understand the likely side effects (including but not restricted to short term memory loss, nausea, headache, jaw pain and muscle ache) e. Understand and believe the consequences of not receiving ECT f. Retain the information long enough to make a decision to receive or not receive ECT g. Freely choose to receive or refuse ECT h. Communicate the decision to consent to ECT i.			
12.	Written records of assessments of capacity to consent to ECT were kept in the patient's clinical file.			

	Consent	Yes	No	Comment

13.	Written consent to the ECT programme and anaesthesia was obtained, including:
	  a. Confirmation that all the points outlined in No. 1 above were discussed with the patient
	  b. Confirmation that the patient was provided with all relevant information
	  c. Confirmation that the patient could withdraw his/her consent at any point during the treatment session			

14.	Written consent was obtained for **each** treatment session, including anaesthesia.			
15.	All consent was obtained by the consultant psychiatrist responsible for the patient or by a registered medical practitioner under the supervision of the responsible consultant psychiatrist, prior to each ECT treatment session and was recorded in the patient's clinical file.			
16.	Consent for ECT was not provided by a relative/carer/guardian on behalf of the patient.			
17.	Coercion or threat was not used to obtain consent.			
18.	ECT was only administered without consent when it had been determined that the patient is unable to give consent; as per Section 59 (1) (b) of the 2001 Act, as amended. Where it is administered in this situation the programme of ECT has been a) approved (in the form specified by The Mental Health Commission) by the consultant psychiatrist responsible			

	Consent	Yes	No	Comment

13.	Written consent to the ECT programme and anaesthesia was obtained, including:
	  a. Confirmation that all the points outlined in No. 1 above were discussed with the patient
	  b. Confirmation that the patient was provided with all relevant information
	  c. Confirmation that the patient could withdraw his/her consent at any point during the treatment session			

14.	Written consent was obtained for **each** treatment session, including anaesthesia.			
15.	All consent was obtained by the consultant psychiatrist responsible for the patient or by a registered medical practitioner under the supervision of the responsible consultant psychiatrist, prior to each ECT treatment session and was recorded in the patient's clinical file.			
16.	Consent for ECT was not provided by a relative/carer/guardian on behalf of the patient.			
17.	Coercion or threat was not used to obtain consent.			

	Consent	Yes	No	Comment
18.	ECT was only administered without consent when it had been determined that the patient is unable to give consent; as per Section 59 (1) (b) of the 2001 Act, as amended. Where it is administered in this situation the programme of ECT has been a) approved (in the form specified by The Mental Health Commission) by the consultant psychiatrist responsible for the care and treatment of the patient b) Authorised (in the form specified by The Mental Health Commission) by another consultant psychiatrist following referral of the matter to him or her by the first mentioned psychiatrist			
19	For each programme of ECT *Form 16: Electro-Convulsive Therapy Involuntary Patient (Adult) – Unable to Consent* was completed by both psychiatrists.			
20.	Both consultant psychiatrists assessed and recorded: a. How the treatment would benefit the patient b. Any discussions with and views expressed by the patient c. Any assistance provided in relation to the above discussion/s d. The patient's ability to give consent to the treatment			

	Consent	Yes	No	Comment
21.	*Form 16: Electro-Convulsive Therapy Involuntary Patient (Adult)* – Unable to Consent was placed in the patient's clinical file. A copy was also sent to the Mental Health Commission in accordance with the specified time-frame.			

	Administration of ECT Part 1: Prescription of ECT	Yes	No	Comment
22.	The programme of ECT was only prescribed by the consultant psychiatrist responsible for the patient.			
23.	The consultant psychiatrist responsible for the patient recorded the decision to prescribe ECT in the patient's file. This record included: a. The reason for the decision to use ECT b. Alternative therapies that were considered or proved ineffective c. Discussion with the patient, and where appropriate, the patient's next of kin or representative d. A current mental state examination e. The assessments included in Rule 6 (see points 26-30 below)			
24.	The initial stimulus dose of electricity to be delivered to the patient was discussed and considered by the treating consulting psychiatrist and the consultant psychiatrist responsible for the administration of ECT in advance of ECT and was prescribed accordingly.			

	Administration of ECT Part 2: Patient Assessment	Yes	No	Comment
25.	A cognitive assessment was completed on the patient before each programme of ECT.			
26.	The patient's clinical status was assessed before and following each ECT treatment session.			
27.	The patient's cognitive functioning was monitored on an ongoing basis throughout the programme of ECT.			
28.	A cognitive assessment, in line with best international practice, was completed for the patient after each programme of ECT.			
29.	The consultant psychiatrist, in consultation with the patient, reviewed the patient's progress and the need for continuation of the programme of ECT. When the ECT programme was terminated reasons for its termination were documented in the patient's clinical file.			
	Administration of ECT Part 3: Anaesthesia	Yes	No	Comment
30.	Anaesthesia for ECT was given by an anaesthetist who had experience in providing anaesthesia for ECT. Where the anaesthetist was not a consultant anaesthetist, he or she was under the supervision of a consultant anaesthetist.			
31.	Formal identification of the patient was confirmed to the anaesthetist.			
32.	The anaesthetist ensured that a pre-anaesthetic assessment had been carried out and this was recorded in the patient's clinical file. This pre-assessment included: a) A detailed medical history and a full physical examination			

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32.	b) Any physical problem was recorded and the anaesthetist was notified c) A detailed medication history, including allergies or previous anaesthetic difficulties, was taken and recorded d) The presence or absence of dental problems and/or dentures were noted e) The length of time the patient had been fasting was recorded f) Relevant haematology and biochemistry investigations that were needed before the start of the ECT programme g) An ECG for patients with cardiovascular disease or who have risk factors for cardiovascular disease was performed h) A chest X-Ray was carried out if the patient had cardio-respiratory problems i) Any other relevant information.			
33.	The anaesthetic risk of the patient was assessed by the anaesthetist and recorded in the patient's clinical file. Any subsequent variation in the anaesthetic risk of the patient was recorded before the ECT treatment session.			
34.	The designated ECT nurse checked that the pre-anaesthetic assessment was completed and made it available to the anaesthetist.			
35.	The patient's consent form, Mental Health Act (2001) documentation, clinical file, medication prescription chart and record of administered drugs and a copy of any other supporting documentation relating to consent was made available to the anaesthetist.			

	Administration of ECT Part 3: Anaesthesia	Yes	No	Comment
36.	The anaesthetic induction agent used for the patient remained consistent throughout the duration of his/her programme of ECT unless such an approach was contraindicated.			
37.	The doses of all anaesthetic agents used, the patient's response and the monitor recordings before and immediately after treatment and recovery were recorded and dated. The record was signed by the anaesthetist and filed on the patient's clinical file.			
38.	The anaesthetist was responsible for anaesthesia and recovery of the patient. He or she did not leave the ECT suite before being satisfied that the patient was fully recovered.			
	Administration of ECT Part 4: Administration of ECT	Yes	No	Comment
39.	The patient's clinical file and the forms required by the Rules / Code of Practice Governing the use of Electro-Convulsive Therapy (Mental Health Commission 2016) were made available to all involved in the administration of ECT.			
40.	ECT was administered by a registered medical practitioner. Where the registered medical practitioner is not a consultant psychiatrist, he or she was under the supervision of a consultant psychiatrist.			
41.	ECT was administered by a constant current, brief pulse ECT machine capable of delivering a wide range of electrical dose, in line with best international practice.			

	Administration of ECT Part 4: Administration of ECT	Yes	No	Comment
42.	ECT was administered to a patient using the same ECT machine throughout his/her programme of ECT, unless in exceptional circumstances. Where the same machine was not used, the rationale for this was clearly documented in the patient's clinical file.			
43.	Stimulus dosing or using recommended starting dose regimes (per age/sex) in line with best international practice, were used and recorded in the ECT record.			
	Administration of ECT Part 5: ECT Suite	Yes	No	Comment
44.	ECT was carried out in a dedicated ECT suite in a service or where deemed appropriate, in a specified location in a critical care area in a general hospital or maternity hospital, in line with best international practice.			
45.	The ECT suite had a private waiting area, an adequately equipped treatment room and an adequately equipped recovery room.			
46.	High risk patients were treated in an environment allowing rapid intervention should complications occur, for example, a theatre suite or its recovery area.			
47.	The recovery room was of sufficient size to accommodate the number of patients receiving ECT at each treatment session.			
48.	There was a facility for EEG monitoring on two channels.			

	Administration of ECT Part 5: ECT Suite	Yes	No	Comment
49.	All machines had a regular programme of maintenance, calibration and service. Records of maintenance were kept safe by the service and confirmation of the service was identifiable from the machine, as is appropriate.			
50.	All materials and equipment in the ECT suite, including emergency drugs, were in accordance with best international practice.			
51.	Up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia were prominently displayed.			
	Administration of ECT Part 6: Staffing	Yes	No	Comment
52.	There was a named consultant psychiatrist with overall responsibility for the management of ECT.			
53.	There was a named consultant anaesthetist with overall responsibility for anaesthesia.			
54.	There was a minimum number of two registered nursing staff in the ECT suite at all times to safely meet the needs of patients, one of whom was designated as having overall responsibility for nursing care for patients receiving ECT.			
55.	The designated ECT nurse was responsible for ensuring that before each ECT treatment session, emergency resuscitation equipment was tested and checked in the ECT suite, and the emergency drugs tray had been recently checked and stocked. All such checks were recorded.			

	Administration of ECT Part 6: Staffing	Yes	No	Comment
56.	The designated ECT nurse was in the treatment room while ECT was being administered.			
57.	All staff involved in ECT had up to date accredited training commensurate to their role, in accordance with best international practice.			
58.	All staff involved in ECT had accredited training and education in basic life support techniques.			
	Administration of ECT Part 7: Documentation	Yes	No	Comment
59.	The ECT Register was completed for the patient on conclusion of a programme of ECT and a copy was filed in the patient's clinical file.			
60.	The Register was made accessible to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.			
61.	Pre-ECT assessments (capacity to consent, consent, pre-anaesthetic assessment, anaesthetic risk, mental state) were completed and filed in the patient's clinical file.			
62.	A record of ECT was completed after each ECT treatment session and filed in the patient's clinical file. The record included: a) Session number; b) Laterality; c) Dose (prescribed and administered); d) Duration and quality of seizure; e) Any/all complications experienced; and f) Signature of registered medical practitioner(s) administering ECT.			

	Administration of ECT Part 7: Documentation	Yes	No	Comment
63.	A record of anaesthesia was completed after each ECT session and filed in the patient's clinical file.			
64.	Post-ECT assessments (clinical status, patient progress) were recorded after each ECT treatment session in the patient's clinical file. A reason for continuing or discontinuing further ECT was outlined. Any adverse events during or following ECT were addressed in full and recorded.			
65	A copy of all cognitive assessments that were completed were filed in the patient's clinical file.			
	Administration of ECT Part 8: Clinical Governance	Yes	No	Comment
66.	A service where ECT is administered to patients has written operational policies and procedures concerning ECT and ensured that such procedures comply with the Rules Governing the use of Electro-Convulsive Therapy (Mental Health Commission 2016).			
67.	Written operational policies and procedures concerning ECT were reviewed annually, in accordance with best international practice.			
68.	Specific protocols were developed in line accordance with best international practice including, but not limited to: a) How and where the initial and subsequent doses of Dantrolene were stored; b) The management of cardiac arrest; c) The management of anaphylaxis; d) The management of malignant hyperthermia; and e) Obtaining consent for maintenance/continuation ECT.			

HSE Mental Health Services

Self-Assessment
Rules Governing the Use of Mechanical Means of Bodily Restraint and the Code of Practice on Physical Restraint Checklist

Appendix 3

(Refer to: Theme 2 Effective Care & Support, Aim 1, Indicator 1.5)

It is recommended that you review all episodes in the last three months.

Name of Centre / Service:	
Date of Self-Assessment:	
Name of person(s) carrying out the Self-Assessment:	
Signature (s) of person(s) carrying out the Self-Assessment:	

Mechanical means of bodily restraint and physical restraint Checklist

This check-list supports staff to self-assess against Aim 1. Those carrying out the self-assessment can use this check-list to help them to determine if Indicator 1.5 in particular, of that standard is being met.

Indicator 1.5

All aspects of *Section 69(2) of the Mental Health Act, (2001) (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") and the Mental Health Commission Rules* Consent was given voluntarily by the patient and she or he knew that she or he could refuse to give consent or withdraw consent for ECT at any time.

Governing the Use of Mechanical Means of Bodily Restraint and the Code of Practice on Physical Restraint are complied with:

	Evidence that indicator is being met (Select a number of records – check each record and aggregate the results)	Yes	No	Comment
	PART 1 – Physical Restraint			
	Initiation of Physical Restraint			
1	The physical restraint of the patient was initiated by a registered medical practitioner or a registered nurse or MDT member.			
2	This decision is recorded in the patient's clinical file.			
3	There is evidence that Physical Restraint was only used in the best interest of the resident when he/ she posed an immediate threat of serious harm to self or others.			
4	The order was for a maximum of 30 minutes.			
5	A designated member of staff was responsible for leading the physical restraint.			
6	The designated member of staff monitored the head and airway of the resident during the restraint period.			

	Initiation of Physical Restraint - Continued			
7	The consultant psychiatrist is notified about the physical restraint by a member of the MDT.			
8.	The notification of the consultant psychiatrist is recorded in the patient's clinical file.	164		
9	If the episode of physical restraint was extended it was extended by a renewal order made by a registered medical practitioner following an examination for a further period not exceeding 30 minutes.			
10	There is evidence that alternatives to the use of physical restraint were implemented prior to ordering physical restraint.			
	Post Initiation of Physical Restraint			
11	The episode of physical restraint was recorded in the resident's clinical file.			
12	The relevant section of the Clinical Practice Form for Physical Restraint (or comparable documentation used in this setting) was completed by the person who initiated and ordered the used of physical restraint within 3 hours of the episode of physical restraint.			
13	The Clinical Practice Form for Physical Restraint was signed by the consultant psychiatrist responsible for the resident or the duty consultant psychiatrist within 24 hours of the episode of restraint.			
	Post Initiation of Physical Restraint - Continued			
14	The resident was informed of the reasons, likely duration of and the circumstances which will lead to the discontinuation of the physical restraint.			

	Post Initiation of Physical Restraint - Continued			
14	The resident was informed of the reasons, likely duration of and the circumstances which will lead to the discontinuation of the physical restraint.			
15	The resident was not informed of the reasons, likely duration of and the circumstances which will lead to the discontinuation of the physical restraint as it was prejudicial to the patient's mental health, well-being or emotional condition and this decision is recorded in the patient's clinical file.			
16	Where the resident has capacity, consent was obtained to inform the resident's next of kin of the physical restraint.			
17	Where consent was obtained, the patient's next of kin or representative was informed of the resident's physical restraint.			
18	Where the capacitated resident did not give consent, the next of kin was not contacted.			
19	For child residents - There is documentary evidence that the patient's parent or guardian was informed of the patient's physical restraint.			
20	Communication/ non-communication to next of kin in relation to the episode of physical restraint was recorded in the resident's clinical file.			
21	Reasons for non-communication of the physical restraint to the patient's next of kin are recorded on the resident's clinical file.			

	Post Initiation of Physical Restraint - Continued			
21	Reasons for non-communication of the physical restraint to the patient's next of kin are recorded on the resident's clinical file.			
	Patient Dignity and Safety			
22	There is evidence that alternatives to physical restraint were considered prior to commencing physical restraint.			
23	There is evidence that any specific requirements / needs of the resident in relation to the use of physical restraint (including any "advance directives") were considered.			
24	There is evidence that the physical restraint was proportional and minimal force was used.			
25	There is evidence that prior to using physical restraint that special consideration was given to a resident who is known to have experienced physical or sexual abuse.			
26	There is evidence of medical and/or nursing staff continuously assessing the resident throughout the use of physical restraint.			
27	Where prone restraint is used, records demonstrate that it's use was: - A) As a last resort B) In exceptional circumstances C) In accordance with best practice D) Used by staff with appropriate training E) Subject to review by the Multi-disciplinary team within 2 normal working days			
28	Use of prone restraint is recorded in the resident's clinical file and clear reasons are provided for its use.			

	Management of a patient during physical restraint			
29	The use of the physical restraint is clearly recorded in the resident's clinical file.			
30	The use of the physical restraint is clearly recorded in the Clinical Practice Form for Clinical Restraint and is present in the resident's clinical file.			
31	The resident was continuously monitored and assessed during the period of restraint.			
32	The assessed needs of the resident were addressed to achieve the goal of bringing the use of physical restraint to an end.			
33	A physical examination was undertaken by a registered medical practitioner no later than 3 hours after the beginning of an episode of physical restraint.			
34	Where a physical examination was not undertaken, the rationale for this is clearly documented in the resident's clinical file.			
	Clinical Governance			
35	There is evidence that the resident was afforded the opportunity to discuss the episode of physical restraint with members of the Multi-Disciplinary Team involved in their care and treatment; post episode.			
36	There is documentary evidence that the episode of physical restraint was reviewed by members of the Multi-Disciplinary Team; as soon as practicable and in any event no later than 2 normal working days after the episode of physical restraint.			
37	There is an annual report on the use of physical restraint available, based on information gathered on the use of seclusion.			

	Evidence that indicator is being met. (Select a number of records – check each record and aggregate the results)	Yes	No	Comment
	Part 2 – Mechanical Restraint			
	Initiation of Mechanical Restraint			
1	The mechanical restraint of the patient was initiated by a registered medical practitioner and / or a registered nurse.			
2	This decision is recorded in the patient's clinical file.			
3	This decision is recorded on the Register for Mechanical Means of Bodily Restraint.			
4	The consultant psychiatrist is notified about the mechanical restraint by the medical practitioner and / or the registered nurse.			
5	The notification of the consultant psychiatrist is recorded in the patient's clinical file.			
6	There is evidence that alternatives to the use of mechanical means of bodily restraint were implemented prior to ordering mechanical means of bodily restraint.			
7	If the mechanical restraint was initiated by a registered nurse. A) An assessment of the patient was carried out prior to the initiation of mechanical restraint. B) This assessment included a risk assessment.			
8	A medical review took place within 4 hours of commencing mechanical restraint.			
9	If mechanical restraint was continued following the medical review the order to continue was made by the medical practitioner and recorded in the patient's clinical file and on the Register for Mechanical Means of Bodily Restraint.			

	Initiation of Mechanical Restraint - Continued			
10	The order to continue mechanical restraint included details of the planned duration of the mechanical restraint.			
11	The duration of the mechanical restraint is no longer than 8 hours from the time of commencement of the mechanical restraint.			
12	If the mechanical restraint was initiated by a medical practitioner. • An assessment of the patient was carried out prior to the initiation of mechanical restraint. • This assessment included a risk assessment. • The order to continue mechanical restraint included details of the duration of the mechanical restraint. • The duration of the mechanical restraint is no longer than 8 hours from the time of commencement of the mechanical restraint.			
	Post Initiation of Mechanical Restraint			
13	The Register for Mechanical Means of Bodily Restraint is signed by the consultant psychiatrist responsible for the care and treatment or the duty consultant psychiatrist within 24 hours of initiating the mechanical restraint.			
14	The resident was informed of the reasons, likely duration of and the circumstances which will lead to the discontinuation of mechanical restraint.			

	Post Initiation of Mechanical Restraint			
15	The patient was not informed of the reasons, likely duration of and the circumstances which will lead to the discontinuation of mechanical restraint as it was prejudicial to the patients mental health, well-being or emotional condition and this decision is recorded in the patients clinical file.			
16	Where the patient has capacity, consent was obtained to inform the patient's next of kin of the mechanical restraint.			
17	Where consent was obtained, the patient's next of kin or representative was informed of the patient's mechanical restraint.			
18	Where the capacitated patient did not give consent, the next of kin was not contacted.			
19	Communication/ non-communication to next of kin in relation to the episode of mechanical restraint was recorded in the patient's clinical file.			
20	For child patients - There is documentary evidence that the patient's parent or guardian was informed of the use of mechanical restraint.			
	Patient Dignity and Safety			
21	Reasons for non-communication of the mechanical restraint to the patient's next of kin are recorded on the patient's clinical file.			

	Patient Dignity and Safety			
22	There is evidence that alternatives to mechanical means of bodily restraint were considered prior to commencing mechanical restraint.			
23	There is evidence that any specific requirements/ needs of the patient's in relation to the mechanical means of bodily restraint (including any "advance directives") were considered.			
24	There is evidence that prior to using mechanical means of bodily restraint that special consideration was given to a patient who is known to have experienced physical or sexual abuse.			
25	There is evidence of medical and/or nursing staff continuously assessing the patient throughout the use of mechanical restraint			
	Management of a Patient during mechanical restraint			
26	The use of the mechanical restraint is clearly recorded in the patient's clinical file.			
27	The use of the mechanical restraint is clearly recorded in the Register for Mechanical Means of Bodily Restraint and is present in the patient's file.			
28	The multidisciplinary team developed a plan of care for the mechanically restrained patient			
29	The plan of care details the monitoring and assessment processes to be followed.			
30	The plan of care details efforts to reduce the use of restraint for the patient.			

	Management of a Patient during mechanical restraint			
31	Where the mechanical restraint is used for longer than one month, it was subject to an independent review by a registered medical practitioner who was not directly involved in the patient's care and treatment.			
32	The patient's individual care and treatment plan demonstrates that the assessed needs of the patient were addressed to achieve the goal of bringing the use of mechanical means of bodily restraint to an end.			
	Clinical Governance			
33	There is evidence that the patient was afforded the opportunity to discuss the episode of mechanical restraint with members of the Multi-Disciplinary Team involved in their care and treatment; post episode.			
34	There is documentary evidence that the episode of mechanical restraint was reviewed by members of the Multi-Disciplinary Team; as soon as practicable and in any event no later than 2 normal working days after the episode of mechanical restraint.			
35	There is documentary evidence of quarterly reviews of all cases of mechanical means of bodily restraint.			

HSE Mental Health Services

Self-Assessment
Physical Environment Checklist

Appendix 4

(Refer to: Theme 2 Effective Care & Support, Aim 5, Indicator 5.1)

Name of Centre / Service:	
Date of Self-Assessment:	
Name of person(s) carrying out the Self-Assessment:	
Signature (s) of person(s) carrying out the Self-Assessment:	

Environmental Check-list

This check-list supports staff to self-assess against Aim 5. Those carrying out the self-assessment can use this check-list to help them to determine if Indicator 5.1, in particular, of that standard is being met.

Indicator 5.1

The premises and facilities (of the mental health service) comply with relevant legislative requirements.

Evidence that indicator is being met	Yes	No	N/A	Comment
1. Rooms are ventilated.				
2. Temperature: There is suitable and sufficient heating with a minimum temperature of 18 °C (65°F) in bedroom areas and 21°C (70°F) in day areas and in bedrooms where service users reside during the day.				
3. Noise levels/acoustics: Private and communal areas are suitably sized and furnished to remove excessive noise/acoustics.				
4. The lighting in communal rooms suits the needs of service users and staff.				
5. The lighting is sufficiently bright and positioned to facilitate reading and other activities.				
6. Appropriate signage and sensory aids are provided to support service user's orientation needs.				
7. Service users have access to personal space.				
8. There are appropriately sized communal rooms, including waiting rooms.				
9. There is an appropriate child friendly visiting area.				

Evidence that indicator is being met	Yes	No	N/A	Comment
10. There are indoor and outdoor recreational spaces (which are not overlooked).				
11. In CAMHS services children and young adults have access to play areas.				
12. The service provides accommodation for each service user to ensure their comfort and privacy, and meets the assessed needs of the service user.				
13. Sufficient spaces are provided for service users to move about, including outdoor spaces.				
14. There is a designated dining area with sufficient space to cater for the service setting population.				
15. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, hard or rough surfaces are minimised in the service.				
16. There is an an environmental assessment of ligature points with appropriate control measures.				
17. Overnight facilities are available for family members (where required and appropriate).				
18. Appropriate security arrangements are in place to avoid unauthorised access.				
19. If children are cared for in an adult service, there are appropriate safeguards in place.				
20. Single room accommodation is available as required.				

Evidence that indicator is being met	Yes	No	N/A	Comment
21. Regarding the seclusion facility (if in use): • all furniture and fittings are safe in design and construction, • the facility is adequately heated and ventilated, has toilet and washing facilities and is clean and furnished, • the facility is located away from the approved centre high-footfall or communal areas, • the facility has no blind spot areas within (i.e. It can be viewed fully from externally to reduce risk).				
22. Bedrooms are not used as seclusion areas.				
23. The centre/service is kept in a good state of repair externally and internally.				
24. Records demonstrate that there is a programme of • general maintenance, • decorative maintenance, • cleaning, decontamination, and repair of assistive equipment.				
25. Necessary maintenance is carried out in a timely manner.				
26. The service is clean, hygienic and free from offensive odours.				
27. Rooms are centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C.				
28. Heating can be safely controlled in the service user's own room, in compliance with health and safety guidance and Building Regulations.				
29. There is a designated space for education which can accommodate all children in the service (children's services only).				
30. There is a sufficient number of toilets and showers/baths/assisted baths for service users.				
31. Toilets are accessible and clearly marked.				

Evidence that indicator is being met	Yes	No	N/A	Comment
32. Separate toilets and washing facilities are in place for males and females.				
33. There is appropriate access to the internet.				
34. Toilets are within reasonably close proximity to day and dining areas.				
35. Sleeping areas are arranged into separate male and female zones.				
36. Toilet facilities that are wheelchair accessible are identified for use by service users and visitors who require such facilities.				
37. There is at least one assisted toilet per floor.				
38. The service has a designated sluice room, as appropriate.				
39. The service has a designated cleaning room, as appropriate.				
40. The service has a designated laundry room, as appropriate.				
41. The service has appropriately sized lifts, where applicable.				
42. The service has dedicated therapy/examination rooms, as appropriate.				
43. All bedrooms are appropriately sized to address the service user's needs.				
44. All bedrooms are personalised to the service users' requirements.				
45. All service user's bedrooms are equipped to facilitate the service user to manage their own property and possessions.				

Evidence that indicator is being met	Yes	No	N/A	Comment
46. The service provides assisted devices and/or equipment available to address service user needs.				
47. The service provides suitable furnishings to support service user independence and comfort.				
48. Where substantial changes are required to the service premises, this is appropriately assessed for possible impact to the current service users and staff prior to implementation. The Mental Health Commission is informed prior to the commencement of works.				
49. Remote or isolated areas of the service are monitored.				
50. Back-up power is available to the service.				

HSE Mental Health Services

Self-Assessment
Infection Control Checklist

Appendix 5

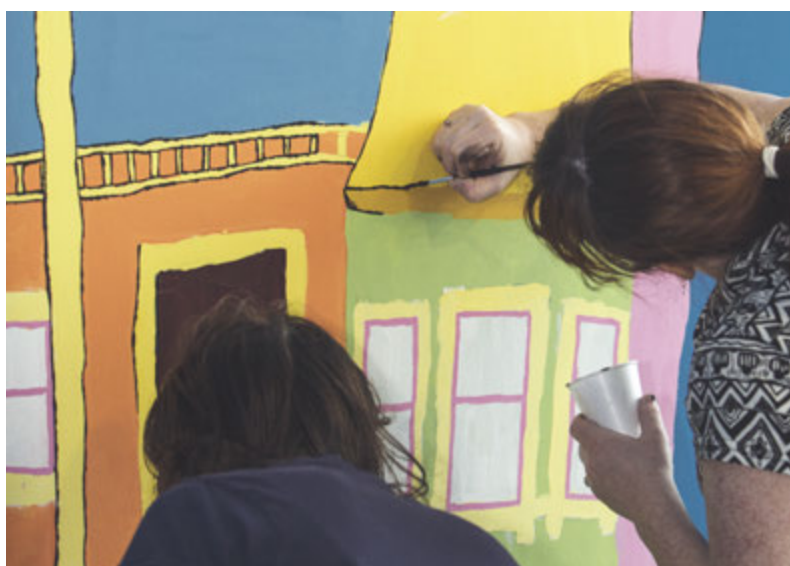**(Refer to: Theme 2 Effective Care & Support, Aim 5, Indicator 5.1, feature 13)**

Name of Centre / Service:	
Date of Self-Assessment:	
Name of person(s) carrying out the Self-Assessment:	
Signature (s) of person(s) carrying out the Self-Assessment:	

This check-list supports staff to self-assess against Aim 5 in Effective Care and Support. Those carrying out the self-assessment can use this check-list to help them to determine if Indicator 5.1 (feature 13) in particular, of that Aim is being met.

Management of Infection in the Environment	Yes	No	N/A	Comments
1. Policies and procedures reflect national standards for the prevention and control of Healthcare Associated Infections and relevant national guidelines.				
2. All staff receive education and training in infection prevention and control that is commensurate with their work activities and responsibilities and is regularly updated.				
Evidence that indicator is being met	Yes	No	N/A	Comment
3. An identified staff member has responsibility for monitoring compliance with national standards for infection prevention and control procedures such as hand hygiene, the use of protective clothing, and the safe disposal of sharps, management of laundry and waste management.				
4. There are clear arrangements in place for staff on making referrals to infection control nurses and public health professionals, who have expertise in infection prevention and control, for advice and support.				
5. Accessible information is available on infection prevention and control for service users, visitors and staff, including availability of appropriate vaccinations for service users and staff.				
6. Hand hygiene is a priority for the approved centre and high standards of hand hygiene are promoted among service users, staff and visitors.				

Evidence that indicator is being met	Yes	No	N/A	Comment
7. Warm water is available in taps at all times. Retain temperature for hand washing between 34 degrees centigrade and 43 degrees centigrade.				
8. There are adequate wash-hand basins, supplies of liquid soap, alcohol hand gels, disposable towels and personal protective equipment available.				
9. The approved centre has a contingency plan in place for dealing with an outbreak, such as an influenza, which takes into account national guidelines.				
10. Outbreaks of infection are managed in accordance with evidence-based practice and are reported in line with national guidelines to local public health authorities.				
11. An identified person has responsibility for medical devices and equipment management, including staff training and safety assurance.				
12. There is a policy on the provision, management, maintenance, cleaning and decontamination, and repair of medical devices and equipment.				

Evidence that indicator is being met	Yes	No	N/A	Comment
13. Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are being implemented to address: • Communicable disease status • Occupational management and prophylaxis • Work restrictions • Personal protective equipment • Assessment of risk to healthcare workers for occupational allergy • Evaluation of new products and procedures				
14. There is appropriate management of hazardous materials and waste including arrangements for safe handling, storage, use and disposal.				
15. Managers and staff are aware of their roles, responsibilities and accountabilities around the management and upkeep of the premises.				

HSE Mental Health Services

Self-Assessment
Medication Management Checklist

Appendix 6

(Refer to: Theme 2 Effective Care & Support, Aim 7, Indicator 7.1)

Name of Centre / Service:	
Date of Self-Assessment:	
Name of person(s) carrying out the Self-Assessment:	
Signature (s) of person(s) carrying out the Self-Assessment:	

Medication Checklist

Using this checklist supports staff to self-assess against Effective Care and Support Aim 7 to determine whether Indicator 7.1, of that standard is being met.

This checklist should be completed at a minimum on a quarterly basis. It is recommended that ten medication prescription and administration records are reviewed as part of this process.

Indicator 7.1

Mental Health services have appropriate Medication Management Policies and Procedures in place and these are implemented effectively in line with regulations and best practice.

Evidence that indicator is being met	Yes	No	N/A	Comment
Medication Policy and Procedure				
1. There are centre specific medication management policies/procedures in place relating to:				
1.1 Prescription of medicines				
1.2 Ordering of medicines				
1.3 Delivery and receipt of medicines				
1.4 Storage of medicines including refrigerated medicine				
1.5 Administration of medicines?				
1.6 Administration of controlled medicines				
1.7 PRN (as required medicine)				
1.8 Emergency situations and the use of verbal and telephone orders?				
1.9 High alert medicines				

Evidence that indicator is being met	Yes	No	N/A	Comment
Medication Policy and Procedure				
1.10 Covert administration				
1.11 Crushing medicines				
1.12 Withholding medicines				
1.13 Refusal of medicines				
1.14 Review of medicines				
1.15 Disposal of medicines				
1.16 The use of codes on the administration section of the prescription chart / record (e.g., MPAR), to indicate refusal, omission, service user on leave, etc.				
1.17 Recording of medicines administered				
1.18 Medicine reconciliation (from the point of delivery of medications from the pharmacy to the service area)				
1.19 Management of medicine at admission, transfer and discharge				
1.20 Medicine incidents/errors				
1.21 Self-medication, if this occurs in the service. (For example, assessments, recording and storage procedures)				
2. Policies and procedures are implemented				
3 Quarterly audits of medication prescription and administration records are undertaken to determine compliance with the policies and procedures and with the applicable legislation and guidelines.				
4.Medication management policies are reviewed at least every three years or more often as required				

Staff Training				
5. All staff involved in medication management have read and understand the local medication management policy and procedures				
6. Staff when questioned can articulate the medication management policy and procedures				
7. All nursing staff have attended/completed up-to-date medication management refresher training (including the management of medication incidents or near misses)				
8. All *non-nursing* staff who have involvement in medication management attended training				
9. All **non-nursing** staff involved in medication management completed medication competency assessments				
Prescription & Administration of Medication				
10. All prescriptions written: a) legibly?				
b) in indelible ink?				
c) in black ink?				

Evidence that indicator is being met	Yes	No	N/A	Comment
11. The Medication Prescription and Administration Record (MPAR) contain the following information:				
a) Service user's name and address				
b) Service user's hospital number				
c) Date of admission				
d) Service user's date of birth				
e) Allergy section completed				
f) Service user's weight when the medication prescribed requires calculation for specific doses				
g) The generic drug name, written in block capitals or un-joined lower case				
h) The dose of the medication				
i) The route of administration				
j) The time/frequency of administration				
k) In the case of short term medicines, the duration the medicine is to be taken for is specified on the prescription i.e. antibiotics				

Evidence that indicator is being met	Yes	No	N/A	Comment
11. The Medication Prescription and Administration Record (MPAR) contain the following information:				
k. In the case of short term medicines, the duration the medicine is to be taken for is specified on the prescription i.e. antibiotics				
l. The date of the initiation of the prescription				
m. Is there a medical practitioner/nurse prescriber signature for each medicine prescribed				
n. Is there a medical practitioner/nurse prescriber signature for each medicine discontinued				
o. Is there a clear discontinuation date for each medication discontinued				
p. Is the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the service user included on the MPAR				
q. Is the Nursing & Midwifery Board of Ireland Personal Identification Number (PIN) of every registered nurse prescriber prescribing medication to the service user included on the MPAR				

Evidence that indicator is being met	Yes	No	N/A	Comment
12. In the case of medicine that is prescribed for "as required" PRN use, are the following in place: a) The maximum dosage to be administered in a 24hr period or the minimal dose interval for PRN medication				
b) A protocol for the use of each PRN prescribed				
c) Reviews of PRN medicines				
13. Only acceptable abbreviations are used				
14. Micrograms written in full - not abbreviated				
15. The forename and surname of the service user used in all designated sections				
16. The times of administration in the administration sheet correspond with the frequency prescribed				
17. There are no unexplained gaps in the administration sheet				
18. Medicines are administered in accordance with the directions from the prescriber and the pharmacist (if supplied by the pharmacist)				
19 Medicines are administered by registered nurses or registered medical practitioners only				

Evidence that indicator is being met	Yes	No	N/A	Comment
20. Expiration dates are checked before medicine is administered (to ensure expired medicines are not administered)				
21. Good hand hygiene and cross infection control techniques implemented during medicine preparation and administration				
22 Weekly/monthly medicines are administered as prescribed				
23. All entries are fully legible and written in indelible ink				
24. All medicines administered are recorded contemporaneously				
25. There is a space in the administration sheet to record comments (i.e. withholding or refusing medicine, or service user on leave, etc.)				
26. There is a note made in the service user's clinical file following all medicine refusal or medicine being withheld				
27. The clinical team are informed of all medicine refused or withheld				
28. In the event of non-administration the correct codes used to indicate / explain the non-administration				

Evidence that indicator is being met	Yes	No	N/A	Comment
31. Writing errors on the MPAR are managed correctly (line through error with initials and date)				
32. There are specimen signatures for all staff who administer medication				
33. Medicine is only administered by the staff member who prepared the medicine				
34. Medicines are never prepared (and placed in individual containers) in advance of administration				
35. The service user understands the nature, purpose and likely effects of his/her current or proposed medication treatment				
36. Service users are informed of their rights and their rights are respected regarding their medicines				
37. For those service users who are voluntarily admitted to the service; their medicines are reviewed at a minimum of six months or more frequently if there is a change in his/her care or condition				
38. All medicine reviews are documented in the service user's clinical file?				

Evidence that indicator is being met	Yes	No	N/A	Comment
39. In the case of a service user who is involuntarily admitted to the service; there a system in place that, following the administration of medicine for a continuous period of three months, the service user's responsible consultant psychiatrist assesses the service user's ability to consent to his/her treatment?				
40. In the case of a service user being involuntarily admitted to the service, where s/he is assessed as being unable to consent to his/her continued administration of medicine, the treatment is approved and authorised by two consultant psychiatrists pursuant to the procedure set out in Form 17.				
41.Where a service user is assessed as being able to understand the nature, purpose and likely effects and is willing to consent to continue taking the medication, this information is recorded in the written consent form				
42. Service users who self-administer have been assessed and their competence to self-administer been confirmed by the multidisciplinary team which includes the pharmacist				
	Yes	No	N/A	Comment

Evidence that indicator is being met	Yes	No	N/A	Comment
43. Where self-administration of medicines is carried out, an individual risk assessment been carried out to determine: a) The service user's choice b) The amount of support a service user needs to self-administer medicines c) The service user's ability to understand the process d) The service user's knowledge of their medicines and treatment plan e) The service user's literacy and ability to read labels f) The service user's dexterity and ability to open bottles and containers g) If the service user can take the correct dose of his/her own medicines at the right time in the right way h) Where the service user's medicines will be stored i) How and when the self-administration will be reviewed				

Ordering and receipt of medicine				
44. There clear records or copies of orders				
45. The dispensed supply is checked against the ordered medicines				
46. Appropriate directions are provided with the dispensed medicine				
47. Where medicine is dispensed for specific service users the dispensed supply is checked against the service user's current prescription sheet				
Storage of Medication				
48. Medicines are stored securely at all times				
49. Medicine storage areas are clean and free from damp, mould, litter, dust and pests, spillage or breakage				
50. Medicine storage areas are free from anything other than medicines e.g. cleaning agents, food & drink etc.				
51. There a cleaning schedule for the medicine storage area				
Evidence that indicator is being met	**Yes**	**No**	**N/A**	**Comment**
52. Medicines are stored in the appropriate environment as indicated on the label or packaging of the medicine, or as advised by the pharmacist				
53. There is a system of stock rotation in use, to avoid accumulation of old stock medicines?				

Evidence that indicator is being met	Yes	No	N/A	Comment
54. The keys for the medicine area or cupboard are not part of the master key system				
55. There is a robust procedure in place for key holding				
56. Scheduled controlled drugs are locked in a separate cupboard from other medicinal products				
57. There is a specifically designated medicine fridge in place for the storage of medicines that require refrigeration				
58. The medicine fridge temperature is monitored through daily checks				
59. All medicines are in date				
60. There is an opening date on creams/lotions that are in use				
61. Where medicine is dispensed to be self-administered it is stored separately from the general medicine stock supply				
62. Where medicine is dispensed to be self-administered it is stored securely in a locked storage unit (with the exception of medicine that should be stored in a refrigerator)				

Evidence that indicator is being met	Yes	No	N/A	Comment
63. An inventory of medicines is conducted monthly and the following are checked:				
a) Name of medicine				
b) Dose of medicine				
c) Quantity of medicine				
d) Expiry date				
64. Medicines that are no longer required are stored securely and segregated from other medicines				
Disposal of medicines				
65. Medicines no longer required are returned to the pharmacy				
66. All disposals of medicines are clearly documented and include:				
• Date of disposal or date of return to pharmacy?				
• Name and strength of medicine?				
• Quantity removed?				
• Service user for whom medicines were prescribed, if applicable?				
• Signature of the member of staff who arranged disposal of the medicines?				
• Signed receipt by the pharmacist who received the returned medicines?				

ADDITIONAL INFORMATION

5

Membership of the
Best Practice Guidance National Steering Group and Project Group

The National Steering Group was established by the National Director of Mental Health.

The Best Practice Guidance Project Group was established by the Steering Group and was reflective of mental health services with a broad range of expertise across the sector.

National Steering Group - Membership

Anne O'Connor (Chair)	National Director, Mental Health
Dr. Margo Wrigley	National Clinical Advisor & Clinical Programme Group Head Mental Health
Linda Moore (Project Lead)	Quality, Standards and Compliance Officer, Mental Health Division
JP Nolan	Lead for Quality Service User Safety – Mental Health Division
Tony Leahy	General Manager Service Improvement Unit
Greg Price	Assistant National Director, Quality Improvement Division
Oliver Claffey	Area Director of Nursing CHO7
Liam Hennessy	Head of Service User, Family and Care Engagement
Teresa Bulfin	Snr. Manager, HSE Mid - West Community Healthcare – CHO 3.

The Project Group - Membership

Linda Moore	Project Lead
Kevin Brady	Head of Mental Health CHO7
Martina McGuinness	Assistant Director of Nursing, Child & Adolescent MHS
Imelda Noone	Nurse Practice Development Coordinator Dublin North City Mental Health Services
James O'Shea	Director of Nurse Education (Mental Health) ONMSD & Mental Health Services Lead for Mental Health Nurse Education
Clare Gallagher	Occupational Therapy Manager
Anne Barrett	Principal Social Worker – CHO 5
Georgina Morrow	Quality and Patient Safety Manager – CHO1
Marina Bowe	Consultant Psychiatrist, Stewarts Care Ltd
Dr Aideen Lewis	Principal Clinical Psychologist St. Vincents Hospital
Michael Ryan	Director of Advancing Recovery Ireland (previous)
Colum Bracken	Program Manager MHD SPPMO HSE Mental Health Division
Amelia Cox	Liaison Person MHA 2001 - CHO 8
Rosalia Kavanagh	Acting Director of Nursing - CHO 8
Anne Buggy	Area Director of Nursing, Carlow, Kilkenny & South Tipperary Mental Health Services

Brian Hartnett	Service User Representative
Sabina Fahy	Acting Clinical Director (Psychiatry of Later Life), St Brigids, Ballinasloe
Caroline Kavanagh	Nurse Tutor, Nursing & Midwifery Planning & Development| Clinical Strategy and Programmes Division
Laura Molloy	Service Improvement Lead, Mental Health Division
JP Nolan	Lead for Quality Service User Safety – Mental Health Division
Con Buckley	Service User Representative
Sean Logue	Compliance and Regulations Officer, Cork Acute Mental Health Services – HSE South
Clare O'Neill	National Risk and Incident Monitoring Support & Learning Officer
Beverley Browne	National Quality Service User Safety Administrator – Mental Health Division

Glossary of Terms

This glossary details key terms and a description of their meaning within the context of this document.

Abuse: may be defined as " any act, or failure to act , which results in a breach of a vulnerable person's human rights, civil liberties, physical and mental integrity, dignity or general well being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms." This definition excludes self-neglect which is an inability or unwillingness to provide for oneself.

Accountability: Being answerable to another person or organisation for decisions, behaviour and any consequences.

Advance Care Planning: A process of a discussion between a service user and his/her care providers about future medical and social care preferences in the event that the service user is unable to speak for his/herself due to emergency or serious illness. Advanced Healthcare Directive: A statement made by the service user with decision making capacity relating to the type and extent of healthcare interventions he/she would or would not want to undergo in the event that the service user is unable to speak for him/her due to an emergency or serious illness.

Adverse Event: An incident which resulted in harm.

Advocacy: An advocate refers to the individual tasked with empowering and promoting the interests of people by supporting them to assert their views and claim their entitlements and, where necessary, representing and negotiating on their behalf.

Automatic External Defibrillator: is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm.

Approved Centre: - An "approved centre" is a centre that is registered pursuant to section 63 of the Mental Health Act 2001. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Act.

ARI: Advancing Recovery in Ireland is a HSE national initiative aimed at bringing about the organisational and cultural change in mental health services necessary to support our services in becoming more "Recovery-oriented". This recognises the reality that true partnership between those who use and those who provide our services invariably provides better outcomes than care driven by one party alone. (Advancing Recovery in Ireland: A guidance paper on implementing organisational and cultural change in mental health services in Ireland) http://hdl.handle.net/10147/613321 (2016)

Audit: A systematic review and evaluation of current practice against research based standards with a view to improving clinical care for service users.

Autonomy: The capacity to make decisions and take actions that are in keeping with one's values and beliefs.

Benchmarking: A continuous process of measuring and comparing care and services with similar service providers.

CAMHS: Child and Adolescent Mental Health Service

Capacity: The ability to understand the nature and consequences of a decision in the context of available

Care Pathway: A care pathway is a multidisciplinary care plan that outlines the main clinical interventions that are carried out by different healthcare practitioners for service users with a specific condition or set of symptoms. They are usually locally agreed, evidenced-based plans that can incorporate local and national guidelines into everyday practice.

Centre: A "centre" means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder.

Charter Of Service User Rights (Patient): a Statement of Commitment by the HSE describing, what you can expect when using health services in Ireland, and what you can do to help Irish health services to deliver more effective and safe services.

Clinical Audit: Clinical audit is the systematic review and evaluation of current practice against research based standards with a view to improving clinical care for service users

Clinical File: A record of the service users referral, assessment, care and treatment while in receipt of mental health services. The document should be stored in one file, if all relevant information is not stored in one file, the file should record where the other information is held.

Clinical Governance: Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver. It is built on the model of the chief executive officer (CEO)/ general manager (GM) or equivalent working in partnership with the clinical director, director of nursing/midwifery and service/professional leads. A key characteristic of clinical governance is a culture and commitment to agreed service levels and quality of care to be provided.

Clinical Guidelines: Clinical guidelines are systematically developed statements, based on a thorough evaluation of the evidence, to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances, across the entire clinical spectrum.

Cognitive Behavioural Therapy: Cognitive behavioural therapy Cognitive behavioural therapy (CBT) is a type of therapy that aims to help you manage your problems by changing how you think and act.

Community Healthcare Organisation: Community Healthcare Services are the broad range of services that are provided outside of the acute hospital system and includes Primary Care, Social Care, Mental Health and Health &Wellbeing Services. These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to people's homes.

Competence: Competence is the ability to undertake responsibilities and perform activities to a recognised standard on a regular basis. It combines practical and thinking skills, knowledge and experience.

Complaint: An expression of dissatisfaction with any aspect of service provision.

Concern: A safety or quality issue regarding any aspect of service provision, raised by a service user, service provider, member of the workforce or general public.

Confidentiality: Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre define confidentiality as follows Confidentiality refers to a duty that a person owes to safeguard information that has been entrusted to him or her by another. In the healthcare context, care providers have confidentiality duties in regard to service users that are founded on and emphasised by both longstanding ethical duties and legal principles.

Consent: is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him/herself to understand the nature, potential risks and benefits of the proposed intervention of service.

CCTV: Any monitoring devise which captures a service users image, either for recording or live observation.

Consultant Psychiatrist: Consultant psychiatrist means a consultant psychiatrist who is employed by the Health Service Executive or by an approved centre or a person whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council in Ireland.

CPD: Continuing professional development is the means by which health and social care professionals maintain and improve their knowledge, skills and competence and develop the professional and personal qualities required throughout their professional life. CPD is an important component in the continued provision of safe and effective services for the benefit of service users.

Corporate Governance: The way in which a mental health service is directed and controlled so as to achieve its organisational goals and to deliver accountability, transparency and probity.

Culture: The shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.

Data Protection Acts 1988 (2003 amendment): the act pertains to the protection of privacy of individuals with regard to personal data.

Do Not Attempt Resuscitation Order (DNAR): A do not attempt resuscitation order id a written order stating that resuscitation should not be attempted if an individual suffers a cardiac or respiratory arrest.

Dignity: MHC Code of Practice on the Use of Physical Restraint in Approved Centres define Dignity as "The right of an individual to be treated with respect as a person in his or her own right

ECT: Electroconvulsive therapy (ECT), Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients is "ECT is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses"

Effective: A measure of the extent to which a specific intervention, procedure, treatment, or service, when delivered, does what it is intended to do for a specified population.

Efficient: Use of resources to achieve optimal results with minimal waste.

Emergency Plan: An emergency plan is a written set of instructions that outlines what staff and others at the workplace should do in an emergency.

End-of-Life Care: Care in relation to all aspects of end-of-life, dying, death and bereavement, regardless of the service user's age or diagnosis or whether death is anticipated or unexpected. It includes care for those with advanced, progressive, incurable illness. Aspects of end-of-life care may include management of pain and other symptoms and provision of psychological, social, and other supports.

Episode of Care: A period of care for a specific medical problem or condition. It may be continuous or it may consist of a series of intervals marked by one or more brief separations. An episode of care is initiated with an initial assessment and acceptance by the organisation and is usually completed with discharge or appropriate referral.

Escalation Policy: Risk and Incident Escalation Procedure outlines the steps that must be taken by each manager to escalate risks and incidents (as appropriate) that occur within their own service are outlined. The Director of Quality and Clinical Care is responsible for leading and working with other National Directors to embed this procedure throughout the HSE

Executive Quality Improvement Walk Around: Quality and Safety Walk-rounds allow executive/senior management team members to have a structured conversation around safety with front-line staff and service users. The walk-rounds are intended to be helpful opportunities to share ideas and provide immediate feedback without taking responsibility away from line managers and front-line teams. The walk-rounds are also great opportunities to identify and celebrate good practices and initiatives across the hospital.

Quality and Safety Walk-rounds are proven quality improvement interventions that allow healthcare organisations to move towards reflective rather than inspection focused programmes, therefore central to the success of walk-rounds is a collaborative open approach.

Evaluation: A formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.

Evidence: Data and information used to make decisions. Evidence can be derived from research, experiential learning, indicator data and evaluations.

Evidence-Based Practice: Conscientious, explicit, and judicious use of current best evidence in making decisions.

FOI: Freedom of Information Act 2014: the act obliged government departments, the Health Service Executive (HSE), local authorities and a range of other public bodies to publish information on their activities and to make the information they held, including personal information, available to citizens

Goals: these are clearly defined objectives specific, proactive if possible and timebound. Each goal should be a statement that indicates the desired outcome.

Governance: In healthcare, an integration of corporate and clinical governance; the systems, processes and behaviours by which services lead, direct and control their functions in order to achieve their objectives, including the quality and safety of services for service users. See also Clinical governance and Corporate governance above.

Hazard: Anything that can cause harm.

HACCP: The word HACCP (Hazard Analysis & Critical Control Point) refers to procedures you must put in place to ensure the food you produce is safe. (FSAI) Hazard analysis and critical control points or HACCP is a systematic preventive approach to food safety from biological, chemical, and physical hazards in production processes that can cause the finished product to be unsafe, and designs measurements to reduce these risks to a safe level.

Health: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO).

Healthcare Associated Infections: A healthcare-associated infection is an infection that is acquired after contact with the healthcare services. This is most frequently after treatment in a hospital, but can also happen after treatment in outpatient clinics, nursing homes and other healthcare settings. Healthcare-associated infections that are picked up in hospital are also known as "hospital-acquired infections that are acquired as a result of healthcare interventions.

HSE Code of Governance: The Health Act, 2004 sets out the legal requirements for the HSE regarding its Code of Governance. It sets out the guiding principles by which the HSE is governed.

Individual Care Plan: An individual care plan, as defined by the regulations, is:
"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."

Key Worker: A key worker is a point of contact on the mental health team who coordinates care, not only within the mental health service, but also across systems (work, education, social welfare, financial resources, recreation, independent organisations, etc). Key workers do not deliver all of your treatment, however are responsible for making sure that people are keeping to what was agreed in the care plan a social worker, mental health worker, or nursery nurse assigned to an individual case, service user, or child.

Mechanical Restraint: Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (MHC, 2009) define as "the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient's body". Version 2 of the Rules specifies that "The use of cot sides or bed rails to prevent a patient from falling or slipping from his or her bed does not constitute mechanical means of bodily restraint under these Rules."

Medical Device: Any product, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability.

Mental Health Commission: An organisation set up under the Mental Health Act to promote high standards and good practices in mental health services and to protect the interests of people detained in hospital. There functions include:

- Appointing persons to mental health tribunals to review the detention of involuntary patients and appointing a legal representative for each patient;
- Establishing and maintaining a Register of Approved Centres i.e. we register inpatient facilities providing care and treatment for people with a mental illness and mental disorder.
- Making Rules regulating the use of specific treatments and interventions such as ECT (Electroconvulsive Therapy), seclusion and mechanical restraint; and
- Developing Codes of Practice to guide those working in the mental health services and enable them to provide high quality care and treatment to service users.
- Appointing the Inspector of Mental Health Services who annually inspects mental health services.

Mental Illness: A state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons.

Mental Health Service: The term used throughout refers to all HSE mental health services including services funded by the HSE.

Mission Statement: A written declaration of an organization's core purpose and focus that normally remains unchanged over time. Properly crafted mission statements (1) serve as filters to separate what is important from what is not, (2) clearly state which markets will be served and how, and (3) communicate a sense of intended direction to the entire organization.

Multidisciplinary Team: A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.), each providing specific services to the service user. The team members independently treat various issues a service user may have, focusing on the issues in which they specialise. The activities of the team are brought together using a care plan. This co-ordinates their services and gets the team working together towards a specific set of goals. Sometimes the service user has a key worker, who becomes the main point of contact for the person.

National Incident Management System: The National Incident Management System (NIMS) is a core enabling system to improve service user and service user safety with more than 110,000 incidents reported annually.

NMBI: Nursing and Midwifery Board of Ireland, NMBI, formerly An Bord Altranais, is the independent, statutory organisation which regulates the nursing and midwifery professions in Ireland. They work with nurses and midwives, the public and key stakeholders to enhance service user safety and service user care.

Open Disclosure: A comprehensive and clear discussion of an incident that resulted or may have resulted in harm to a service user while receiving healthcare. Open disclosure is an ongoing communication process with service users and their families or carers following an adverse event.

Patient: Refers to a person to whom an admission order or renewal order relates, i.e., a person who is involuntarily admitted pursuant to Section 14 of the Mental Health Act 2001. This does not include a person under the age of 18, unless that person is, or has been, married.

Payment scheme for reimbursement of service users, family members, and carers, (Mental Health Division): The payment scheme for service user family and carer stakeholder payment is a national HSE division initiative that recognises the unique expertise that service users family members and others can offer the MH division in delivering a quality recovery orientated service and allows services to engage such individuals on a parity of esteem basis with staff through offering them a payment and reimbursement of expenses for a limited number of predefined recovery focused activities once they meet the eligibility criteria for the scheme.

Part M Building Regulations: Building Regulations apply to the construction of new buildings and to extensions and material alterations to buildings. In addition, certain parts of the Regulations apply to existing buildings where a material change of use takes place.

Peer Advocates: Peer advocates are people who have experienced mental health difficulties and having achieved a sufficient level of recovery, complete an accredited training course. Therefore advocates are in a unique position to understand the difficulties and problems faced by people with mental health difficulties.

A peer advocate in mental health is someone who has overcome a mental health difficulty achieved a good level of recovery and who has successfully completed a peer advocacy training course. They provide information, support and choice for those who have experienced difficulties with their mental health and wellbeing. (Irish Advocacy Network).

Peer Support Worker: A Peer Support Worker is an individual who has had personal lived experience of mental health issues and now enjoys a good level of recovery who is employed in a professional role to use their expertise and experience to inspire hope and recovery in others who are undergoing similar mental health experiences. They facilitate and support information sharing to promote choice, self determination and opportunities for connection with local communities allowing the individual to engage and pursue their own recovery journey as they themselves define it.

Performance Indicator: Performance indicators (PI's) are measurable indicators that demonstrate progress towards a specified target. They enable decision makers to assess progress towards the achievement of an outcome, objective or goal within an agreed timeframe.

Personal Evacuation Emergency Plan: It is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.

Policy: A written statement that clearly indicates the position and values of the organisation on a given subject.

PPE: personal protective equipment.

Procedure: A procedure is a written set of instructions that describe the approved and recommended steps of a particular act or sequence of events. Procedures supplement policies with specifics and completes the information users need.

Process: series of goal-directed, inter-related activities, events, mechanisms or steps and communications which accomplish a service for a service user / client.

Professional Development Planning: People working in health are encouraged to review their goals and achievements on a regular basis and to maintain a personal development plan (PDP).

Physical Restraint: is defined in the Code of Practice on the Use of Physical Restraint in Approved Centres (MHC,2009) as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others".

Quality: Doing the right thing consistently to ensure the best outcomes for patients, satisfaction for all customers, retention of staff and a good financial performance.

Quality and Safety Committee: multidisciplinary committees who consider the quality and safety of care provided, monitor this on a routine basis, provide respectful challenge and act to improve care.

Recovery: Recovery is best defined as a process of self determination by services users as what it means to them individually and how it should be accessed and supported. Recovery is a process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness'. (Anthony, 2003)

Regulation: Mental Health Act 2001 (approved Centres) Regulations 2006.

Registered Proprietor: The 'registered proprietor' is the person whose name is entered in the register as the person carrying on the centre. In this case, a person can also mean a corporate body such as a company or a state agency.

Risk: The likelihood of an adverse event or outcome.

Risk Management: Risk Management is the planned and systematic approach to identifying, evaluating and responding to risks and providing assurances that responses are effective. Risk Management is a key element of good governance and underpins the ability to provide safe and effective care to our patients; it refers to strategies that reduce the possibility of a loss or harm. It consists of proactive and reactive components. Proactive components include activities to prevent adverse impacts, and reactive components include actions in response to adverse events. The HSE has in place a comprehensive integrated risk management policy with related procedures and tools.

Risks may be categorised as:

- Strategic risks These concern the long term strategic objectives of the HSE. These may be external or internal to the organisation.
- Operational risks These relate to the procedures, technologies and other factors relating to the short to medium term objectives of the HSE.

Risk Register: A risk register is a database of risks that face an organisation at any one time. Always changing to reflect the dynamic nature of risks and the organisation's management of them, its purpose is to help managers prioritise available resources to minimise risk and target improvements to best effect.

Seclusion: Seclusion is defined in the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (MHC, 2009) as "the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving."

Serious Reportable Event: Serious Reportable Events (SREs) are a defined list of serious incidents, many of which may result in death or serious harm.

Service Level Agreement/ Arrangement: Document which explicitly describes the nature of the service being provided to the HSE by an external agency.

Service User: The term used throughout this guidance document includes patients, clients and residents of the HSE who use our services and of the services funded by the HSE.

Skill Mix: The combination of competencies including skills needed in the workforce to accomplish the specific tasks or perform the given functions required for safe high quality care.

Statement of Purpose: A description of the aims and objectives of the service including how resources are aligned to deliver these objectives. It also describes in detail the range, availability and scope of services provided by the overall service.

Terms of Reference: define the purpose and structure of a project, committee, meeting, negotiation, or any similar collection of people who have agreed to work together to accomplish a shared goal.

Taxonomy: A system for describing and organising terms into groups that share similar characteristics.

The Register: The Commission shall establish and maintain a register which shall be known as "the Register of Approved Centres" and is referred to in Section 64(1) of the Act as "the Register".

The 2006 Regulations: Means the Mental Health Act 2001 (Approved Centres) Regulations, 2006.

Vision for Change: A Vision for Change' is a strategy document which sets out the direction for Mental Health Services in Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.

WRAP: Wellness Recovery Action Planning.

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