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.

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

Indicator 1.2

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 preferred identifiers to be used for each service user, as identified by the service, 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 appropriate service user identifiers are used. Analysis is completed to identify and respond to issues identified.

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

Indicator 1.3

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].

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.

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, 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.

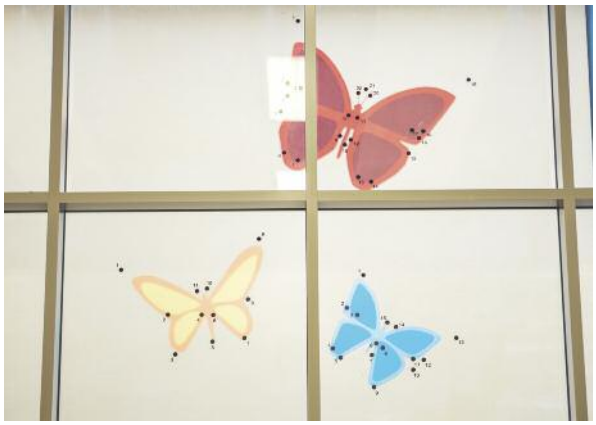
14. A daily activity timetable for schooling is available for each child service user receiving educational services within the approved centre.

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.

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 on whether or not, to participate in activities is respected and documented, as appropriate.

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 at least two choices for meals that reflect his or her preference and dietary requirements. The menu varies regularly and takes into account feedback from service users. Hot meals are provided on a daily basis. There are a variety of wholesome and nutritious food choices, including portions from different food groups as per the food pyramid.
9. Menus are approved by a 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.

Indicator 2.5

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.

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 in the event of a sudden or unexplained 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.

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 indelible 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.
- Each entry includes 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.

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 (using a validated audit tool) and hygiene audit; and action is taken to address any improvements required.

15. Ligature points are minimised to the lowest practicable level, based on risk assessment.

16. 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.