

# **THEME 1**

**RECOVERY ORIENTED  
CARE & SUPPORT**

# Theme 1

## Recovery Oriented Care & Support

### Aim 1

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

#### Indicator 1.1

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

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

1. There are policies and procedures in place relating to engaging service users, family and carers in the governance of the mental health service (*HSE Code of Governance, 2015*).
2. The policies and procedures relating to engaging service users, family and carers in the governance of the mental health service are implemented.
3. There are policies and procedures in place to actively involve service users, family and carers in planning, service delivery, evaluation at all levels (e.g. satisfaction surveys, interviews, focus groups, advocacy networks, service user participation in evaluation of services), including specific approaches to involve marginalised groups. All responses from service users, family and carers are kept confidential and the appropriate consent is obtained.
4. Terms of reference are in place, which describe the responsibilities of committees and boards for partnering with service users, family and carers.
5. Relevant documentation from committees and meetings reflect service user, family and carers' representation and involvement in governance activities. All responses from service users, family and carers are kept confidential and the appropriate consent is obtained.
6. An Area Lead for Service User, Family and Carer Engagement is appointed to the Area Mental Health Management Team in each Community Health Organisation (CHO) area.
7. An appropriate number of local fora are in place to involve service users, family and carers. The meetings should be at least every three months and the venue agreed.
8. Each service user, family and carer forum has clear terms of reference.
9. Minutes from service user, family and carer fora are provided to the Area Mental Health management team and responses and actions are documented with all documentation treated confidentially.

10. There is a process for analysing engagement with service users, family, and carers.
11. Financial and physical resources are provided to support service users, family and carers to participate and input at governance level, as per the payment scheme for reimbursement of service users, family members and carers, within the mental health division, as applicable.
12. Service users, family and carers have access to previously published Mental Health Commission inspection reports (Copies are available in the service area).
13. A dedicated time and location are made available to service users, family and carers to speak to the Mental Health Inspectorate while they are on inspection. There is a collaborative approach to this.
14. Where there are Peer Support Workers, these are employed in accordance with contracts of employment and job descriptions.
15. Training is available for those service users, family and carers involved in governance.
16. There is evidence of both local service management and the CHO senior management team meeting directly with service user, family and carer fora, where necessary.
17. There is evidence of communication of responses and actions by management from matters arising from any engagement with service users, family and carer fora.

## Indicator 1.2

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

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

1. There are policies and procedures in place which describe the role of service users, family and carers in strategic and operational planning and design.
2. The policies and procedures on the role of service users, family and carers in strategic and operational planning and design are implemented.
3. There is documented evidence of regular collaboration (minimum quarterly) between the Area Lead of Service User, Family and Carer Engagement and the Head of Mental Health Services.
4. There are policies and procedures in place in relation to working with families and carers, incorporating, confidentiality and consent.
5. These policies and procedures are implemented.
6. There is service user involvement in the co-production/co-designing any service design or reconfigurations:
  - Minutes of meetings reflect attendance and input into design meetings, planning, co-production of strategies and policy.

7. All documentation provided to service users, family and carers is in a clear and understandable format with glossaries provided as required.
8. Committee terms of reference, membership, selection criteria, papers and minutes demonstrate service user, family and carer engagement in strategic and operational planning.
9. Training is provided for service users, family and carers and staff participating in meaningful engagement.

### Indicator 1.3

**Service users, family and carers are partners in the planning of their treatment, including but not limited to, areas of consent<sup>1</sup>, capacity, choice, rights and responsibilities.**

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

1. The human and legal rights of all service users are upheld.
2. The service user is involved in all aspects of his/her assessment, treatment, care and recovery planning, (e.g. Wellness Recovery Action Planning – (WRAP), Individual Care Planning (ICP), including discharge planning.
3. The best interest of the person should be the principal consideration with due regard given to the interests of other persons particularly where risk exists.
4. The mental health service, with the service user's informed consent<sup>2</sup> includes family and carers, other service providers and others nominated by the service users in their assessment.
5. Subject to service user consent, on-going information is provided to service users, family and carers about proposed treatment in a manner which meets the service users' assessed wishes.
6. Up to date written information is available regarding organisations that are present in the community to support the recovery process, as set out in the service users discharge plan. This includes information on advocacy services<sup>3</sup>.
7. Where peer supports are available and appropriate the service user is informed and an appointment is offered to them to discuss their recovery plan.
8. Completed consent forms by service users demonstrate informed consent.
9. The views of service users, and the history of previous treatment is considered and documented prior to administration of new medication and/or other technologies.
10. The treatment and support provided, where applicable, is developed and evaluated collaboratively with the service users, family and carers. This is documented in the ICP.

1. Health Service Executive National Consent Policy, 2013

2. Same as above

3. Section 20(1)(d) Mental Health Act 2001 (Approved Centre) Regulations 2006

11. Attendance at planning meetings and consultation is documented. (e.g. this is recorded in the service user experience forms). In the event that the service user cannot or refuses to attend a meeting, this is documented.
12. Feedback from service users, family and carers is used to improve the experience for service users.
13. Service user fora are regularly facilitated in the centre/service.

## Aim 2

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

#### Indicator 2.1

#### **Admissions, transfers and discharges are in line with best available practice and where relevant, legislation, Regulations and Codes of Practice<sup>4</sup>.**

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

1. There are policies and procedures in place for admissions, transfers, discharge and temporary absence of service users. Where applicable, this is in accordance with the *Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre; 2010 with Regulation 28 of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Transfer of Residents, and the Mental Health Commission Code of Practice relating to Admission of Children under the Mental Health Act 2001. HSE Policy on Transfer to and Admission to an Approved Centre S20,21&22 MHA, 2001.*
2. The policies and procedures are implemented.
3. The policies and procedures details the referral processes for the service, including the processes for planned, urgent and self-referrals.
4. Relevant staff have read and understand the policies and procedures on admissions, transfers and discharge.
5. Relevant staff can articulate the processes as set out in the policies.
6. The service is monitoring the implementation of the policies.

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

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

## Admissions

7. Admissions<sup>5</sup> to the service are in accordance with the statement of purpose and the admissions policy and takes account of the legal provisions in the Mental Health Act, (2001).
8. No person under the age of 18 years is admitted to an adult service, or other adult service (save by order of the District Court or in exceptional circumstances).
9. In the exceptional circumstances where children are admitted to an adult unit, the rationale and action taken to locate an alternative arrangement is recorded. Daily input from the young adult or CAMHS team in the service users clinical file.
10. If, in exceptional circumstances, the admission of a person under the age of 18 years to an adult service occurs, the service submits a detailed report to the Mental Health Commission outlining why the admission has taken place, in accordance with the *Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act (2001)* (and completion of the associated clinical practice form within this section).
11. The admissions process<sup>6</sup> considers the wishes, needs and safety of the individual and the safety of other service users currently in the service.
12. If a child (any person under the age of 18, unless married)<sup>7</sup> has been admitted for care and treatment, consent<sup>8</sup> to the admission and treatment is documented.
13. The entry process for planned and unplanned admissions to the mental health service is a defined pathway with service specific entry points that meet the needs of the service user.
14. Admissions to the service are planned, in so far as is possible, through engagement with the service user and relevant stakeholders in a pre-admission process. This includes a pre-admission assessment and plan.
15. Family and carers are involved in the admission process, where appropriate. Families of service users who may require involuntary admission under the *Mental Health Act 2001*, are informed of the availability of Authorised Officers to complete the required forms.
16. On admission to the service, the service user<sup>9</sup> is provided with a written agreement of the terms on which they shall access the service. The agreement sets out the services to be provided and the fees to be included, if applicable. This agreement is reviewed regularly.

5. Section 14 Mental Health Act, 2001 (as amended)

6. Section 25 Mental Health Act, 2001 (as amended); Child Care Act, 1991 (as amended); Health Service Executive National Consent Policy; Mental Health Commission Code of Practice on Admission of Children under the Mental Health Act 2001

7. Child and Adolescent Mental Health Services (CAMHS) Standard Operating Procedure

8. Section 25 Mental Health Act, 2001 (as amended); Child Care Act, 1991 (as amended); Health Service Executive National Consent Policy

9. Mental Health Commission Statutory Forms

17. Records show that admission<sup>10</sup> to the mental health service is efficient with minimised delay; in accordance with *the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre 2009*; with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 18 Transfer of Residents*, the *Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act (2001)* and the *Memorandum of Understanding between An Garda Síochána and the Health Service Executive*.
18. Assisted admissions<sup>11</sup> are in accordance with the service level agreement and HSE Policy on Assisted Admissions.
19. A key worker is assigned to each service user in accordance with *Vision for Change (2006)* and the *Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre 2009*.
20. Evidence of a physical examination is documented at the time of the admission.

## Transfers

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

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

0. Section 14 Mental Health Act, 2001 (as amended)

11. Section 63 of the Health Miscellaneous Provisions Act 2009 (Assisted Admissions)

22. Documentation that supports verbal and written communication with the receiving facility is available, including agreement of service user receipt prior to transfer. Verbal communication and liaison takes place between the service and the receiving facility prior to the transfer taking place. These shall include a discussion of:
  - the reasons for transfer;
  - the service user care and treatment plan (including needs and risk); and
  - if the service user requires accompaniment on transfer
23. Transfers are in accordance with the Statement of Purpose, the service admissions, transfers and discharge policy and takes into account the provisions in the Mental Health Act 2001.
24. Where a service user is transferred<sup>12</sup> (including emergency transfers), from a centre / service to or from another centre / service hospital or other place all relevant information is provided to the receiving centre / service, hospital or other place and records of this are maintained. This information is sent in advance<sup>13</sup>, or at least accompanies the service user upon transfer, to a named individual. (This regulation relates to service users who have been transferred for care and treatment, but remain a service user of the approved centre. It does not apply to service users who have been discharged to another facility).
25. The following information is issued (with copies retained) as part of the transfer of service user documentation;
  - letter of referral, including a list of current medications;
  - service user transfer form; and
  - required medication for the service user during the transfer process.
26. In the case of an emergency transfer, communications between the service and the receiving facility are documented and followed up with a written referral in a timely period.
27. Checklists are completed by the service to ensure comprehensive service user records have been transferred to the receiving facility.
28. Copies of all records relevant to the service user transfer process are retained in the service user's clinical file.
29. A log of transfers is maintained and reviewed, to ensure relevant information is provided.
30. Systematic review and analysis is completed of each transfer to identify opportunities to improve information provision during transfers. This is documented.
31. An assessment of the service user is completed prior to the transfer including individual risk assessment relating to the transfer and the service user needs. This is documented and provided to the receiving facility/service<sup>14</sup>.
32. The service where a person is transferred<sup>15</sup> to, is suitable in meeting the needs of the service user.
33. The decision to transfer the service user is discussed with the service user and with the receiving service prior to the transfer taking place.

12. Section 22 Mental Health Act, 2001 (as amended)

13. Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (as amended) 2010

14. As above

15. Sections 20 – 22 of Mental Health Act, 2001 (as amended)



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

## **Discharge**

35. The service user's discharge plan is commenced on admission and is included in their individual care plan upon transfer.
36. The discharge plan is developed in consultation with the service user and, where consent has been given, with their family and carer.
37. A comprehensive pre-discharge assessment is carried out by the multi-disciplinary team prior to discharge. This assessment is completed in conjunction with the service user.
38. General Practitioners/Primary Care Teams and/or community mental health services are informed of the discharge of a service user within 24 hours.
39. When a service user is discharged<sup>16</sup>, a discharge summary is sent to the General Practitioner/Primary Care Team/community mental health services responsible for follow up care within 3 days of discharge.
40. If this is not practicable, a preliminary discharge summary (and prescription information) may be sent initially, followed by a comprehensive discharge summary within 14 days.
41. Discharge summaries are compiled in accordance with the Mental Health Commission Code of Practice on Admissions, Transfer and Discharge to and from a Service.
42. Every effort should be made to identify the support needs of the family/carer, where appropriate, prior to discharge.
43. Comprehensive information is provided by the key-worker to the service user and his/her family/carer and/or chosen advocate, with the service users consent, in plain, understandable language upon discharge, which includes: contact details of community mental health services; details of how to access these services; contact details of other support services such as advocacy services; relevant voluntary organisations; relevant community groups and supported employment services; a crisis point of contact and details of how to re-access inpatient services (including during out of hours).
44. Services provide the service user and family, where appropriate with the consent of the service user, with a minimum of 2 days' notice of discharge. If this does not occur the reasons for it should be clearly documented in the service user clinical file.
45. A defined process is in place to return property to service users in accordance with the regulations.
46. A follow up appointment is made with the service user, post discharge based on the service user's needs and an assessment of risk by the supporting community mental health service team.
47. Delays to discharges are reviewed on at least a weekly basis.
48. A process is in place to monitor and manage delayed discharges.

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

## Indicator 2.2

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

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

1. The pathways for access to a 24-hour seven days a week, mental health service, are clearly defined.
2. Brochures and posters including information about how to contact mental health services are available, in languages, as needed.
3. Information is provided to the public, service users, family and carers on what services are available, how they work, and how to access them, especially in a crisis. This includes information for minority groups. This information is included on the mental health service website, with links to relevant options. (e.g. [www.yourmentalhealth.ie](http://www.yourmentalhealth.ie))
4. The mental health service promotes equality in accessing a service, regardless of the service user gender, marital status, family status, sexual orientation, religion, age, disability, ethnicity, membership of the traveller community or social class.
5. There is an identified community team coordinator who is a contact for the General Practitioner.
6. Information on the range of services are available such as:
  - Liaison Psychiatry in the Emergency Department.
  - Self harm liaison nurses in the Emergency Department, seven days a week, for extended hours.
  - Suicide Crisis Assessment Nurses (SCAN), available to General Practitioners.
  - Authorised Officers, available to families.
7. There is a defined process for emergency admissions in place in accordance with the Mental Health Commission Code of Practice for Admission, Transfer and Discharge (2010).
8. There are joint protocols for emergency admissions between adult and child services, demonstrating collaborative working, in accordance with HSE policy and CAMHS standard operating procedure.
9. Data on waiting times to access the mental health service is analysed and strategies are developed and implemented to reduce the waiting times for service users and improve ease of access to services. All information is maintained confidentially and data is secured to prevent data breaches.
10. Technology is used to improve access to services; this includes data bases, mobile phone text/email appointments, skype and video technologies in accordance with HSE Electronic Communications Policy and service user preferences.
11. The mental health service analyses information and data to improve attendance, (including discharge metrics, and non-attendance data at clinics and appointments with any team member).

12. The service maintains a record of non-admissions and the reason for non-admissions, as well as the follow up action that was taken for those who were not admitted. This is maintained in accordance with the *HSE Records Retention Policy (2013) and Regulation 27 of Mental Health Act 2001 (Approved Centres) Regulations 2006*.
13. There are procedures in place to expedite service users through the Emergency Department, based on the service user's clinical assessed needs.

### Indicator 2.3

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

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

1. The mental health service is located in accessible premises, where applicable.
2. Part M Building Regulations (2000) "access for people with disabilities" are complied with. Other legislation including *Safety Health and Welfare at Work Act 1989/2005*, the *Employment Equality Act 1998/2004*, the *Equal Status Act 2000-2004*, the *Disability Act 2005* are complied with.
3. The four main dimensions of access are reviewed and evaluated and include:
  - Physical access- for people requiring the use of wheelchairs or walking aids, the provision of handrails, ramps, lifts and lowered counters.
  - Sensory access- for people with hearing and visual impairment, tactile markings, signs and labels, hearing augmentation listening systems, audio cues for lifts and lights.
  - Communication access- for people who have difficulty with the written word, vision speech and language problems and those who do not speak English.
  - Cognitive access- for people who have impaired awareness perception, reasoning and judgement.
4. The service consults with people from ethnic minority groups regarding cultural factors in the built environment, if appropriate.
5. The dementia specific care setting has a design and layout that encourages and aids independence, including appropriate signage, use of colours, sensory stimuli, own personalised space and lighting in accordance with best practice dementia care principles.
6. Service users with a disability are consulted about the design of new premises, if appropriate.
7. Available public transport options to access individual services and directions are detailed on the mental health service website and on notice boards in relevant areas.

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

## Aim 3

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

#### Indicator 3.1

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

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

1. The mental health services' values are clearly defined, articulated and reflected in practice.
2. The service user is consulted regarding their individual values and staff respond sensitively, as appropriate.
3. The service user has access to the HSE Charter of Rights. This is available and on display for the service user to access.
4. The service user is aware of the HSE Charter of Rights.
5. The service user has access to an advocacy service to support them to understand his or her rights and responsibilities.
6. The service user has access to an interpreter service, where necessary, to support them to understand his or her rights and responsibilities.
7. The involuntary service user is provided with information on the involuntary admission process and is supported to read and understand the contents at an appropriate time. This includes the information as specified by the Mental Health Commission, in accordance with *Section 16 Mental Health Act (2001)*.
8. Information is available to service users, family, carers, GP, Gardaí, etc. on the involuntary admission process, including the assisted admission process, if applicable.
9. Cultural awareness training is provided to staff, as necessary.
10. Accessible information about involuntary admission and rights is delivered in context, and is repeated as required, to service users, family and carers e.g. the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2009
11. Recovery approaches are encouraged to support service users to be involved in the assessment and management of risk, and to take positive and therapeutic risks within their day to day lives. This is in accordance with the HSE Risk Management in Mental Health Services Policy.

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

20. Section 16 Mental Health Act, 2001 (as amended)

## Personal Property and Possessions<sup>21</sup>

12. There are written operational policies and procedures on service user's personal property and possessions, in accordance with of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 8 Residents Personal Property and Possessions.
13. At a minimum, the policies and procedures on personal property and possessions includes:
  - The roles and responsibilities of the service to support service users to manage his or her personal property and possessions.
  - The communications with the service user, and his or her representatives, regarding the service users' entitlement to bring personal property and possessions into the service at admission and on an ongoing basis.
  - The process to record, secure and manage the personal property and possessions of the service user, including money.
  - The process to allow a service user access to, and control over, his or her personal property and possessions, unless this poses a danger to the service user, or others, as indicated under an individual risk assessment and the service user's individual care plan.
14. Relevant staff are recorded as having read and understood the policies and procedures on service users' personal property and possessions.
15. Relevant staff can articulate the processes for service users' personal property and possessions as set out in the policy.
16. A record is maintained of each service users' personal property and possessions and is available to the service user in accordance with the service's written policy.
17. A detailed property checklist is compiled on admission of each service user's personal property, and possessions. The checklist is updated on an ongoing basis in line with the approved centre's policy.
18. The property checklist is kept separate to the service user individual care plan, in accordance with of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 8 Residents Personal Property and Possessions. This is available to the service user.
19. Service users are provided with new clothing<sup>22</sup> where necessary, where they do not have an adequate supply. Night clothes are not worn during the day, unless this is specified in the care plan, in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 7 Clothing. (Such clothing should be individually labelled).
20. Service users retain control over their own personal property and possessions except under circumstances where this poses a danger to the service user or others, as indicated by the service users' individual care plan, and/or in accordance with the approved centre's policy.
21. The service user's personal property and possessions are maintained safely when the centre assumes responsibility for them.

21. Regulation 8 Mental Health Act 2001 (Approved Centres) Regulations 2006, Residents Personal Property and Possessions

22. Regulation 7 of the Mental Health Act 2001 (Approved Centre) Regulations 2006, Clothing

22. Secure facilities are provided for the safe-keeping of the service user's monies, valuables, personal property and possessions, as necessary.
23. The service user is entitled to bring personal possessions with him/her, the extent of which is agreed at admission.
24. The access to and use of service user monies is overseen by two members of staff and the service user or their representative.
25. Where any money belonging to the service user is handled by staff, signed records of the staff issuing the money is retained. Where possible, this is counter-signed by the service user or their representative.
26. Service users are supported to manage his or her own property, unless this poses a danger to the service user or others as indicated in their individual care plan.
27. Personal property logs are monitored.
28. Analysis is completed to identify opportunities to improve the processes for service users' personal property and possessions. This is documented.

## Religion<sup>23</sup>

29. Service users are facilitated, in so far as is reasonably practicable, in the practice of their religion, in accordance with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 10 Religion*.
30. There is a policy and procedures on the practice of religion, and at a minimum the policy and procedures includes:

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

31. Relevant staff are recorded as having read and understood the policies and procedures on religion.
32. Relevant staff can articulate the processes for facilitating service users in the practice of his or her religion as set out in the policies and in the service users' Integrated Care Plan.
33. The implementation of the policy and procedures to support service users' religious practices is reviewed to ensure it reflect the identified needs of the service user. This is documented.

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

**34.** Implementation of the policies and procedures includes:

- Service users' rights to practice religion are facilitated within the service insofar as is practicable.
- There are facilities provided within the service for service users' religious practices, insofar as is practicable.
- Service users have access to their nominated spiritual representative (e.g. a Cleric, Imam, Minister, Pastor, Priest, Rabbi or other).
- Service users have access to local religious services and are supported to attend, if deemed appropriate following a risk assessment.
- Care and services that are provided within the service are respectful of the service users' religious beliefs and values.
- Any specific religious requirements relating to the provision of services, care and treatment are clearly documented.
- The service user is facilitated to observe or abstain from religious practice in accordance with his/her wishes.

**Searches<sup>24</sup>**

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

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

- The management and application of searches of a service user, his or her belongings and the environment in which he or she is accommodated.
- The consent requirements of a service user regarding searches.
- The process for carrying out searches in the absence of consent.
- The process following the finding of illicit substances during a search, including as appropriate Garda liaison and /or assistance.
- The roles and responsibilities in relation to the implementation of service user searches.
- The application of individual risk assessment in relation to service user searches.
- The processes for communicating the service's search policies and procedures to service users and staff.
- The processes for informing the service user being searched of what is happening and why.
- The considerations to be provided to the service user in relation to his or her dignity, privacy and gender during searches.
- The requirement to record searches, including the reason for the search and the outcome of the search.

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

37. Consent is sought prior to all searches. The request for consent and the received consent is documented for every search of a service user and every property search.
38. General written consent may be sought on admission for routine environmental searches.
39. Where consent has not been received, this is documented and the policies and procedures relating to searches without consent are implemented.
40. The policies and procedures on searching are implemented. An audit is carried on a six-monthly basis to ensure that the policies and procedure is adhered to.
41. Relevant staff have read and understand the policies and procedure on searches. This is documented.
42. Relevant staff can articulate the searching process as set out in the policy.
43. Service users are aware of the policies and procedures on searching. This is communicated to all service users.
44. There is a minimum of two appropriately qualified staff in attendance when searches are being conducted.
45. Searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the service user and staff and following a risk assessment.
46. Risk is assessed prior to a search of a service users, their property or the environment, appropriate to the type of search being undertaken.
47. Where a service user is required to be searched, he /she is informed of what is happening and why.
48. All searches are undertaken with due regard to the service users' dignity, privacy and gender. At least one of the staff members conducting the search is the same gender as the service user being searched.
49. A written record is maintained of each search carried out (including property searches) and includes the reason for the search and the names of both staff members who undertook the search and details of who was in attendance for the search.
50. Each search record is systematically reviewed to ensure the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 13 Searches have been complied with. Analysis is completed to identify opportunities for improvement of search processes. This is documented.
51. A log of searches is maintained and a systematic review of the data is undertaken to ensure the requirements of the regulation on searches is complied with. An analysis is conducted and documented to identify opportunities for learning and improvement.
52. The centre has written operational policies and procedures in relation to the finding of illicit substances and procedures for Garda involvement, if appropriate. This is implemented, as required. Staff have read and understood the policy and this is recorded.



## Indicator 3.2

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

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

1. A register of interpreters and support services are available to the workforce, service users, family and carers, in accordance with of *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 20 (d), Details of Relevant Advocacy and Voluntary Agencies are Provided.*
2. The services user is supported and encouraged to contact advocacy services.
3. A copy of the Mental Health Commission “Your Guide to the Mental Health Act 2001” is available to the service user, in an understandable form and language.
4. The service user is informed as to how information is shared about them.
5. The service user’s right to privacy is respected and the duty of confidentiality upheld.
6. Personal information regarding the service user is not communicated to a third party e.g. family, carer, advocate, health professional in another health care setting or outside agency, without the service user’s consent, unless the service user poses a significant risk of harm to themselves, another person or society and duty of care requires this information to be shared.
7. The service user’s clinical records reflect assessment of need including risk and the interventions and support provided.

## Indicator 3.3

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

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

1. Written information about access to a range of independent advocacy services is available in brochures and on posters throughout the service, in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 20, (d) details of relevant advocacy and voluntary agencies is provided.
2. Service users are able to access peer support workers, if employed in the relevant area.
3. Job descriptions are in place for peer support workers outlining accountabilities and confidentiality requirements to service users and to the mental health service.
4. The service user’s records demonstrate that he/she has independently determined who will represent his/her views.
5. The mental health service has properly informed the Mental Health Commission of service users who have been involuntarily detained.
6. The Mental Health Commission has appointed a lawyer for the service user if involuntarily detained under the Mental Health Act (2001).

## Indicator 3.4

### Mental Health Services cooperate fully with Mental Health Tribunals<sup>25</sup> (Adult Services only)

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

1. There are written policies and procedures available in relation to the facilitation of Mental Health Tribunals.
2. At a minimum, the policies and procedures includes:
  - The roles and responsibilities in relation to Mental Health Tribunals relevant to the service.
  - The relevant legislative requirements in relation to Tribunals.
  - The provision of information to the service user regarding the Mental Health Tribunals.
  - The communication processes between the service and external parties involved in the Mental Health Tribunals.
  - The resources and facilities provided by the service to support service users attending a Mental Health Tribunal, including the availability of staff to attend a Tribunal, as necessary.
3. Relevant staff have read and understood the policies and procedures relating to Mental Health Tribunals and this is documented.
4. Relevant staff can articulate the policies and procedures for facilitating Mental Health Tribunals.
5. The implementation of the policies and procedures in relation to facilitating Mental Health Tribunals is monitored, to ensure that the rights and needs of the service user are appropriately supported.
6. Analysis is completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.
7. The service provides private facilities to support the Mental Health Tribunal process.
8. The service provides adequate resources to support the local Mental Health Tribunal process.
9. Staff attend Mental Health Tribunals and provide assistance, as necessary, when the service user requires assistance to attend or participate in the process.
10. Staff provide support to the service user after the tribunal outcome is known.

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

## Indicator 3.5

**The mental health service supports and promotes opportunities to enhance service users' positive social connections<sup>26</sup> with family, children, friends and their community.**

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

1. There is a mission statement which identifies recovery processes and outcomes, which is developed in consultation with service users, family, carers, and staff.
2. There is access to inpatient and community fora, peer support groups, family and carer member peer groups. Information from interactions with service users is maintained confidentially.
3. Multi-disciplinary teams encourage referrals and access to peer support workers and peer support services, where available.
4. Information is provided to staff, service users, family and carers about the range of support networks that are available in the community (e.g. peer support services, services outside mainstream mental health services, local day services and educational institution and recovery colleges).
5. The service user's care plan includes actions to increase social inclusion and participation in local and community groups. This includes mainstream social inclusion activities and supports.
6. Appropriate arrangements are made for service users to receive visitors, in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 11 Visits, having regard to:
  - The nature and purpose of the visit.
  - The needs of the service user.
  - Reasonable times are identified during which a service user may receive visits.
  - All reasonable steps to ensure the safety of service users and visitors.
  - The freedom of a service user to receive visits and the privacy of a service user during visits are respected, in so far as is practicable, unless indicated otherwise in the service user's individual care plan.
  - The visiting room/area is suitable for visiting children.
  - Ensuring that children visiting are always accompanied, to ensure their safety and ensuring that this is communicated publicly.
7. Written operational policies and procedures are available in relation to visits.

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

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

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

- 9.** Relevant staff have read and understood the policies and procedures on visits and this is documented.
- 10.** Relevant staff can articulate the policies and procedures for visits.
- 11.** The implementation of the policy on visits is reviewed to ensure it is appropriate to the identified needs of service user.
- 12.** Restrictions on service user's rights to receive visitors is monitored and reviewed on an ongoing basis.
- 13.** Analysis is completed to identify opportunities to improve visiting processes.
- 14.** Visiting times are appropriate and reasonable and are publicly displayed.
- 15.** Justifications for visiting restrictions are documented in the service user's clinical file.
- 16.** The clinical file documents the names of the visitors the service user does not wish to see and those who pose a risk to the service user.
- 17.** A separate visitor's room or visiting area is provided where service users can meet with visitors in private (unless there is an identified risk to the service user, an identified risk to other or a health and safety risk.)
- 18.** Appropriate steps are taken to ensure the safety of service users and visitors during visits.



## Aim 4

**Service users are enabled to participate<sup>27</sup> in making informed decisions about their care.**

### Indicator 4.1

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

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

1. There are policies and procedures in place within the service that provide ongoing information to service users.
2. At a minimum, the policies and procedures include:
  - The roles and responsibilities for the provision of information to service users.
  - The information provided to service users at admission.
  - The information provided to service users on an ongoing basis.
  - The process for identifying the service users' preferred ways of receiving and giving information. The methods for providing information to service users with specific communication needs.
  - The interpreter and translation services available within the service.
  - The process in place to manage the provision of information to service user representatives, family and next-of-kin, as appropriate.
  - The advocacy arrangements.
3. The policies and procedures on providing ongoing information to service users are implemented.
4. All staff have read and understand the policy on the provision of information to service users. This is documented.
5. All staff can articulate the processes for providing information to service users, as set out in the policy.
6. The service user's communication needs are assessed on admission and documented in their individual care plan.
7. Information is provided in a manner which meets each service user's assessed needs.
8. Relevant documentation from committees and meetings demonstrates service user involvement in developing service user information resources.

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

9. A database of interpreter and other advocacy and support services (including voluntary agencies) is made available to the workforce, service users, family and carers. This includes peer and self-advocacy.
10. The Provision of information to service users, is in accordance with Regulation 20 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 -, and is in an accessible, booklet format, provided at admission and includes at a minimum:
  - Details of the service user's multidisciplinary team.
  - Verbal and written information on the service user's diagnosis.
  - Suitable written information relevant to the service user's diagnosis unless in the service user's psychiatrist view the provision of such information might be prejudicial to the physical and/or mental health, well-being or emotional condition of the service user.
  - Housekeeping practices, including arrangements for personal property.
  - Mealtimes.
  - Visiting times and visiting arrangements.
  - Service Users' rights.
  - Complaints policy and procedure<sup>28</sup>.
  - Details of advocacy
  - Service user information is offered in formats that is appropriate and supports his/ her individual needs.
11. Information is provided on relevant care practices appropriate to the service user's needs, (e.g. use of medication, diagnosis, recovery pathways, general and mental health, roles and responsibilities of team members).
12. Service users are provided with written and verbal information regarding their diagnosis unless the service users' psychiatrist considers that the provision of such information might be prejudicial to the service users' physical or mental health, well-being or emotional condition. The justification for restricting information regarding a service users' diagnosis is documented in their clinical file.
13. Each service user has access to information resources available. (e.g. pamphlets, DVD, education resources, ICT programmes) to support their needs and to help them to make informed decision about their care.
14. Information is provided to the service user as to any potential effects of treatments, including the risks and possible side effects.
15. Medication information sheets, as well as verbal information, are provided in a format that is appropriate to the service user's needs. effects.

28. Section 45 Health Act 2004 (as amended)

16. The content of the medication information sheets includes information on indications for use of all medications to be administered to the service user, including any possible side-effects.
17. The information in the documents provided by, or within, the service is evidence-based.
18. Information documents provided by, or within, the service are appropriately reviewed and approved prior to use.
19. Service Users have access to interpretation and translation services as required.
20. The implementation of the policy on the provision of information to service users is monitored and continuously improved.
21. The provision of information to service users is monitored on an ongoing basis to ensure the information is appropriate and accurate, particularly where information changes occur e.g. information on medication and housekeeping practices.
22. Review and analysis is completed to identify opportunities to improve the processes for providing information to service users. The findings and the lessons learned from this process are shared and documented.

#### Indicator 4.2

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

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

1. There are policies and procedures on advance care directives and Do Not Attempt Resuscitation orders (DNARs), in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 14, Care of the Dying and HSE Policy.
2. The policies and procedures on advance care and directives and DNARs are implemented.
3. Staff have read and understood the policies and procedures, and this is documented.
4. Staff training is provided on the policies and procedures regarding Advance Care Directives and DNAR's.
5. The service user receives timely and appropriate assistance to discuss a plan for his or her end of life care, if required- including documentation relating to Advance Care Directives. There is support from advocacy if necessary.
6. Each service user has an opportunity to obtain relevant information and participate in discussions regarding end of life care planning including;
  - His or her preferences regarding decision making and communication.
  - His or her wishes in relation to end of life care, including symptom control and nutrition and hydration.

7. The service user's preferences in relation to end of life care, including advance care directives and DNAR are documented in his or her care plan reflective of the HSE National Consent Policy (2013) Part 4 DNAR.
8. If the service user has difficulty in expressing his or her wishes and preferences or lacks functional capacity, all reasonable steps are taken to maximise his or her ability to participate in the decision-making process.
9. Advance Care Directives relating to end of life care as well as DNAR orders and associated documentation are clearly evidenced in the service user's clinical file.
10. There are systems in place to manage the DNAR in accordance with the service policy.
11. All consultation with the service user, family and carers regarding a (DNAR) decision are detailed in their clinical file. This is subject to the consent of the service user, where possible.
12. The service user is provided with the agreed end of life care, as set out in his or her care plan.
13. Staff can articulate the processes for advance care directives and DNAR's.

## Aim 5

### **Service users' informed consent<sup>29</sup> to care and treatment is obtained in accordance with legislation and best available evidence.**

#### Indicator 5.1

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

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

1. There are policies and procedures on obtaining and acting in accordance with the informed consent of service users in line with the *HSE National Consent Policy and the Mental Health Act (2001)*.
2. The Policies and procedures on obtaining and acting in accordance with the informed consent is referenced with the *Mental Health Act (2001)* which addresses the arrangements that protect the best interest of children<sup>30</sup> and service users who lack capacity under the legislation and vulnerable adults.
3. The HSE National Consent policy (2014) is implemented.
4. Staff receive training on the policies and procedures, the *Mental Health Act (2001)* and Assisted Decision (Capacity) Legislation (2015) as appropriate.

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

30. Child and Adolescent Mental Health Service (CAMHS) Standard Operating Procedure 2015



5. The mental health service has arrangements in place to support the service user in making valid and informed consent to treatment and care and the provision of confidential information. These arrangements are in accordance with the provisions of the *Mental Health Act (2001)*, where appropriate, Mental Health Commission Statutory Form describing the assistance provided to the patient i.e. Form 17.
6. In the absence of service user consent to treatment, the provision of sections 59 (*Electro-convulsive therapy*), 60 (*Administration of medicine*) and 61 (*Administration of medicine to a child*) of the *Mental Health Act (2001)* (as amended)<sup>31</sup> must be complied with regards to detained service users.
7. In the case of a child, informed consent is obtained from either parent or the legal guardian or the courts. The view of the child is taken into consideration.
8. Service users confirm that they understand decisions about their consent, treatment and care, where possible. This is provided through discussion with service users.

## Aim 6

### Service users' dignity, privacy<sup>32</sup> and autonomy are respected and promoted at all times.

#### Indicator 6.1

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

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

1. There are policies and procedures in place in relation to service user dignity and privacy and autonomy, in accordance with the *Mental Health Act (2001)*, (*Approved Centres Regulations 2006*, Regulation 21 Privacy).
2. At a minimum the policies and procedures on service users' dignity, privacy and autonomy include:

- The roles and responsibilities for to the provision of service user privacy and dignity.
- The method for identifying and ensuring, where possible, the service user's privacy and dignity expectations and preferences.
- The layout and furnishing requirements to support service user privacy and dignity within the practice setting.
- The mental health service 's process to be applied where service user's privacy and dignity is not respected by staff.

31. *Mental Health Commission Memorandum on the Mental Health (Amendment) Act 2015 (03.02.16)*

32. *Regulation 21 of the Mental Health Act 2001 (Approved Centre) Regulations 2006, Privacy*

3. The policies and procedures in relation to service user dignity, privacy and autonomy are implemented.
4. All staff have read and understand the policies and procedures relating to dignity, privacy and autonomy, and this is documented.
5. All staff can articulate the processes for ensuring service users' dignity, privacy and autonomy as set out in the policies.
6. An annual review is undertaken to check that the policies are being implemented, and that the premises and facilities in the service are conducive to service users' privacy. This is documented.
7. Review and analysis is completed to identify opportunities to improve the processes relating to service users' privacy and dignity. The findings and lessons learned are shared and documented.
8. The service user's privacy and dignity is respected at all times.
9. The recovery approach informs every level of service provision so that each service user is facilitated to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks and pursue their goals.
10. Information is provided on mental health and the recovery approach in a language appropriate to the service user's health, literacy and language.
11. Each service user's recovery pathway includes partnership, listening, hope, choice and social inclusion.
12. The service user's treatment, care and recovery plans reflects his or her involvement, while incorporating family and carer insight, where agreed with the service user.

### **Communication<sup>33</sup>**

13. Written operational policies and procedures are available within the service in relation to service user communication.
14. At a minimum, the policies and procedures in relation to service user communication includes:

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

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

15. Relevant staff have read and understood the policies and procedures on communication. This is documented.
16. Relevant staff can articulate the policies and procedures for communication as set out in the policy.
17. Service user communication needs and restrictions on communication are monitored on an ongoing basis.
18. Analysis is completed to identify opportunities to improve communication processes. This is documented.
19. Individual risk assessments are completed for service users as deemed appropriate in relation to any risks associated with their external communication and documented in the individual care plan.
20. The Clinical Director or a senior member of staff designated by the Clinical Director may only examine incoming or outgoing communication if there is reasonable cause to believe that the communication may result in harm to the service user or to others. In line with Regulation 12 of Mental Health Act 2001 (Approved Centres) Regulations 2006, Communication.
21. The service user is free to communicate at all times, and has access to mail, fax, email, internet (where available), telephone or any device for the purposes of sending or receiving messages or goods unless otherwise risk assessed with due regard to the service users' wellbeing, safety and health.

### **Privacy<sup>34</sup>**

22. All bathrooms, showers and toilet and single bedrooms have locks on the inside of the door, unless there is an identified risk to a service user. Locks should have an override function.
23. Where the service user shares a room, the bed screening ensures that their privacy is not compromised.
24. All observation panels on doors of treatment rooms and bedrooms have blinds, curtains or opaque glass.
25. Rooms are not overlooked by public areas. If so, the windows have opaque glass.
26. Noticeboards do not detail the service user's name or other identifiable information.
27. The creation and storage of records ensures confidentiality and respect. In situations where disclosure of information is required, by law or advisable from an ethical perspective, the rationale for sharing such information should be documented and the service user informed and where applicable consent sought. This is in accordance with *Data Protection Acts 1988 – 2003; HSE Records Management Policy; Criminal Justice Act 2011; Criminal Justice (Withholding of Information of Offences Against Children and Vulnerable Persons) Act, 2012 ; Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2016)*.

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

28. Service users are facilitated to make private phone calls.
29. The Health Service Executive Mobile Phone Device Policy on the use of staff mobile phones is complied with.
30. Service users are called by their preferred name and title.
31. Staff are observed to interact with service users in a respectful and dignified manner (evidenced through the demeanour of staff, the appearance and dress of staff and staff interactions with service users, seeking permission before entering bedrooms or areas where intimate care is provided).
32. Staff ensure that no ageist, racist, sexist or other inappropriate comments, 'banter' or 'jokes' are made.
33. Staff are discreet when discussing the service user's care and treatment needs.

### **Clothing<sup>35</sup>**

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

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

36. Relevant staff have read and understood the policies and procedures on service users' clothing. This is documented.
37. Relevant staff can articulate the policies and procedures for service users' clothing.
38. The implementation of the policies and procedures relating to service user clothing will be reviewed and updated in response to identified service user needs.
39. Service users are provided with emergency personal clothing that is appropriate to the service user and considers the services user's preferences, dignity, bodily integrity, religious and cultural practices.
40. The availability of an emergency supply of clothing for service users is monitored on an ongoing basis. This is documented.
41. The service user wears clothing of his or her personal choice that respects their privacy and dignity, e.g. no soiled clothing, inappropriate size or type of emergency clothing.

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

- 42. Service user clothing is clean and appropriate to the service user' needs.
- 43. Night clothes are not worn by the service user during the day unless specified otherwise in their individual care plan. A record is maintained of service users who wear night clothes during the day. This is monitored - (where a service user chooses to wear their night clothes during the day, this does not need to be recorded or specified in the individual care plan).

### **Autonomy**

- 44. Records demonstrate a focus on autonomy and the right of the person to self-determine unless a specific assessment of capacity has determined otherwise. This is outlined in the Individual Care Plan.
- 45. Clinical and support staff help service users regain and maintain their autonomy and sense of individual choice throughout all aspects of their care pathway.
- 46. Staff recognise the lived experience of the service user and support individual strengths and abilities.

### **Closed Circuit Television**

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

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

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

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

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

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

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

52. The CCTV equipment is checked regularly to ensure they are operating appropriately. This is documented.

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



## Aim 7

**Service users' complaints<sup>37</sup> are responded to promptly, openly and effectively with clear communication and support provided throughout this process.**

### Indicator 7.1

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

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

1. There are policies and procedures in place that describe the processes for making, handling and investigating complaints from any person about any aspect of the service, care and treatment provided in or on behalf of the service. This is in accordance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 31, Complaints Procedures.
2. At a minimum, the policies and procedures include:
  - The roles and responsibilities associated with the management of complaints within the service, including a nominated person responsible to deal with all complaints.
  - The process for the management of complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in, or on behalf of, the service.
  - The communication of the complaints policy and procedure with service users, their representatives, family and next-of-kin, as well as visitors.
  - The methods available to all persons to make complaints regarding the service, care or treatment by the service.
  - The confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.
  - The timeframes for complaint management, including the timeframe for the service to respond to the complaint, and for the complaint to be resolved.
  - The documentation of complaints including the maintenance of a complaints log by the nominated person.
  - Communication with the complainant during the complaint process.
  - The process to escalate complaints that cannot be addressed by the nominated person.
  - The appeal process available where the complainant is dissatisfied with the outcome of the complaint investigation.
3. The complaints policies and procedures are implemented.
4. The details of the complaints procedure and the nominated person for dealing with complaints are on display in a prominent position within the service.

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

5. If the nominated person for complaints is not based in the mental health service, their contact details are publicly displayed.
6. Relevant staff are trained on the complaints management processes (including the nominated person for dealing with complaints, and other staff involved in screening, investigating and managing complaints).
7. All staff are recorded as having read and understood the policies and procedures relating to complaints.
8. All staff can articulate the policies and procedures for making, handling and investigating complaints, as set out in the policy. They can differentiate between the processes for managing a complaint that is raised informally and a formal written complaint.
9. Complaint forms are available for the service user to complete.
10. Service users have a secure comments, compliments and complaints box. Compliments forms and complaint forms and pens are present in a prominent and publicly accessible place.
11. The service user and their representative are made aware of the complaints procedure, and all methods by which a complaint can be made, as soon as practicable after admission to the mental health service.
12. The service user is supported to make a complaint where they wish to make one.
13. A consistent and standardised approach is implemented for the management of all complaints.
14. Service users, and their representatives, are facilitated to make complaints using the methods detailed within the complaints policy and procedure, which may include:
  - Verbal
  - Written
  - Electronically by email
  - Telephone
  - Through complaint, feedback or suggestions forms.
15. The service ensures access, insofar as practicable, to advocates to facilitate the participation of the service user and his or her representative in the complaints process.
16. The service's management of complaints processes is well publicised and accessible to service users and their representatives.
17. All complaints and the results of any investigations into the matters complained, and any actions taken on foot of a complaint, and whether the service user was satisfied, are fully and properly recorded. Such records are in addition to and distinct from the service user's individual care plan.
18. The nominated person for dealing with complaints maintains an up-dated complaints log.
19. All records relating to complaints are stored confidentially in accordance with legislation.



20. All complaints whether oral or written are investigated and managed promptly, in accordance with the time-frame for the management of complaints, as set out in the mental health service policy and in line with national policy. This is documented.
21. All complaints are handled appropriately and sensitively.
22. All Timeframes are provided for:
  - Responding to the complainant following the initial receipt of the complaint.
  - The investigation period for complaints.
  - The required resolution of complaints.
  - Where timeframes are not achieved, or further investigation time is required in relation to the complaint, this is communicated to the complainant.
  - The complainant is informed promptly of the outcome of the complaint investigation and details of the appeals process. This is documented.
23. A method for addressing minor complaints within the service is provided. Minor complaints must be documented.
24. Where minor complaints cannot be addressed locally the nominated person must deal with the complaint.
25. All complaints (that are not minor complaints) are dealt with by the nominated person, who is available to the service and recorded in the complaints log.
26. Where complaints cannot be addressed by the nominated person they are escalated in accordance with the service's policy. This is documented in the complaints log.
27. The registered proprietor ensures that the quality of the service, care and treatment of a service user is not adversely affected by reason of the complaint being made.
28. The service user is informed promptly of the outcome of their complaint and details of the appeals process (in line with policy time-frames).
29. Information on how to contact the Office of the Ombudsman is provided to service users and others, making complaints on behalf of the service user.
30. Where services, care or treatment are provided on behalf of the service by an external party, the nominated person is responsible for the full implementation of the services's complaints management process, including the investigation process and communication requirements with the complainant.
31. All information obtained through the course of the management of the complaint, and the associated investigation process, is treated in a confidential manner and meets the requirements of national guidelines and legislative requirements.
32. The service has a system in place to analyse complaints data and identify trends from the complaints received. Details of this analysis are considered by senior management. Required actions are identified and implemented to ensure continuous improvement of the complaints management process and the quality of the service. (See Theme 4, Leadership, Governance and Management, Aim 4, indicator 4.1)
33. Audits of the complaints log and related records are completed, the audits are documented and the findings are acted upon.

## Aim 8

**Mental health service users are supported in maintaining and improving their own health and well-being<sup>38</sup>.**

### Indicator 8.1

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

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

1. There are policies and procedures in place on general health and well-being, in accordance with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 19 General Health* and in accordance with Health Service Executive policies. These policies are available to service users.
2. There are policies and procedures in place on responding to emergencies, in accordance with the *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 19, General Health* and in accordance with health service policies.
3. At a minimum, the policies and procedures on general health includes:

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

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

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

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

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

7. The implementation of the policies on the provision of general health services and responding to medical emergencies is monitored and continuously improved
8. A systematic review is undertaken to ensure six-monthly reviews of general health needs take place.
9. Review and analysis is completed to identify opportunities to improve general health processes. The findings are implemented.
10. All clinical staff can articulate the processes for the provision of general health services and for responding to medical emergencies as set out in the policies.
11. The service develops and delivers initiatives to promote general health and well-being, in accordance with the services objectives and in consultation with people who access the service.
12. The service cooperates with other service providers and other statutory and non-statutory agencies to promote the health and development of the service user.
13. Staff have the necessary competencies and skills to support health promotion initiatives.
14. Records are available demonstrating the services users completed general health checks and the associated results, including records of any clinical testing, e.g. Lab results.
15. The service user is provided with information and has access to screening, according to age and gender, early detection and the full range of universal health services including Breast check, Cervical screening, Retinal checks (for diabetics only) Bowel screening and Prostate screening. Take up of screening is recorded and monitored, where applicable.
16. The service user has access to general health services, and for referral to other health services as required, in accordance with *Regulation 19 of Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 19, General Health.*
17. The service user's health care needs are assessed regularly as per their individual care plan, at least every six months, in line with *Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 19, General Health.*
18. At a minimum, the six monthly general health assessment documents the following:
  - Physical examination
  - Family/personal history
  - Weight/BMI Waist Circumference
  - Blood pressure
  - Smoking status
  - Nutritional status (diet and physical activity, including sedentary lifestyle)
  - Medication review (per prescriber guidelines)
  - Dental health
19. For services users on antipsychotic medication, there must be an annual assessment of the following unless more regular review is indicated by physical examination.
  - Glucose regulation (fasting glucose / HbA1c)
  - Blood lipids
  - ECG
  - Prolactin

20. There is a documented review to ensure all service users have a six-monthly review.
21. Each service user is supported to live healthily and take responsibility for his or her own health.
22. The service user is offered appropriate health information, education and interventions, both within the service and in the community.
23. Information is provided to service users regarding the national screening programmes available through the service and the service user is enabled to register for such programmes.
24. This includes information on the following:
  - Mental well-being.
  - Mental health recovery.
  - Healthy eating.
  - Recreation, interests and activities.
  - Smoking, alcohol and drug consumption.
  - Physical activity.
  - General Anxiety Disorders.
  - Relationships and sexual health.
25. Each service user has opportunities for new experiences, (e.g. social participation, recreation, education, training and employment as applicable).

#### **Medical Emergencies:**

26. The service has an emergency trolley and staff have access at all times to an AED.
27. Weekly checks are completed on the resuscitation trolley/tray and on the AED, if located in the service.
28. Records are available of any medical emergency that occurred within the service and the care implemented.
29. Protocols are in place to ensure effective and efficient emergency medical access for ambulance or crash teams to service users within the service.



