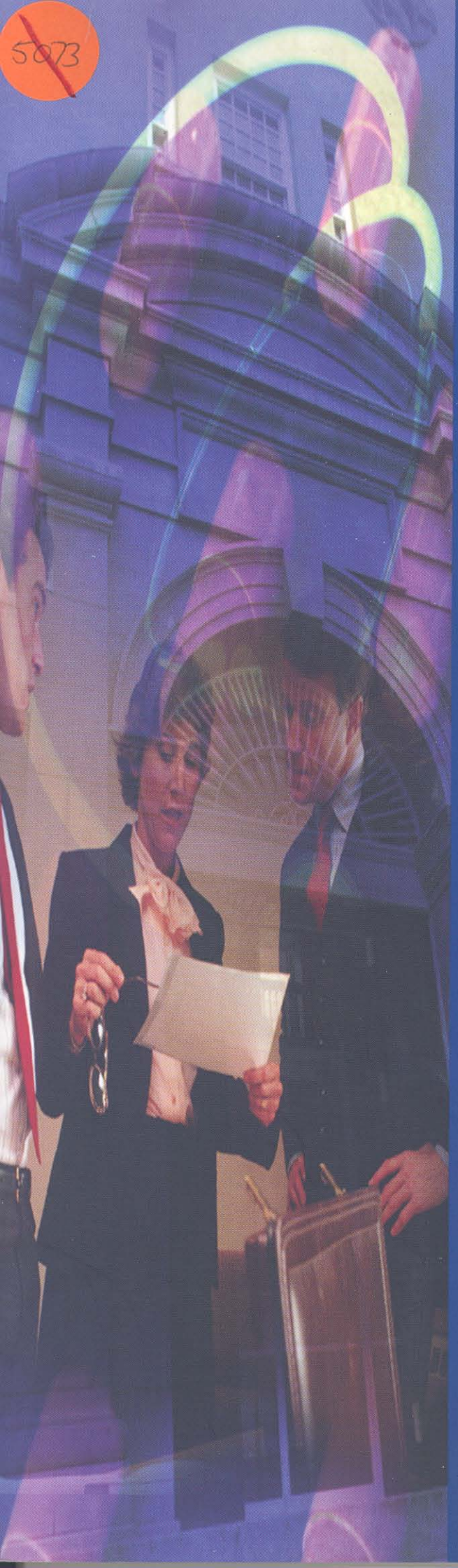

Guidelines on Good Practice and Quality Assurance in

Mental Health Services

DEPARTMENT OF HEALTH AND CHILDREN
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Guidelines on Good Practice and Quality Assurance in Mental Health Services

Contents

1. Introduction

1.1 The Department of Health policy document — **Shaping a Healthier Future,** set out the Government's strategy for effective health care in the 1990s and stressed the Government's commitment to "ensuring that our health services should help first and foremost those people whose need is greatest" as a primary societal value in relation to health care delivery. Included in this group are those suffering from mental illness, particularly severe mental illness, many of whom will spend substantial periods in psychiatric care. Pivotal to this commitment is "the pursuit of quality at all levels of the service". The Strategy document stresses there are three underpinning considerations which are fundamental to the satisfactory delivery of health care, including mental health care. These are equity, quality of service and accountability. The Inspectorate of Mental Hospitals has monitored and reported on the quality of care in mental health services on an annual basis. This, while not of itself sufficient or all embracing, has nevertheless shown the way to quality assessment and assurance in mental health services.

1.2 In pursuance of excellence in care delivery and to assist Health Boards and individual service providers in attaining this objective, the Inspectorate deems it prudent to formulate guidelines on good clinical practice and quality assurance in mental health services. Over recent years the Inspectorate has formulated, refined and revised a checklist embracing the main issues relating to the establishment of satisfactory clinical and administrative practice in mental health services. Initially this checklist was used on individual service visits and its framework formed the basis for questions asked of senior clinicians and administrators about individual services. Parts of this exercise were seen by the Inspectorate as an educational endeavour towards increasing awareness of the main quality issues in service delivery and their monitoring, refinement and improvement. The Inspectorate now feels that it is appropriate to formalise this checklist in the form of a guide towards good practice and quality assurance and intends circulating it to all mental health service providers in the country. It is not envisaged that the document will be perceived to be exhaustive or that it is immutable. Rather it is preferred that it will form the basis for reflection and thought, in addition to audit and self examination, by all of us who are privileged with the responsibility of providing for those affected by mental illness. It is hoped that comment, criticism and discussion will follow so that the document itself will improve in quality as a result of the comments of experienced clinicians and administrators. These guidelines must therefore be seen as a tentative and first attempt towards indicating how the principles of equity, quality of service and accountability can be reflected in daily clinical practice and administration in mental health services.

1.3 These guidelines specifically exclude consideration of the medical treatment of patients. This matter must remain the exclusive domain of individual clinicians.

2. Ethical Considerations and Guiding Principles

It maybe useful to think of the main elements involved in the delivery of mental health care as the Consumer, the Product/Process and the Setting.

The Consumer: The consumers are patients, patients' relatives and the community.

The Product/Process: The product is mental health and the process is its delivery in its preventive and treatment aspects.

The Setting: The setting is wherever services to patients are provided in psychiatric settings, such as in-patient units, day hospitals, community-based residences run by psychiatric services etc.

2.1 The Consumer

The consumer is, in the first instance, the patient. The relatives are carers who very often provide more quantitative input to patient care than professionals and who, in that sense, are part of the mental health team. The wider community, which the mental health services also serves, is an integral part of patient and service support and the degree to which it, too, participates and facilitates professional effort is based on its perception of mental illness and its responsibilities towards those of its members who are mentally ill.

2.2 The Product

The product is the highest level of mental health care possible, delivered in a manner which is transparent and informed by clinical practice, audit and research to the highest possible level of communication between professionals, patient, family and community, having regard to the rights of all participants in this interaction.

2.3 The Setting

The setting is the community, hospital or in-patient base and the full range of community based services which must be near and accessible to the patient and provided in the least restrictive manner possible, for appropriate care and treatment.

3. The Consumer — Information and Transparency

3.1 Introduction and Identification

The patient should be introduced to the professional team responsible for his/her care. Accordingly, the patient's consultant should introduce himself/herself and any other members of the team as appropriate to the patient so that he or she is in no doubt as to who is responsible for his or her care and management. If the receiving professional is a junior doctor then that doctor should indicate to the patient who his or her consultant is. All patients have the right to meet with their treating consultant. Similarly nurses, social workers and other professionals should identify themselves to the patient as soon as any professional or clinical interaction takes place between them. To facilitate this all staff members should wear identifying name badges which indicate their role within the professional team. Staff members should be available, for patients and relatives within reasonable time of request.

3.2 The Treatment Plan

Patients should be informed of diagnosis on request and provided with suitable documentary literature on their condition, as deemed appropriate. Treatment plans should be discussed with patients, the nature of treatment fully outlined and the treatment plan, including any medication, clearly recorded in the case notes. Patients should be given reasonable time to consider the acceptance of the treatment plan outlined for them including any medication, possible side effects etc. and time for discussion with relatives before acceptance. Professional clinical staff must be available for further discussion of the treatment plan, if requested. Patients should be made aware of any voluntary or self-help group relevant to their illness and put in contact with it on request.

3.3 Protection of the Consumer — Complaints

There must be an adequate complaints or dissatisfaction procedure available to patients at all levels of care. Patients must be aware of its existence and informed of how to use it. Patients should be encouraged to make a verbal or written complaint to the complaints body of the local service when they feel aggrieved or dissatisfied. Notices to this effect should be prominently displayed at every treatment location with the name of the complaints officer. A handbook containing this information as well as information on patients' rights to learn about treatment plans and medications as well as other matters relating to the service should be available to patients and relatives for information and reference. Information must be available for patients and relatives on how to make a verbal or written complaint or make suggestions for improvement in service provision. There should be written procedures for dealing with complaints from patients and relatives available in each local service. The local

written policy and procedure on complaints should indicate the level of authority expected to deal with complaints. There should be a specific book for the recording of complaints which the complaints officer should maintain. There should be written guidelines on the handling of complaints alleging abuse/ill-treatment/neglect of patients in the mental health services and these should be known to all staff members and available on request to patients and families. In addition, notices communicating this information should be prominently displayed in in-patient centres.

3.4 Protection of the Consumer — Mental Health Legislation

Patients should be informed of their right of appeal, under present legislation, to the President of the High Court, the Minister for Health and Children or the Inspector of Mental Hospitals. All staff members should be aware of patients' rights in this regard and communicate them to patients as appropriate. Notices conveying this information should be displayed prominently in every in-patient location.

While mental health legislation must always recognise patients as unique individuals whose civil rights must be upheld to the fullest degree compatible with their right to obtain treatment for mental illness, legislation does not necessarily, and possibly cannot, ensure or guarantee the setting and maintaining of high standards of practice and administration. Nor can legislation ensure that the principles of mental health care delivery are upheld. These encompass the right to care and treatment, in the least restrictive setting, easy accessibility of care, provision of care as near to domicile as possible, the right to information concerning care and treatment, the right to refusal of treatment and the necessity of informed consent and the right to choice of consultant psychiatrist within a catchment area. Patients have a right of access to spiritual care as appropriate.

3.5 Research

Research undertaken in psychiatric settings will, of course, be governed by the Clinical Trials Acts 1987 to 1990 so that fully informed consent is unequivocally available and obtained from each patient participating in a clinical trial. A representative and properly constituted ethics committee should sanction and monitor all clinical trials.

3.6 The Product/Process/Partners in Care

The patient and his family are partners with the clinician in care delivery. Care managed in this way implies a diagnosis and a step-by-step treatment and care plan of which the patient is fully cognisant and to which he or she acquiesces. This involves initiatives in medical, nursing, social, pharmacological and psychological dimensions. Treatment plans should be decided at multi-disciplinary team meetings, whether in in-patient or community-based settings. These meetings should be informed by a full case presentation involving psychiatric, nursing, psychological and social work inputs leading to a diagnosis and a definitive action care plan. Such planning should be adequately recorded in medical case notes. An individual nursing care plan for each patient should also evolve on an agreed model of nursing care with specific goals,

target dates and review dates. The nursing assessment should be incorporated into nursing care plans concerning such areas as disturbed behaviour and, where appropriate, physical nursing care i.e. risk assessment in the areas of pressure sores and infection control. All care plans, medical, paramedical and nursing, should be clearly documented in the appropriate section of the case file. All entries should be signed in full with dates, times and designation of the person making the entry.

Subject to the patient's agreement, family members may discuss patient care with the consultant and other members of the professional team. Similarly and where the patient agrees, family members and carers should have right of access to information and advice regarding the patient's illness, as deemed appropriate by the patient's consultant psychiatrist. This will include the treatment care plan devised for the patient, possible prognosis and advice as to what to do in general management terms. In particular, advice on the action to be taken should there be deterioration or recurrence of symptoms should be readily available. Carers should have a right to all possible information concerning the patient's illness and its treatment and should be put in touch with voluntary and self-help groups when that is deemed appropriate. Relatives, too, have the right to complain and to derive satisfaction from a transparent and intelligible complaints procedure within the local service. Similarly, they have the right of external appeal, under current mental health legislation, to the persons referred to earlier i.e. the President of the High Court, the Minister for Health and Children and the Inspector of Mental Hospitals.

3.7 The Right to Privacy

At all times, interviews between patients and relatives and mental health staff should be effected in settings of privacy.

4. The Process

4.1 Admission to In-patient Care

There should be an agreed and fully documented admission policy and procedure in each service. In all ordinary circumstances and because of the implication of resource utilisation and patients' expectation of their illness management, admission decisions should preferably be made by consultant psychiatrists. In particular, decisions to admit patients involuntarily should be the exclusive right of consultant psychiatrists and they alone should complete temporary patient reception orders. The admission procedure itself, from both the medical and nursing point of view, should be effected in physical surroundings that are reassuring, comfortable and private. All necessary information as outlined earlier should be transmitted to the patient at this time. As far as possible, and in keeping with the principle of the least restrictive alternative, any patient who, notwithstanding an application for reception on a temporary patient reception order, indicates his/her willingness to remain in hospital or gives no indication of wanting to leave, should be asked to enter hospital as a voluntary patient.

4.2 Clinical Review

During care in hospital, some special considerations apply which need stressing. All patients who have been admitted involuntarily should have their clinical condition reviewed on a daily basis, and as soon as it is deemed appropriate, this status should be changed to voluntary. In all cases newly admitted patients should be clinically reviewed on a daily basis and the results of such review, clinical and otherwise, be documented in the case notes. All entries by professional staff on clinical documentation should be dated with time of entry and signed legibly and in full. The designation of the professional staff member should also be recorded. Initials, of themselves, are not acceptable and specimens of signatures opposite the printed name should be maintained on a register of clinical staff. There should also be a written policy on the care of patients' case notes and other personal patient documentation stating who is responsible for their maintenance, who has access to them and specifying the regulations governing the transfer of clinical records or their contents to other agencies. Case records should contain clearly and, for each admission, name, address, date of birth, gender, religion, telephone number, next of kin, admission date and time, legal status, marital status, occupation, allergies, drugs taken prior to admission, name of referring general practitioner and other referral agent, discharge date and final diagnosis on discharge. Case notes should be kept in a satisfactory condition with correspondence and investigation reports correctly filed in chronological order and copies of previous discharge summaries readily available. Social work, psychology and occupational therapy and other professional progress notes should be completed by such staff and be easily accessible in patients' care records.

The case record in regard to each patient should contain information on the history of the illness for which the patient is being treated, the personal history of the patient, the family history of the patient, the diagnosis of the patient's illness, classification of the patient, particulars of medical examination on reception, particulars of any material change in the mental condition of the patient, particulars of any occurence in relation to the patient including accidents, date of discharge, assessment prior to discharge. In the case of death, particulars of cause of death should be recorded.

4.3 Medical Preparations

There should be a written policy for ordering, prescribing, storing and administering of medicines which is signed, dated and available in each clinical area. This policy and procedures documentation should contain information on staff responsibilities in relation to ordering drugs from the pharmacy, supervising their storage, taking drug stocks, administering drugs to patients, including the recording of such administration, mode of administration and the drugs given to patients on discharge. There should be written criteria for the use of prescriptions and one signature and one date for each prescription. The discontinuation column of the prescription card should have one signature and date for each prescription. Written guidelines are required for the use of PRN medications, i.e. medication prescribed whenever necessary rather than at fixed times.

4.4 Electro-Convulsive Therapy (ECT)

This procedure should be administered to patients only with their fully informed written consent. There should be a written protocol for its administration including prescription and compliance with all the physical investigations and examinations preliminary to its administration. There should be an appropriate consent form for ECT with provision for the patient's signature, relative's signature, if appropriate, and a section indicating that the doctor explained fully the procedure to the patient or relatives, if appropriate. A named consultant should be responsible for the ECT programme and should oversee its administration.

Guidelines for its administration should be displayed prominently in the treatment room including pre-ECT and post-ECT nursing checklists. There should be a specific ECT treatment record form which contains patient information, i.e. name, date of birth, sex, name of treating doctor and whether the patient is an inpatient or outpatient. The diagnosis, current medication, allergies, outcome of physical/ anaesthetic assessment should be clearly stated on the treatment record form. Provision should also be made for the recording of the signature of the anaesthetist and psychiatrist indicating any complications, comments and clinical response.

The treatment facilities should be adequate and incorporate a waiting room and separate treatment and recovery rooms. It is essential that there be adequate monitoring and resuscitation equipment available in the unit. Staff should have (and not merely for purposes of ECT administration) regular cardio-pulmonary resuscitation and foreign body airway obstruction training which should be carried out at regular

intervals. It is particularly important that adequate clinical note-taking on the administration and clinical response to ECT be documented in patients' case notes.

4.5 Primary Nursing in the Hospital Setting

Each patient should be allocated a nurse who is directly responsible for his/her care at ward level and on a day-to-day basis. This nurse may also have direct responsibility for another small number of patients as determined by the nurse in charge. He/she will be responsible for nursing care plans, documentation and for presentation of clinical aspects of the patient's condition at multi-disciplinary review meetings.

4.6 Seclusion and Restraint

Seclusion and mechanical restraint have now largely been eliminated from the repertoire of mental health care. However, there are still a very small number of instances when these measures are resorted to but this should only happen as a last resort. Where seclusion occurs, there should be a clear written seclusion policy incorporating the procedures to be followed when it is utilised, including the definition of seclusion and with extracts from the Mental Treatment Act, 1945 and amending legislation. Staff should be fully informed of the need for a separate nursing seclusion care plan for the patient including information on events prior to the episode, the actual behaviour, the interventions used prior to seclusion, patient's response to seclusion and the reason for seclusion. Seclusion should only be prescribed in writing by a consultant psychiatrist and should be reviewed on a six hourly basis. The same conditions apply to mechanical restraint although this is virtually never used now.

In every case where seclusion or bodily restraint is applied, particulars describing the means of seclusion or restraint, and the grounds therefor, shall be entered in the register as prescribed in Article 24 of the Mental Treatment Regulations (S.I. No. 261 of 1961) and signed in full by the medical officer who ordered such seclusion or restraint. Section 6(1) of the Mental Treatment Regulations (S.I. No. 261 of 1961) requires a nurse to visit the patient in seclusion at least every 15 minutes. All visits and observations that are made should be fully documented by the nurse.

4.7 Persons Detained Under Reception Orders

Absence on Trial

Section 203 of the Mental Treatment Act, 1945 as amended by Section 22 of the Mental Treatment Act 1961 permits a person detained in an institution to be absent from such institution on trial for a period not exceeding 30 days which may be extended for a further two periods of thirty days to a total of 90 days.

The decision to grant a patient absence on trial or to extend the period should rest with the patient's consultant psychiatrist and, as it can be an important part of a patient's treatment plan, the patient must be fully involved in the decision. Absence on trial, should be well planned and involve consultation with relatives and staff in

community settings. The patient must be asked to consent to any consultation with relatives or other professional staff thought necessary before the decision to grant absence on trial is made. Decisions relating to absence on trial should be recorded in the patient's case file outlining the date absence on trial commenced and the conditions attached. A separate record should be kept of the relevant dates and attached to the reception order. Written policy guidelines relating to absence on trial should be available in each service. The guidelines should give information on the procedures for informing relatives of a patient's absence on trial if appropriate and for informing professionals in the community responsible for patient follow up and for the recording of decisions in the administrative and medical file.

Absence on Parole/Pass

Section 204 of the Mental Treatment Act, 1945 as amended by Section 22 of the Mental Treatment Act 1961 permits a person detained to be absent on parole/pass for any period not exceeding forty eight hours. Each service should have clearly written absence on parole guidelines to ensure that there can be no confusion about a patients parole/pass status. All decisions to grant parole/pass should be made by a consultant psychiatrist or a doctor of the service in consultation with a consultant psychiatrist. Decisions to grant parole/pass should be recorded in the patient's case file and nursing notes with the precise return time, the signature of the authorising doctor and the conditions attaching to each parole/pass.

4.8 Discharge

It is essential that well planned discharge policies and procedures are in place. Most patients are able to return home with little or no support, while others will require a package of care to support them and some patients with complex care needs may require continuing care from the Community Mental Health Service which may include supported housing accommodation. A clear discharge plan designed for the safe discharge of the patient should be in place. This will include documentation and a pre-discharge checklist to ensure all appropriate information is given and all appropriate services are arranged prior to the patient's actual discharge.

Immediately following discharge, a discharge summary should be sent to the general practitioner and to members of the psychiatric services providing aftercare, setting out the principal details of the patient's management and treatment while in hospital, including medication on discharge and whether and for how long it is to be continued. The patient too should be supplied with a standard information form giving information on the drugs prescribed, the name of his or her general practitioner and the telephone number of the mental health centre or service where staff can be contacted and a domiciliary visit or other intervention be carried out in case of an emergency. The type of aftercare planned for the patient should be discussed with the patient taking into account the patient's diagnosis, needs, physical and emotional and personal preferences. Arrangements must be made for the first review of the patient post discharge. An aftercare plan for the patient should be recorded in detail in the patient's case file and available to each member of the professional team

responsible for the patient. The discharge plan should be drawn up by the patient's treating consultant psychiatrist and should fully consider and provide for the immediate and long term needs of the patient and include an assessment of the risk of the patient harming himself or others. Aftercare should be properly co-ordinated and supervised under the general direction of the patient's treating consultant psychiatrist. A mechanism should be in place to review patients who have been lost to follow up and everything possible done to find out what has happened to the patient and to take appropriate action.

5. The Setting

5.1 Hospital and Unit

Residential settings should be adequate for their purpose i.e. acute in-patient unit, hostel or group home. All premises should be clean and neat, well maintained and, where appropriate, such as in an in-patient unit, provide a variety of daytime activities. Such accommodation should include private bathing facilities, single gender toilet facilities, access to smoking and non-smoking areas and to private outdoor space. All units should be comfortable and maintained in good decorative order, appropriately furnished and with adequate provision of single rooms and with appropriate levels of safety and security for patients and staff. Patients and residents should have easy access to a private telephone, public transport, churches and shopping facilities. Units should be provided with a calendar, clock and wall unit thermometer which is checked regularly to ensure accurate working and adequate temperature control. Grounds and buildings should be maintained in good condition with adequate signposting, both internal and external in the case of in-patient hospital units. All premises should have adequate facilities for the physically disabled, for leisure activities and for visitors.

5.2 Catering

The quality of food for patients should be satisfactory and patients should have a reasonable choice. There should be a written printed menu with a weekly cycle available in all hospital units and reviewed at periodic intervals. The physical environment of dining areas and the quality of tableware should be satisfactory. There should be appropriate training for catering staff. Meals should be provided at socially acceptable times.

5.3 Maintenance

There should be ready access to maintenance services by the unit or hostel manager and these services should be supplied promptly and adequately. All furniture, floor coverings and diningware accoutrements should be of good quality, design and decoration and adequately maintained. All lavatory and bathing facilities should be kept clean with the provision of soap, towels and other toilet requisites on a personalised basis, individual to each patient. Grounds and gardens should be maintained to a proper standard. Sufficient staff should be available to ensure that this is the case.

5.4 Privacy and Dignity

Every effort should be made to maintain and improve the privacy and dignity of patients in residential settings. Therefore, patients should have adequate storage space for clothing and belongings. All clothing should be personal to the patient and identifiable to him or her and to others as his or her own. There should be adequate

equipment to wash and dry personal clothing. In both in-patient units and community-based residential facilities, sleeping accommodation should be adequate in floor area, uncluttered and uncrowded. In in-patient units where communal sleeping areas exist, there should be curtains and rails to ensure the possibility of isolation, retreat and privacy for both patients themselves and visiting relatives.

In-patient units should have reasonably generous visiting times and these times should be permanently displayed. Exceptionally, relatives should have visiting rights outside these hours where circumstances prevent them from visiting during designated times.

Unless it is part of the treatment plan as determined by the consultant psychiatrist or because of physical needs, patients should never be deprived of appropriate daytime clothing with the intention of restricting their freedom of movement.

5.5 Safety Procedures

There should be a written safety statement for all hospital and local units adhering to the standards and procedures set by the Safety and Welfare at Work Act, 1989. There should be a Safety Committee with an identifiable Safety Officer and written records of safety committee meetings as held. There should be safety statements available in each local area and hazard control sheets should be available indicating periodic safety audits of all areas.

5.6 Fire Precautions

There should be a Fire Committee which meets regularly and keeps appropriate recordings of such meetings. Any incident concerning a fire outbreak should be recorded together with the action taken by staff in the particular circumstances. There should be training courses for staff in fire precaution techniques and evacuation procedures in all residential settings. There should be regular checking and inspections of equipment, safety exits and escapes. All fire exits should be clearly marked and fire orders should be prominently displayed in all areas and there should be an evacuation plan in all locations which is known and understood by all staff. An automatic fire detection system should be installed in each location. In all residential premises there should be a telephone and residents should be aware of telephone numbers to contact in case of emergency, i.e. relevant nursing or administrative staff, ambulance, fire brigade etc.

5.7 Out-patient Facilities

Out-patient clinics, day hospitals and day centres should be suitably located for easy access, be of adequate structural and spatial quality and with secretarial and reception staff and with an appropriate appointment system which is known to referral agents and which ensures that, as far as possible, patients have a minimal wait for attendance. This appointment system should ensure adequate time for consultation with professional staff. Mental health centres should form the operational base of

mental health teams and a variety of services should flow from them to patients' homes and other community locations. They should allow close co-ordination and integration with primary health care teams to enable information transfer, referral, consultation and, where necessary, case conferences to take place. Such facilities should include secretarial assistance to ensure that letters following consultation issue to referral agents in the minimum time possible. Adequate documentation in terms of case records, treatment plans etc. should be maintained and safely stored in such locations.

5.8 Community Residences

Accommodation in community residences should be of good quality, comfortable and well designed and furnishings and decor should meet the needs of residents. Residents should be involved in choosing or planning changes to furniture and decor in the house as appropriate. There should be a system which monitors the implementation of operational policies and procedures. Catering should be efficient, meals varied, well presented and flexibly provided. Residents should be encouraged to help with purchase and preparation of food, cooking and clearing up. The accommodation should not be easily recognisable as an institution and there should be reasonable access to public transport and community facilities (workplace, shops, church etc.) Houses should be satisfactorily decorated and maintained internally and externally and with adequate security provided to protect property and residents. All residences should contain telephones and residents should know who to contact in an emergency and contact telephone numbers should be available. All residences should be protected by an automatic fire detection system. Fire exits should be clearly marked and written fire orders displayed. A written record should be kept of all fire drills and evacuation exercises. Residences should be visited and inspected periodically by a fire prevention officer, health and safety officer, fire equipment service personnel and senior nursing personnel. Current scale of weekly charges to residents should be specified. Arrangements for residents unable to look after their day to day finances should be satisfactory and subject to regular checking. Management and housekeeping accounts should be satisfactory and subject to regular checks and audit. As far as possible, residents should be encouraged to take charge of their own financial affairs and matters relating to the running of their residence themselves, i.e. open bank account, pay service charges (water, electricity etc.).

6. Personal Safety for Staff

6.1 Training

All staff should be trained in the techniques of management of violence and aggression through participation in a recognised training course. Training courses should be organised on an on-going basis so that all staff have the opportunity to attend refresher courses periodically. All staff should be trained in the manual handling of loads and safe lifting techniques.

6.2 Personal Safety Equipment

All staff should be aware of their responsibility in relation to personal safety and the safety of patients and colleagues and their responsibility in the reporting of identified hazards. If considered appropriate, staff should carry personal safety alarms which will enable a speedy response to be available to them in emergencies. In addition, locations, such as interviewing rooms or offices where staff may work in isolation, should have panic alarm systems installed.

7. General Administrative Arrangements

There should be a document of good quality and design setting out the philosophy and principles of service delivery. There should be a local mental health programme (in each sector, for example) designed to meet the objectives and targets of the service as a whole. There should be a clear understanding between policy makers and service deliverers on the budgets available so that clinicans and others have responsibility to maximise resources to ensure effectiveness and efficiency. Units/ward/day care/day hospital/community residential facilities should have operational policies, setting out how that particular unit of the service operates. This policy should be available in written form so that it can be read and understood by all staff members and, if necessary, by patients and relatives. There should be an annual review of quality, efficiency and effectiveness of the service as a whole and of each of its constituent parts. This should identify strengths and weaknesses in policies and programmes with a view to improvement and revision. Each service should provide an annual report and copies should be available to all staff members and others. There should be good working relationships and communication between health board members, senior executives and service providers.

8. Checklist — Guidelines on Good Practice and Quality Assurance

This checklist is a quick reference to what is contained in the guidelines. The checklist is arranged in sections which, it is hoped, are logical and encompass the main dimensions and components of mental health care. It is designed to stimulate thoughtful reflection to enable service providers examine their service and practice with a view to improving them.

3. CONSUMER INFORMATION AND TRANSPARENCY

3.1 Introduction and Identification

- The patient should be introduced to the professional team responsible for his/her care.
- The patient should know the treating consultant and have reasonable access to the consultant and members of the multi-disciplinary team.
- Patients should have a right to meet with their treating consultant.
- Staff members should wear identity badges, indicating designation within multidisciplinary team.
- On request, all staff should be available for patients and relatives within a reasonable time.
- Staff should identify themselves to the patient as soon as any professional or clinical interaction takes place.

3.2 The Treatment Plan

- Patients should be informed of diagnosis and provided with suitable information and literature on their condition in all appropriate circumstances.
- Treatment plans should be discussed with patients.
- Treatment plans, including medication, should be clearly recorded in patients' case notes.
- The nature of treatment and medication should be explained to patients in language they understand.
- Written information should be available to patients on prescribed medication relating to its effect and side effects.
- Patients should be given reasonable time to consider treatment plans and medication, and have the opportunity to discuss treatment plans with relatives if required.
- Patients should be made aware of voluntary self help groups relevant to their illness and how to access them.

3.3 Consumer/Complaints

- A written procedure for dealing with complaints from patients and families should be available. Patients should be made aware of its existence and how to use it.
- Patients should be encouraged to make a complaint (verbal or written) to the local service if they feel aggrieved or dissatisfied.
- Notices to this effect should be prominently displayed at every treatment location with the name of the local complaints officer.
- A handbook containing information on complaints procedure and patients' rights to learn about his/her treatment plan and medication should be available for patients' and relatives' information and reference.
- Written procedures for dealing with complaints from patients and relatives should be available in each local service.
- This written procedure on complaints should indicate the level of authority expected to deal with complaints.
- There should be a specific register for the recording of complaints with a designated complaints officer maintaining this record.
- There should be a consistent approach to recording and investigation of complaints.
- There should be written guidelines on complaints alleging abuse and ill treatment of patients.
- These guidelines should be known to staff members and available on request to patients and families.

3.4 Protection of the Consumer — Mental Health Legislation

- There should be written information for patients and relatives on their rights under the Mental Treatment Act, 1945 and amending legislation.
- Patients should be cared for in the least restrictive environment possible.
- Patients should be informed of their right of appeal when they are not satisfied with the local complaints procedure.
- Patients should be able to access care and treatment as near as possible to their homes.
- There should be full information on care and treatment available to the patient and, if appropriate, his/her relatives, if the patient agrees.
- Patients should have informed consent and be aware of their rights in relation to refusal of treatment.
- Patients should have access to specialised treatments and spiritual care as appropriate.

- Patients should have a right to change their treating psychiatrist within the catchment area team.

3.5 Research

- All patient participation in clinical trials should be in accordance with clinical trials legislation.
- There should be a representative and properly constituted ethics committee which approves all clinical trials.
- Formal written informed consent of the patient should be unequivocally obtained before the participation of the patient in any clinical trial.

3.6 The Product/Process/Partners in Care

- There should be a diagnosis and step-by-step treatment and care plan for each patient.
- Treatment plans for patients should be decided at multi-disciplinary meetings, whether in in-patient or community-based settings.
- Multi-disciplinary team meetings should be informed by a full case presentation involving psychiatric, nursing, psychological and social inputs leading to a diagnosis and definitive action care plan.
- All care planning should be adequately recorded in medical case notes.
- Nurse care planning should evolve on an agreed model of nursing care with specific goals, target dates and review dates.
- The nurse care planning system should commence with a nursing assessment covering all aspects of patient care — physical, psychological and social.
- Care plans should incorporate specific problems such as disturbed behaviour and where appropriate, physical nursing care.
- Risk assessment in areas of pressure sores and infection control should be included in the care plan as appropriate.
- Medical, paramedical and nursing care plans should be clearly documented in the appropriate section of the case file and entries signed in full with date and time.
- Family members should have the opportunity to discuss a patient's care and treatment with the consultant and members of the multidisciplinary team subject to the patient's agreement.
- Family members should have access to advice and information on all aspects of the patient's illness and treatment prognosis and caring arrangements if the patient agrees.
- Subject to the patient's agreement, carers should have a right to all possible information concerning the patient's illness and its treatment and should be put in touch with voluntary and self-help groups when that is deemed appropriate.

- Relatives should be made aware of their right to complain and their rights of external appeal under current mental health legislation.

3.7 The Right to Privacy

- Interviews between patients and relatives and mental health staff should be effected in settings which provide privacy.

4. THE PROCESS

4.1 Admission to In-patient Care

- A fully documented admission policy and procedure document should be available in each service.
- Admission decisions should generally be made by consultant psychiatrists.
- Decisions to admit patients involuntarily should be the exclusive right of consultant psychiatrists and they alone should complete temporary patient reception orders.
- The physical surroundings in the admission/reception area for patients should be reassuring, comfortable and private.
- Patients indicating a willingness to remain in hospital and giving no indication of wanting to leave should be asked to enter hospital as a voluntary patient.
- All necessary information relating to a patient's stay in hospital, their rights under the Mental Treatment Act, 1945 and amending legislation, should be transmitted to the patient and, to their relatives where appropriate at the time of admission.

4.2 Clinical Review

- Involuntary patients should have their status changed to voluntary as soon as it is deemed appropriate.
- All newly admitted patients should be clinically reviewed on a daily basis and the results of such review documented clearly in the case notes.
- All entries by professional staff in clinical documentation should be signed legibly and in full with the designation of the professional staff member stated.
- There should be a written policy on the care of patients' case notes.
- Administrative and biographical details (name, address, date of birth etc.) should be completed in full for each admission.
- A section of this form should contain information relating to discharge date, final diagnosis on discharge and this should be completed in full.

  Individual patients' case records should contain information on the following:—

  - History of the illness for which the patient is being treated, personal history of the patient, patient's family history.
  - Diagnosis, legal status of the patient.
  - Particulars of medical examination on reception and all reviews, changes in the

mental condition of the patient, any unusual occurrences, absence on leave/parole/pass.

- Date of discharge, assessment prior to discharge and in the case of death, the cause of death.

- Correspondence and investigation reports should be correctly filed in chronological order and copies of previous discharge summaries should be readily available in case notes.

- All professional progress notes (e.g. social worker, psychologist, occupational therapist) should be completed by such staff and readily accessible in patients' care records.

4.3 Medical Preparations

- There should be a written policy for the ordering, prescribing, storing and administering of medicines.

- The medical preparations policy should be signed, dated with an appropriate review date and available in each clinical area for information and reference.

- The medical preparations policy and procedure should contain information on staff responsibility relating to ordering drugs, storage and checking drug stocks, administering drugs, mode of administration and information on drugs given to patients on discharge.

- There should be written instructions for the use of prescription cards with one signature and one date for each prescription.

- The discontinuation column of the prescription card should have one signature and one date for each prescription.

- The drug administration recording card should have provision for a nurse's signature in full.

- There should be written guidelines for the use of PRN medications, i.e. medication prescribed to be given whenever necessary rather than at fixed times.

4.4 Electro Convulsive Therapy (ECT)

- This procedure should only be administered to patients with their fully informed written consent.

- There should be a written protocol for the administration of ECT.

- Guidelines for the administration of ECT should be displayed prominently in the treatment room including a pre and post ECT nursing checklist.

- A named consultant psychiatrist should be responsible for the ECT programme and oversee its administration.

- There should be a specific ECT treatment record form incorporating the consent form.

- The treatment facilities for ECT should incorporate waiting, treatment and recovery rooms.
- Adequate monitoring and resuscitation equipment should be available in each treatment unit.
- The administration and clinical response to ECT should be documented clearly in patients' case notes.
- All staff working in the service should have regular cardio pulmonary resuscitation and foreign body airway obstruction training.

4.5 Primary Nursing in the Hospital Setting

- Each patient should be allocated a nurse directly responsible for the patient's care at ward level on a day to day basis.
- The nurse in charge should determine the number of patients each primary nurse should have direct responsibility for.
- The assigned primary nurse should have responsibility for nursing care plan documentation and for the presentation of clinical aspects of the patient's condition at multi-disciplinary review meetings.

4.6 Seclusion and Restraint

- Where seclusion occurs there should be a clear written seclusion policy including the definition of seclusion with relevant extracts from the Mental Treatment Act, 1945 and amending legislation.
- A separate nursing seclusion care plan for the patient should be introduced once a patient is placed in seclusion.
- Seclusion should only be prescribed in writing by a consultant psychiatrist and should be reviewed on a six hourly basis.
- In the rare instances mechanical restraint is used, the same procedures should apply.
- A seclusion register should be maintained and the fifteen minute nursing observation should be fully documented.

4.7 Persons detained under Reception Orders

- The patient must be involved in the decision relating to absence on trial and must consent to any consultation with relatives relating thereto.
- Decisions relating to absence on parole/pass rest with the consultant psychiatrist and should be appropriately recorded in the patient's case file.

4.8 Discharge

- Before discharge, the service should ensure that patients' housing conditions are satisfactory and that the patient's family is aware of the patient's discharge.

- Following discharge, a discharge summary should be sent to the general practitioner or other components of the psychiatric service responsible for follow-up.
- The discharge summary should set out the principal details of the patient's management and treatment while in hospital including medication on discharge.
- The discharge summary should detail follow-up plans including the role of the general practitioner and give details of diagnosis, treatment and medication in hospital and the results of any tests or investigations carried out.
- Patients on discharge should be supplied with a standard form giving them information on drugs prescribed for them.
- The name of the patient's general practitioner should be supplied to the patient.
- The telephone number of the mental health centre where staff can be contacted and a domiciliary visit or other arrangements carried out in the case of emergencies should be supplied to the patient.

5. THE SETTING

5.1 Hospital and Unit

- Residential premises should be clean, neat, well maintained and where appropriate provide a variety of day time activities.
- In-patient units should provide:—
  - appropriate levels of safety and security for patients and staff;
  - private bathing facilities;
  - single gender toilet facilities;
  - access to smoking and non-smoking areas;
  - access to private outdoor space;
  - access to public telephone;
  - easy access to public transport, churches and shopping facilities;
  - adequate facilities for the physically disabled;
  - facilities for leisure activities and
  - adequate facilities for visitors.
- All units should be comfortable, maintained in good decorative order and appropriately furnished.
- Grounds adjoining the units and the buildings should be maintained in good condition.
- There should be adequate internal and external signposting.
- All residential in-patient units should be provided with a calendar, clock and wall thermometer.

5.2 **Catering**

- The quality of food for patients should be satisfactory and patients should have reasonable choice.
- There should be a written printed menu reviewed periodically and on display for patients' information.
- The physical environment of dining areas and the quality of tableware should be satisfactory.
- Meals should be provided at socially acceptable times.
- Catering and ancillary staff should be provided with appropriate training.

5.3 **Maintenance**

- There should be easy and ready access to maintenance services which should be supplied promptly and adequately.
- Grounds and gardens should be maintained to a proper standard and sufficient staff should be available to ensure that this is the case.
- All toilet and bathing facilities should be kept clean with the provision of soap, towels and other toilet requisites on a personalised basis, individual to each patient.

5.4 **Privacy and Dignity**

- All clothing should be personal to the patient and patients should have adequate storage space for clothing and belongings.
- There should be adequate equipment to wash and dry personal clothing.
- Sleeping accommodation should be adequate in floor area, uncluttered and uncrowded.
- Patients should have rails and curtains for each bed in the multi-bed areas of in-patient units to ensure privacy.
- Visiting times should be prominently displayed and these should be reasonably generous.
- Relatives should have visiting rights outside the normal visiting times where circumstances prevent them from visiting during designated times.
- Patients should never be deprived of appropriate day time clothing with the intention of restricting their freedom of movement unless it is part of a treatment plan determined by a consultant psychiatrist.

5.5 **Safety Procedures**

- The hospital and local units should have a written safety statement.
- There should be a safety committee with an identifiable safety officer.

- Written records of safety committee meetings should be kept.
- Hazard control sheets indicating periodic safety audits and follow-up should be kept in each local area.

5.6 Fire Precautions

- Each service should have a fire committee which meets periodically.
- Records of fire committee meetings should be kept.
- Incidents concerning a fire outbreak should be recorded together with action taken by staff in the particular circumstances.
- All staff should have ongoing training courses in fire precaution techniques and evacuation procedures.
- There should be regular checking and inspections of equipment, safety exits and fire escapes.
- Fire orders should be prominently displayed and fire exits clearly marked.
- Residential premises external to the hospital in-patient setting should be provided with a telephone and residents should be aware of telephone numbers to contact in case of emergency.

5.7 Out-patient Facilities and Mental Health Centres

- Out-patient clinics, day hospitals and day centres should be suitably located for easy access.
- An appointment system, known to referral agents ensuring patients have a minimal wait for attendance should be in operation in all community facilities.
- The appointment system should ensure adequate time for consultation with professional staff.
- Mental health centres should form the operational base of mental health teams.
- Mental health centres should allow close co-ordination and integration with primary health care teams.
- Such facilities should include secretarial assistance to ensure letters are issued within the minimum time possible following consultation.
- Adequate documentation in terms of case records and treatment plans should be maintained and safely stored.

5.8 Community Residences

- Community residences should be good quality, comfortable, well designed with furnishings and decor to meet the needs of residents.
- Residents should have involvement in choosing or planning changes to furniture and decor in their residence as appropriate.
- There should be a system which monitors the implementation of hostel operational policies and procedures.
- Catering should be efficient with meals varied, well presented and flexibly provided.
- Residents should be encouraged to help with the preparation of food, cooking and cleaning up.
- Patient residential accommodation should not be institutional in appearance.
- There should be reasonable access to public transport and community facilities.
- Residences should be satisfactorily decorated and maintained with adequate security provided to protect property and residences.
- Residences should contain telephones and residents should know who to contact in an emergency and contact telephone numbers should be readily available.
- All community residences should be protected by an automatic fire detection system.
- Fire exits should be clearly marked and written fire orders prominantly displayed.
- Written records should be kept of fire drills and evacuation exercises.
- Residences should be visited and inspected periodically by the fire prevention officer, health and safety officer, fire equipment service personnel and senior nursing personnel.
- Residents should be encouraged to take charge of their own financial affairs.
- Residents should play an active part in the furnishing and decoration of their homes.
- The weekly scale of charges to residents should be specified and these should be reviewed and revised periodically.
- Arrangements for residents unable to look after their day to day finances should be satisfactory and subject to regular checking.

6. PERSONAL SAFETY FOR STAFF

6.1 Training

- All staff should be trained in the techniques of management of violence and aggression through participation in a recognised training course.
- Training courses relating to management of violence and aggression should be organised on an ongoing basis so all staff have the opportunity to attend refresher courses periodically.

- All staff should be trained in the manual handling of loads and safe lifting techniques.
- If considered appropriate staff should carry personal safety alarms.

7. GENERAL ADMINISTRATIVE ARRANGEMENTS

7.1 Administrative Arrangements

- There should be a document outlining the philosophy and model of care delivery for the service as a whole, and the document should be available in each component of the service and available and understood by every staff member.
- There should be a written local mental health programme adapted to meet the objectives and targets that are enshrined and understood in the philosophy and model of care.
- There should be a written strategy identified and understood by which these targets and objectives may be met.
- There should be mechanisms in place to ensure that through the strategy the programme and its aims are working towards the final targets.
- Mechanisms, such as a service management group, sector groups and so on should be in place to ensure that the strategies, programmes etc. can be applied and realistic targets achieved.
- There should be a clear understanding between service deliverers and policy makers on the budget available so that targets which are feasible and possible, may be achieved.
- At the unit/ward level, day centre/day hospital level or mental health sector headquarters there should be an operational policy which records the agreed information about how that particular component of the organisation operates.
- This policy should be available in written form so that it can be read and understood by all staff members and if necessary by patients and visitors.
- There should be an annual review of the quality, efficiency, and effectiveness of all aspects of the mental health service.
- The review should identify strengths and weaknesses in policy programmes with a view to modifying and improving them.
- These programme goals should be written down and anchored to local objectives.
- A written report of the annual review should be kept.
- Service objectives should be discussed, understood and approved by health board members.
- There should be a good working relationship between health board members, senior executives and service providers.

9. Other Guidelines

In addition to issues dealt with in the text of this document and in the checklist Mental Health Services should review and provide guidelines and policy documentation in relation to the following:—

Absconding/Absent (AWOL)
Access to Health Records
Accessing Emergency Services (Fire Brigade, Gardaí, Ambulance)
Accidents and Incidents
Challenging behaviour (management of)
Code of Conduct (Health Board/Hospital Authority)
Code of Professional Conduct (An Bord Altranais — Nursing)
Communication with patients' relatives by telephone or in person
Confidentiality
Dealing with the media
Emergencies
Escorts of patients
First Aid Policy
Guidance on the use of computers in the patient care area (Data Protection Act 1988)
Guidance to Professional staff on dress and appearance
Handling/Lift Policy
Harassment and Bullying
Hepatitis B Vaccination
Human immunodeficiency virus and protocol post-potential HIV/Hepatitis exposure
Hygiene
Illegal drugs
Induction guidelines, policies and procedures for each member of the Medical Staff
Infection Control
Injection — (administering with resistance)
Injury to staff member due to violence or accident in the course of their work
Lodger status
Making a will
Medical preparations
Misuse of illicit substances and alcohol
Needlestick injury and other exposure incidents
Panic Alert Activation Policy
Patients dying in hospital (management of)
Patients failing to keep appointments at out-patient department
Patients money (policy for handling and care of)
Patients voting rights
Personal searches of patients and their belongings
Policy and procedure for the operation of bank accounts
Report writing (Guidelines)
Reporting of spiritual needs of patients

Response to parasuicide
Resuscitation
Search procedure for missing patients
Smoking and Health
Special Nursing Supervision & Nursing observation
Special reports
Staff appearing in court (guidance notes)
Sudden deaths
Suicide and self harm
Theft
Transfer of patients
Transfer of patients under Section 208, Mental Treatment Act, 1945 to the Central Mental Hospital
Untoward incidents and non-accidental injury involving patients
Use of gloves by clinical staff
Violence and guidelines for the management of patients who may exhibit violence
Visitors
Wards of Court

Conclusion

The Guidelines and policies should be systematically derived statements based on clinical/administrative practice and research which assist staff to make decisions about clinical and administrative matters relating to the appropriate care of patients and the needs of staff providing that care. They should provide a framework for a consistent approach and enable staff make decisions with guidance and support. Policies should be formally introduced to relevant staff, ensuring awareness and understanding of content. Guidelines will be amended and updated in the light of ongoing changes in mental health care delivery, innovations in clinical practice and new mental health legislation.

If current practices are affected by any new or revised policy, relevant training and education should be given if appropriate.

Management of the service should review and update guidelines/policies in accordance with service needs, current good practice and national and international trends. In order to reduce risk, each guideline/policy/protocol should have a multidisciplinary focus and a central file of current and superceded policies should be maintained.

Policies and guidelines should be available in each area for staff information and reference and should be updated regularly, dated, indexed and in separate folders. Additional policies pertinent to local needs should be included, if appropriate.