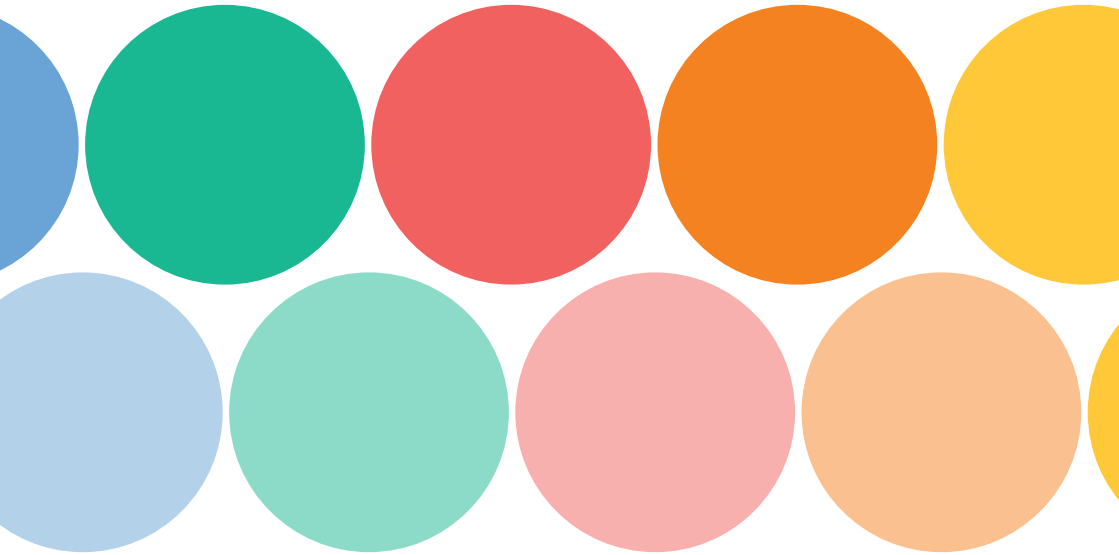
A Guide to Support Approved Centres / Services

With the Mental Health Commission Inspections

In conjunction with the

HSE Best Practice Guidance for Mental Health Services



Developed by Quality and Service User Safety, Health Services Executive, National Mental Health Division

Mental Health Services

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

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Introduction

This practical guide has been developed by Quality and Service User Safety (QSUS) in the HSE National Mental Health Division. It has been reviewed by the Mental Health Commission Standards & Quality Assurance Department and staff from our mental health services and the feedback has been incorporated.

The following are comments from the staff who have reviewed this document

"It is very comprehensive, easy to follow and a great aid to preparing for an Inspection. I'm sure going forward it will be welcomed by all staff.

"*I think this will be a really useful document in providing guidance and clarity for staff regarding inspections, particularly in relation to actions post inspection. The document reads well and is very comprehensive. Overall a welcome supportive document*".

This document aims to support Approved Centres /Services with preparing for the inspection process. It will help you to understand the Mental Health Commission's inspection process. It will also suggest how best to prepare for inspections, as clinicians, managers and staff.

Reviewing this guide should not only assist you in preparing for an inspection, but will also offer tips and advice on compliance, before, during and after inspections.

We welcome the Mental Health Commission's inspections. In addition to being a regulatory requirement, these are an opportunity to: -

- Showcase the good work and the improvements that have been made
- Improve quality and safety of our mental health services.
- Demonstrate staff knowledge of the areas for improvement and the plans to address these (including those that are identified using the HSE Best Practice Guidance for Mental Health Services)
- Demonstrate how feedback is gathered about the service and the care provided; how services learn, share this learning, collaborate with relevant stakeholders in improving the quality of care within services and improve the recovery journey for service users

Section 1 Understanding the Inspection Process

About Inspection

Inspections are always unannounced. Inspectors can arrive at any time into the Approved Centre/service, either during the day, or night.

Inspectors have the authority under the Mental Health Act 2001 to:

"**Visit and inspect at any time, any approved centre or other premises** where mental health services are being provided and to be accompanied on such visit by such consultants or advisors as he/she may consider necessary or expedient for the performance of his/her functions.

Require any person in such an approved centre or other premises **to furnish him or her with such information** in possession of the person as he or she may reasonably require for the purposes of his or her functions (as an inspector).

To make available any record or other document in his or her power of control, that in the opinion of the inspector, is relevant to his or her functions.

To examine and take copies of, or of extracts from, **any record or other document** made available to him or her as aforesaid **or** found on the premises.

To require any person who, in the opinion of the inspector, is in possession of information, or has a record in his or her power or control, that, in the opinion of the inspector, is relevant to the purposes aforesaid **to furnish to the inspector any such information or record** and, where appropriate, require the person to attend before him or her for that purpose.

To examine and take copies in any form of, or of extracts from any record that, in the opinion of the inspector, is relevant to the review or investigation and for those purposes **take possession of any such record, remove it from the premises and retain it** in his or her possession for a reasonable period.

To take evidence on oath and for that purpose to administer oaths (Section 51 (2) Mental Health Act, 2001).

A staff member who obstructs or interferes with Inspectors during an inspection or who fails to give any information within his or her knowledge, that may be reasonably required during the inspection, shall be guilty of an offence under section 53 of the Mental Health Act 2001.

However, notwithstanding the above, while an inspection is under way, service users' needs and safety come first at all times. This should be expected and understood by Inspectors. So, during an inspection, if staff are busy with a service user, inform the inspector that they are engaged and that they will be with them as soon as possible. Together, endeavour to keep disruption to the service and to service users to a minimum.

Pre-Inspection

Prior to inspection, the Inspector of Mental Health Services will write to the Registered Proprietor, requesting a range of specific documentation. This can include soft copies of: -

- Policies pertaining to Regulations, Rules and Codes of Practices, with an index detailing which specific Regulation, Rule and Code of Practice each policy relates to
- Training needs analysis and associated training plans
- Annual Health and Safety Statement

- Most recent fire inspection reports and records of corrective actions taken
- Most recent environmental health officers' reports and records of corrective actions taken
- Details of Insurance for the Approved Centre / Service

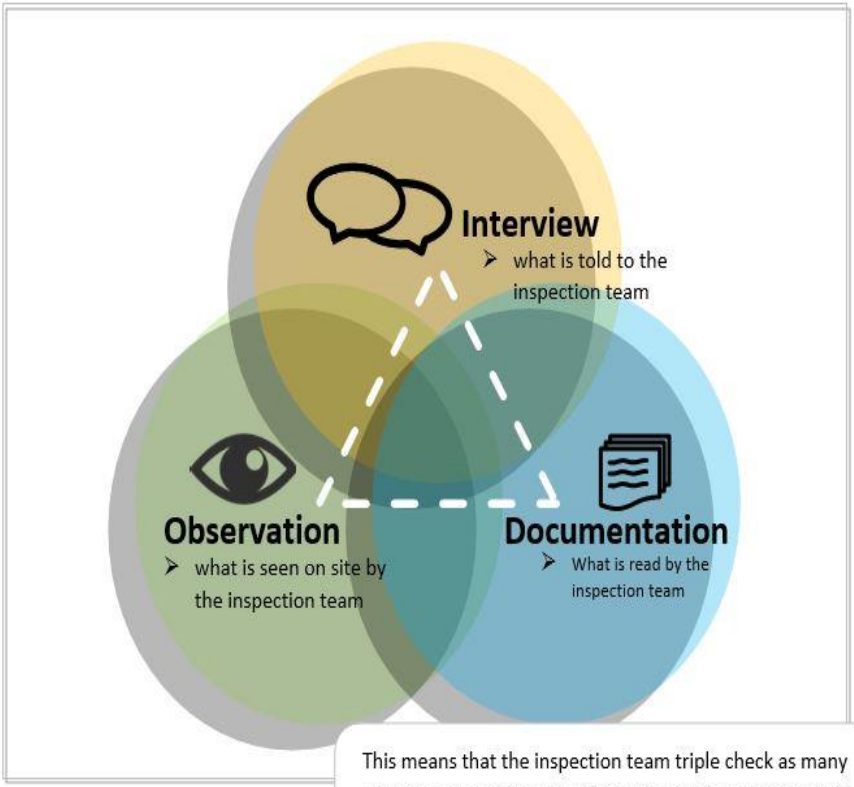
Because of the size of some of the above documents; it is important to send the information over several emails (the Mental Health Commission currently has a capacity to receive files no larger than 20 megabytes per individual email).

The Inspection Process

Inspections typically involve a number of inspectors (a lead inspector and an inspection team) visiting the Centre / Service. A triangulation approach is taken to testing compliance with Regulations, Rules, Codes of Practices and Part 4 of the Act (consent to treatment). Triangulation involves

- Interviewing relevant people (service users / staff / management)
- Checking various relevant documentation and
- Observing practice and the environment

Figure 1: Triangulation



Section 2 Preparing the Management / Multi-Disciplinary Team for inspection

1. All documentation submitted to the Inspector of Mental Health Services in advance of the inspection is:

    - In date (particularly policies, health and safety statement, insurance)
    - In line with the Regulations, Rules and Codes of Practice
    - Submitted strictly in line with specified timelines

2. Review the update on the Corrective and Preventative Action plans, (CAPAs) that were submitted to the Mental Health Commission following the previous inspection. Gather the evidence to demonstrate that the actions identified have been completed.

3. Ensure that the following documentation is readily available and up to date in the Approved Centre / Service at all times. *(This is not an exhaustive list).*

    - The correct editions of all policies relating to the approved Centre / Service (Managers should regularly spot check to ensure any older versions / editions of policies are removed and not in use)
    - Staff training records for all disciplines. It may be worth noting that these records need to be able to easily identify staff of the approved centre. It will not suffice to provide training records for a service area or CHO

- A record of complaints, to include individual complaints and details of the management of the complaint (it is better if there is a clear, well organised folder with all complaints. This should include a complaints log showing the progress with the management of each complaint and a summary of learning and review of the complaints log)
- It is important that 'minor complaints' are also recorded. Services should have a policy that clearly defines what is and isn't a 'complaint' to ensure they are recording complaints accurately. Staff should have a good understanding of this and be able to tell an inspector, if asked
- Staff should also be able to provide the Inspector with a list of the therapeutic services provided within the service. A therapeutic programme timetable should be available. This list should not include recreational activities. Staff should be able to differentiate between recreational activities and therapeutic services/programmes
- Incident report records
- Records of the maintenance programme
- Register of residents
- The risk register
- Minutes of the Executive Management Team meetings for the previous 12 months
- Minutes of the Quality, Safety and Risk Committee meetings (or equivalent) for the previous 12 months
- Bed occupancy rates

- Audits relating to Regulations, Rules, Codes of Practice and Part 4 of the Mental Health Act (2001) – including action plans and records / proof of implementation of actions resulting from audits
- Staff rosters- planned and actual
- Details of clinical teams admitting to the Approved Centre / Service, including the name of the consultant psychiatrist (s), medical, nursing, health and social care professionals. This should include the areas of speciality and sectors for the clinical teams, and vacant posts
- The fire register / fire records
- The certificate of registration (displayed in a prominent area)
- Clinical files
- Food records; food safety reports
- Records of patient/service user meetings
- Records of relevant staff meetings

4. Review the above information regularly to ensure it is maintained up to date, accessible and well organised.
5. Have a dedicated area (E.G. set shelving unit) for core information required by the inspection team in a secure but accessible part of the Approved Centre / Service. This information may be stored on the Guidance Assessment Improvement tool, (GAIT), provided by QSUS National Division to teams undertaking the self-assessment against the HSE Best Practice Guidance.
6. All outdated information (policies, files, records) are archived or removed from the Approved Centre / Service.

Section 3 Preparing Staff Teams

1. Regular updates are provided for staff on the Regulations, Rules, Codes of Practice and the Judgement Support Framework and that staff are aware of these and of their responsibilities under these. The clearer staff are on the Regulations, Rules and Codes of Practice and Judgement Support Framework, which are included in the HSE Best practice Guidance for Mental Health Services; the more they can demonstrate compliance. This also helps staff to be more confident in respectfully questioning inspectors for clarification and in confidently putting forward evidence to inspectors.
2. Sufficient numbers of up-to-date copies of the Mental Health Act (2001) and Amendments, Regulations, Rules and Codes of Practice, and the Judgement Support Framework are readily available in the Approved Centre / Service.
3. Implement the HSE Best Practice Guidance for Mental Health Services self-assessment process in a structured planned manner, involving staff in this.
4. All up-to-date policies are available to staff at all times.
5. Staff have read and signed off the policies of the Approved Centre / Service. Retain the sign in sheets in an accessible place.
6. Ascertain staff knowledge of the core elements of policies, this will support, their application to practice.
7. Go through this guide with staff on a regular basis. Explore the Regulations and findings from previous inspections, thereby making regulation a continuous feature rather than a once off

event. Staff are supported to take responsibility for compliance and addressing any failings identified.

8. Encourage all staff to become involved in audits, in self-assessment and in monitoring and improving the quality of records and practice.

9. Encourage all staff to familiarise themselves with where the team/services core inspection related documentation is held (e.g. staff rotas, policies, information leaflets, meeting minutes, the register of residents, the audit folder, the complaints log, incident reports, staff training records, the patient information leaflet / booklet, the communication book / diary, shift plans, etc.).

10. Involve staff in and inform staff of corrective and preventative action plans/planning, (CAPA). These CAPAs are developed and reviewed by the multidisciplinary team.

11. All staff are made aware of the positive practices and improvements that have been made in the service.

12. All staff are made aware of the improvements that are required and the action plans in place for addressing these. These may be stored on the GAIT.

Section 4 Facilitating the Inspection

On commencement of the Inspection

1. It is important that you request to see the inspector's identification / warrant card.
2. Ask the inspector to sign the sign in book provided.
3. Welcome the inspection team and respectfully request 5-10 minutes to organise yourself, informing people (staff and service users) that the inspection team is present.
4. The most senior member of your team, the Registered Proprietor and the Head of Mental Health are informed of the inspection team's arrival.
5. Inform service users that the inspectors are on the premises and are available if they wish to talk with them.
6. Inform staff that the inspectors are on the premises, and they may wish to speak with them.
7. Provide the inspection team with an overview of any immediate high-risk issues so that they are made aware of these.
8. Display a notice in public areas, starting that an inspection is under way.
9. Provide the inspection team with a lockable room, for the duration of the inspection. Ideally this should not be the main office or a busy working area.
10. Provide the inspection team with access to a photocopier, printer and a computer password where necessary.

11. Provide the inspection team with access to all areas as appropriate.
12. Identify a contact person, together with their telephone number to the inspection team for the duration of the inspection.
13. Provide the inspectors with all information requested, e.g. the information set out in section 2 of this document.
14. Be available to inspectors to clarify any requests for information.

During the Inspection

1. Be open, honest and helpful.
2. Ensure that the focus remains on maintaining a therapeutic and safe environment, while facilitating the inspection process.
3. The inspection process is an opportunity to showcase good work practices and compliance with Regulations.
4. If an inspector asks you a question and you do not understand the question or do not know the answer; do not panic. Seek clarification from the inspector or let the inspector know that you will endeavour to respond to their question.
5. If an inspector asks you for additional information endeavour to act promptly in providing this.
6. Keep conversations away from public areas to avoid disruption or any breach of confidentiality.
7. Support service user, family member or carer involvement in the inspection process.
8. Respect service user privacy and dignity, especially if accompanying inspectors on walk-arounds.

9. If an inspector identifies an immediate risk, respond promptly and responsively. Escalate this matter promptly to the management team.

The feedback meeting

A feedback meeting is part of the inspection process and is held prior to the conclusion of the inspection. The purpose of the meeting is to provide preliminary feedback, identify the good practice, areas for improvement and any immediate actions required (e.g. health and safety or patient safety issues). The inspectors may seek clarity on any findings. It is an opportunity for the approved centre/service to provide further details of quality improvements and compliance in relation to the findings during the inspection.

The following should attend the feedback meeting where possible:

- The Registered Proprietor (or Nominee)
- The General Manager / Business Manager
- The Clinical Director / Executive Clinical Director
- The Director of Nursing
- Consultant Psychiatrists
- Assistant Director of Nursing (ADON) of the Approved Centre / Service
- The Clinical Nurse Managers of the Approved Centre / Service
- The Occupational Therapy Manager
- The Principal Psychologist
- The Principal Social Worker
- Relevant others (as decided by the Registered Proprietor / Inspection Team)

What should you do at the feedback meeting?

- Agree a lead person from the Centre / Service for this meeting
- Be prepared when attending this meeting. This includes collating any additional evidence that has not been presented to / viewed by inspectors during the inspection, but which might be necessary to present
- If concerns / non compliances have been raised during the inspection and you have addressed these, inform the inspection team of the action that has been taken and provide evidence of this
- Remain professional and courteous at all times
- Take detailed notes of the preliminary feedback provided by the inspection team and any actions agreed by the approved centre/service during the meeting
- Clarify any inaccuracies, with factual evidence / comments
- Clarify any queries from the inspector / inspection team

Section 5 Post Inspection

Debriefing

1. Where possible, have a multidisciplinary team de-brief following the inspection or as soon as this can be arranged. Discuss the key findings from the inspection, including the good practice, areas for improvement and the evidence provided.
2. If you, as a team, feel that certain available evidence / information was not accessible and/or needs to be provided to the Inspection team retrospectively, then an appropriate individual should be identified to forward this to the inspection team / Mental Health Commission.
3. Provide debriefing and support to service users as required.
4. Provide preliminary feedback to the staff team.
5. Explore with the team what went well and anything learnt from the inspection.

Implementing immediate high risk actions

1. Ensure that any high risk / immediate actions identified are addressed promptly and effectively (if this has not already been done during the course of the inspection).
2. Communicate any high level immediate changes to all relevant staff.
3. Complete any necessary records demonstrating implementation of high risk actions.

Dealing with follow up enquiries from the Mental Health Commission / Inspector

1. Where follow-up enquiries are made by an inspector; ensure that these are responded to promptly and completely.
2. Make a record of the enquiry received, including, who it was received from and the response provided.
3. Ensure Senior Management / Senior Clinicians are informed of any such requests and are involved in formulating the response, where necessary.

Acting on the draft report

You will receive a draft report prior to publication of the final report.

1. Collaborate with the relevant people to review the factual accuracy of the report and its contents (e.g. consider including the Consultant Psychiatrist, the Director of Nursing, the Assistant Director of Nursing, the Clinical Director, Heads of Disciplines, the CNM11/111 involved in the inspection and others, as relevant).
2. Ensure a collaborative review of the report – including all members of the team.
3. Go through the report for factual inaccuracies. Be very specific in your response if you are questioning a finding – demonstrate (and include) evidence of why you are questioning this.
4. Be courteous and professional in your response if questioning a factual inaccuracy.
5. Be timely in submitting any factual inaccuracies. You will be given a designated date by the Mental Health Commission by which to respond by.

Feedback on the inspection process:

1. A review and comment form is emailed to the Registered Proprietor by the Mental Health Commission following the inspection as an opportunity to provide feedback on the factual accuracy of the draft inspection report.

2. In addition, Within five days of the inspection, the Mental Health Commission email the Registered Proprietor and Clinical Director in the approved centre inviting them to complete a short survey, to provide feedback on the inspection process, (not the inspection report).

3. The Registered Proprietor and Clinical Director are asked to forward the email (which contains a link to this survey) to all members of staff who were involved in the inspection process.

4. The survey can be completed online at https://www.surveymonkey.com/r/InspPro2017

5. If there is a complaint about the quality of the service that you receive from the Mental Health Commission, the complaints procedure is available on the mental health commission website http://www.mhcirl.ie/About Us/Complaints-Procedure/

Completing Corrective and Preventative Action Plans (CAPAs)cc

When completing your Corrective and Preventative Action Plan

1. Develop all CAPAs with the input of the multidisciplinary team members.
2. Ensure that the SMART criteria set out below are applied when addressing all non-compliances.

3. The approved centre/service will be asked to identify corrective and preventative action plans. The corrective action is the action that you will take to correct the non-compliances. The preventative action is the action you will take to minimise the

risk of future occurrences. It is important to clearly distinguish between corrective actions and preventative actions.

4. Ensure that realistic and achievable timeframes are set for completing the actions specified.
5. In addressing the non-compliances identified, prioritise the actions to be taken in terms of the risk and outcome to the service user and staff.

Some sample CAPAs are provided as an appendix to this document.

Distributing the learning from the inspection process / inspection report

1. Once you receive the inspection report and as a team have finalised the CAPAs distribute and discuss these with staff.
2. Use forums such as staff meetings and Quality and Patient Safety meetings to share the learning from the inspection and to raise awareness of positive outcomes and improvements required. The CAPAs and the progress made will feature as a standing agenda item at all meetings.

Follow-up action

1. Encourage shared ownership by everyone on the team and clear identification of individuals responsible for actions as set out in the CAPAs.
2. The CAPAs form part of the wider quality improvement agenda, as set out in the HSE Best Practice Guidance for Mental Health

Services. The CAPAs can be inputted onto the Guidance Assessment Improvement Tool, (GAIT) and monitored using the quality improvement plans reports function.

3. Monitor progress with the implementation of actions as set out within the CAPAs.

4. Gather and store the evidence of actions that have been taken following the inspection. This may be stored within an accessible location where other evidence for inspections is maintained. This may be also stored on the GAIT.

5. Where actions are not implemented within the agreed timeframe, this is discussed at the quality and safety committee, and at the area mental health management team and the non-compliances addressed accordingly.

Appendix 1 Sample Corrective and Preventative Action Plans

Sample 1. Regulation 32: Risk Management Procedures				
Area (s) of non-compliance	**Specific** *Define **corrective and preventative action** (s) to address the non-compliant finding **and** post-holder (s) responsible for implementation of the action (s)*	**Measurable** *Define the method of monitoring the implementation of the action (s)*	**Achievable / Realistic** *State the feasibility of the action (s) (i.e. barriers to implementation)*	**Time Bound** *Define timeframe for implementation of the action (s)*
1. "There were no policies in the Approved Centre describing the process of control for: i. Resident absent without leave ii. Suicide and self-harm iii. Assault and iv. Accidental injury to residents or staff As required by regulation 32, (2) (c)"	**Corrective action (s)** The existing policy has been updated and includes 1. Resident absent without leave 2. Suicide and self-harm 3. Assault and 4. Accidental injury to residents or staff All staff have read and signed to say they have understood the revised policy. Post holder (s): Heads of Discipline/ service and Policy Review Group **Preventative action (s)** – All policies will be reviewed annually and updated on a three yearly basis or more often if required. Post holder (s) Heads of Discipline/ service and Policy Review Group	Action is completed.	Achieved – Action completed.	Completed November 30th 2016

Sample 2. Regulation 15: Individual Care Plan				
Area (s) of non-compliance	**Specific** *Define **corrective and preventative action** (s) to address the non-compliant finding **and** post-holder (s) responsible for implementation of the action (s)*	**Measurable** *Define the method of monitoring the implementation of the action (s)*	**Achievable / Realistic** *State the feasibility of the action (s) (i.e. barriers to implementation)*	**Time Bound** *Define timeframe for implementation of the action (s)*
1. Three out of the 10 Individual Care Plan's, (ICP's) inspected did not have evidence of MDT review.	**Corrective action (s)** 1. All ICP's have been reviewed and updated by the relevant MDT members. This is documented in the individual ICP's. Post holder (s): Members of the MDT.	ICP's are reviewed on a weekly basis and non-attendance at the review meeting or any deficits are discussed with the heads of service and the Executive Clinical Director.	Achieved. Completed	Completed 24th March 2017
	Preventative action (s) 1. Service users ICP's are reviewed and updated on a weekly basis as required by the MDT. This is documented. Post holder (s) Each Head of Discipline	Audits of the ICP's take place on a quarterly basis and improvements required will be documented and implemented.	Achievable – No barriers	Audit to commence on 30th June 2017 and three monthly thereafter. The results of the audits will be discussed at QPS meeting and disseminated through the heads of discipline meetings.
2. Seven out of 10 ICP's did not have evidence of service user involvement.	**Corrective action (s)** Service users are now involved in the review and updating of ICP's on a weekly basis. The service user is supported to complete the weekly expectation sheet, if they do not wish to attend the MDT meeting. Service user's involvement or choice not to attend the review meeting is documented. Post Holder (s) – ADON & Key worker	Spot check of service users ICP's is completed weekly. Any deficits identified are discussed with the relevant key worker/MDT member.	Achievable – No barriers	Audit to commence on 30th June 2017 and three monthly thereafter. The results of the audits will be discussed at QPS meeting and disseminated through the heads of discipline meetings.
	Preventative action (s) Staff will encourage service users to be involved in the development and review of their ICP. Through meeting with service users, increased signage and the information booklet provided on admission. Post Holder (s) – ADON & Key worker	Audits of the ICP's take place on a quarterly basis and improvements required will be documented and implemented.		

Sample 3 Regulation 23: Medication Management				
Area (s) of non-compliance	**Specific** *Define* ***corrective and preventative action*** *(s) to address the non-compliant finding* ***and*** *post-holder (s) responsible for implementation of the action (s)*	**Measurable** *Define the method of monitoring the implementation of the action (s)*	**Achievable / Realistic** *State the feasibility of the action (s) (i.e. barriers to implementation)*	**Time Bound** *Define timeframe for implementation of the action (s)*
The storage of medication was not appropriate, for example, inspectors found medication on the lockers of two residents.	**Corrective action (s)** All staff spoken with regarding the storage of medication. This was discussed by the ADON at staff nurse and CNM meetings. This was repeated to include all nursing staff. Minutes maintained. Post holder (s): ADON **Preventative action (s)** All staff responsible for the administration of medication will attend medication administration training in June and July. See schedule attached. Post holder (s) ADON and Pharmacist.	Daily checks of storage of medication is carried out by the CNM2 and this is documented. Weekly audits of medication are carried out by the pharmacist and this is documented. Weekly review of the staff training records by the ADON and an agenda item on the fortnightly QPS meeting.	Achievable Achievable	Staff nurse and CNM meetings 19, 20 and 22 May, 2017. Daily checks of storage of medication commenced 19 May 2017. Weekly audits of medication commenced week ending 19 May 2017. 30th July 2017.

Further Information & Support

The Quality and Service User Safety Team are available to provide further support to Approved Centres/Services, as necessary and can be contacted for further advice.

Contact details

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