Mental Health Commission

Addendum to Judgement Support Framework – Codes of Practice

WORKING TOGETHER
FOR QUALITY MENTAL
HEALTH SERVICES

MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

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Disclaimer

"The following is a Guidance document for Approved Centres regarding the matters which the Office of the Inspector of Mental Health Services shall address during the course of its annual inspections and may address during the course of any other focused inspections. This document is provided to Approved Centres by way of assistance only. It is not intended to be a complete or authoritative statement on the legal requirements and obligations of Approved Centres. Each Approved Centre will need to be aware of and take responsibility of compliance with all of its legal requirements and obligations. The law in the area of mental health is continuously evolving and therefore, any statements in relation to the law as set out in this Guidance document are as of the date of publication."

PART 1: INTRODUCTION

Section 33(3)(e) of the Mental Health Act 2001 provides that the Mental Health Commission shall prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services.

Best practice requires that the Codes be followed to ensure that the appropriate care and treatment is provided in the mental health services.

The Mental Health Commission Codes of Practice provide good practice guidance in relation to the following:

1. Admission, Transfer and Discharge to and from an Approved Centre (2009)
2. Admission of Children under the Mental Health Act 2001 (2006), including Code of Practice Relating to Admission of Children under the Mental Health Act 2001 Addendum (2009)
3. Notification of Deaths and Incident Reporting (2008)
4. Guidance for Persons working in Mental Health Services with people with Intellectual Disabilities (2009)
5. Use of Electro-Convulsive Therapy for Voluntary Patients (2009)
6. Use of Physical Restraint in Approved Centres (2009)

This document is an addendum to the Judgement Support Framework (MHC-FRM-010 Rev 0) which was published on the 1st of July 2015. This document reviews each of the Codes referenced above and details their requirements in the same format as that of the Judgement Support Framework. Where requirements of the Codes are reflective of requirements detailed within the Judgement Support Framework, this document will cross reference the related sections. The scoring tables detailed for each Code of Practice are also reflective of the Judgement Support Framework scoring mechanisms to support their utilisation by the Mental Health Commission Inspectors.

As with the Judgement Support Framework, this document will focus specifically on the application of the specific requirements relevant to the Approved Centres, rather than the wider mental health services.

PART 2: CODE OF PRACTICE ON ADMISSION, TRANSFER AND DISCHARGE TO AND FROM AND APPROVED CENTRE

Title

Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre. Issued Pursuant to Section 33(3)(e) of the Mental Health Act, 2001 (September 2009).

Purpose

This Code applies to persons admitted, transferred or discharged to and from an Approved Centre, including both voluntary and involuntary residents. The Code is without prejudice to any legal requirements for the admission, transfer and discharge of involuntary patients under the 2001 Act.

The Code of Practice on Admission, Transfer and Discharge to and from and Approved Centre overlaps with a number of the legal and best practice requirements as reflected in the Judgement Support Framework. Where relevant, the corresponding Judgement Support Framework section is detailed in italics after the Code guidance. Relevant corresponding sections for this Code include:

- Regulation 7 – Clothing
- Regulation 8 – Residents' Personal Property and Possessions
- Regulation 15 – Individual Care Plan
- Regulation 18 – Transfer of Residents
- Regulation 20 – Provision of Information to Residents
- Regulation 23 – Ordering, Prescribing, Storing and Administration of Medicines
- Regulation 27 – Maintenance of Records
- Regulation 32 – Risk Management Procedures

The defined processes, training, monitoring and implementation requirements for the admission of children to Approved Centres are addressed within the Code of Practice on Admission of Children under the 2001 Act.

Guidance for Compliance:

1. ***Defined processes in place***:

1.1 Policies, procedures and protocols shall be available within the Approved Centre in relation to the admission, transfer and discharge of residents to and from an Approved Centre which shall detail the processes and requirements in relation to the following:

1.1.1 The processes for the admission, transfer and discharge of residents/patients.

1.1.2 The roles and responsibilities of all members of staff in relation to admission, transfer and discharge of residents/patients.

1.1.3 The process relating to the involuntary admission, transfer and discharge of residents/patients.

1.1.4 The staff training requirements for admission, transfer and discharge. This includes, but is not limited to, training in relation to individual care and treatment planning, Multidisciplinary Team working, risk assessment and risk management.

1.1.5 The process for the management of discharge against medical advice.

1.1.6 The process for how a resident transfer is arranged and effected in a safe and timely manner. It also includes processes and provisions for emergency transfers (e.g. transfer to psychiatric intensive care units), and where applicable provisions for transfers abroad. The safety of the resident and staff involved in the transfer process is a key consideration in this policy and procedure.

1.1.7 The process for how Approved Centres and Community Mental Health Services work collaboratively to develop local follow-up policies and procedures. Follow up policies and procedures available include:

• Relapse prevention strategies

and crisis management plans,
- The roles and responsibilities of the various health professionals in providing follow-up care,
- When and how much followup contact residents should have,
- A way of following up and managing missed appointments.

1.1.8 A protocol for dealing with urgent referrals, including referrals from emergency department and primary care. This protocol shall make reference to Registered Medical Practitioner/Primary Care Teams being requested to telephone in advance and follow up with a fax of written referral if possible.

1.1.9 A protocol for dealing with individuals who self-present or in the company of a relative, parent or guardian. This protocol shall address the assessment that takes place.

1.1.10 A communication protocol, developed between Approved Centres and both Registered Medical Practitioner/Primary Care and Community Mental Health Services, for timely communication and exchange of information from the time of referral to discharge. This protocol shall include:
- Reference to pre-admission assessments,
- Referral letters,
- Provision of appropriate information to the service user and discharge summaries,
- It shall also include reference to both verbal and written communication and to the mechanisms (i.e. form, mode, content) by which information can be best communicated.

1.1.11 The Approved Centre works with the relevant social, housing and homeless agencies to develop a protocol for information sharing and discharge planning for homeless persons with mental illness admitted to Approved Centres. The policy shall take into consideration the importance of continuity of care for each homeless person. The protocol shall make reference to joint working at the earliest possible opportunity following the admission of a homeless person and to the management of his/her discharge.

1.1.12 The Approved Centres that admit people with intellectual disability have a protocol for the admission and discharge of people with intellectual disability for mental health care and treatment. This protocol addresses the specific post discharge needs of this group, including the provision of residential accommodation, where necessary.

1.1.13 The Approved Centre shall work with alternative care settings, including nursing homes, to develop a protocol for the discharge of older persons.

1.2 Associated Policies and Procedures shall incorporate processes and requirements that relate to the admission, transfer and discharge of residents to and from an Approved Centre and include:

1.2.1 The policy and procedure on individual care and treatment place specifies who may be a key worker, his/her role and arrangements for when the key worker is absent.

1.2.2 The policy and procedure on medication, includes the handling of medication, both prescribed and non-prescribed, which is brought into the Approved Centre by the resident. It also makes reference to prescriptions and the supply of medication on discharge, as appropriate.

1.2.3 The policy and procedure on personal property and possessions in accordance with Article 8 of the Regulations shall take account of the best interests of the person and respect his or her right to dignity, bodily integrity, privacy and autonomy. It shall also include reference to risk assessment (as per Regulation 8 Residents' Personal Property and Possessions – Judgement Support Framework).

1.2.4 The policy and procedure on privacy, confidentiality and consent ensures personal information is handled with the highest level of professionalism, that the person's right to privacy is respected and the

duty of confidentiality upheld and information is not communicated to a third party without consent. Such a policy is consistent with the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 2014.

1.2.5 A policy and procedure is in place that addresses required access to records on a 24 hour basis.

1.2.6 The Approved Centre implements the risk management policies and procedures in accordance to Article 32 of the Regulation (as per Regulation 32 Risk Management Procedures – Judgement Support Framework).

2. ***Training:*** All health professionals working in an Approved Centre shall be aware, understand and, where required, trained in the admission, transfer and discharge policies and procedures of the Approved Centre and adhere to the processes outlined within them. There is documentary evidence that relevant staff have read and understood the policies and procedures.

3. ***Monitoring:*** The Approved Centre shall monitor the processes relating to the admission, transfer and discharge or residents to and from an Approved Centre. This shall include:

3.1 An audit of the admission, transfer and discharge policies and procedures to ensure that they are being fully and effectively implemented and adhere to in clinical practice. Article 29 of the Regulations, relating to operating policies and procedures, provides that the written policies and procedures of an Approved Centre must be reviewed at least every 3 years, with due regard to any recommendations made by the Inspector of Mental Health Services or the Mental Health Commission. The policies and procedures specify the roles and responsibilities of staff in this regard (as per Regulation 29 Operating Policies and Procedures – Judgement Support Framework).

3.2 Incident reports are recorded for non-compliances identified in relation to the policies and procedures, protocols and associated processes.

3.3 Analysis is completed to identify opportunities for improvement to the admission, transfer and discharge processes.

4. ***Evidence of Implementation***

GENERAL REQUIREMENTS

4.1 A copy of the admission, transfer and discharge policies shall be available in the Approved Centre (as per Section 1 Regulation 18 Transfer of Residents – Judgement Support Framework).

4.2 Personal information shall be handled with the highest level of professionalism.

4.2.1 A person's right to privacy shall be respected and the duty of confidentiality upheld.

4.2.2 Personal information shall not be communicated to a third party e.g. family, carer, advocate, health professional in another health care setting or outside agency, without the resident's consent, outside the course of that necessary to fulfil legal and professional requirements (as per Section 1.1 & 4.13 Regulation 18 Transfer of Residents – Judgement Support Framework)

4.3 Approved Centres shall comply with Article 32 of the Regulations in respect of risk management procedures (as per Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.4 Fax may be used to facilitate timely transfer of information. However, reasonable safeguards shall be employed to ensure the confidentiality of information. Fax machines shall be located in secure areas, the receiving facility shall be notified in advance of sending information, a cover sheet shall be sent with all faxes and information shall be checked by both the sending and receiving facility for clarity, legibility and completeness (as per Section 1.1 & 4.13 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.4 In general, email shall not be used for the transfer of confidential information.

3.5 The roles and responsibilities assigned for the admission, transfer and discharge processes shall be clearly documented. This includes the roles and responsibilities of the Multidisciplinary Team in relation to assessment following admission (as per Section 4.13 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.6 The Approved Centre shall comply with Article 27 of the Regulations in respect of maintenance of records (as per Regulation 27 Maintenance of Records – Judgement Support Framework).

ADMISSION

Unplanned Referral to an Approved Centre

3.7 Where a person presents as an urgent referral, he or she shall be assessed as soon as is practicable and a record of this assessment shall be maintained.

3.6.1 This assessment shall include a risk assessment.

3.6.2 Urgent referrals shall be dealt with in accordance with the service's protocol for urgent referrals.

3.7 Where a person presents as a self-referral, he or she shall be assessed as soon as is practicable and a record of this assessment shall be maintained.

3.7.1 This assessment shall include risk assessment.

3.7.2 Assessment shall be carried out in accordance with the service's protocol for self-referrals.

3.8 Every reasonable effort shall be made to make contact with the individual's Registered Medical Practitioners/ Primary Care Team or Community Mental Health team to obtain all relevant information.

Admission Criteria

3.9 Admission shall only occur when the individual's primary complaint is one of mental illness or mental disorder.

3.10 The best interests of the individual shall be the primary consideration when deciding whether or not to admit with due regard being given to the interests of others who may be at risk of serious harm if the person is not admitted.

3.11 If it is clinically determined that the individual is in need of immediate inpatient mental health care and treatment after reference to the above criteria, he or she shall be admitted to the Approved Centre. This shall occur regardless of whether he or she meets any additional criteria of the Approved Centre (e.g. catchment area, health insurance status) unless a safe direct admission to the appropriate Approved Centre can be arranged.

Decision to Admit

3.12 The decision to admit shall be made by a Registered Medical Practitioner or a Consultant Psychiatrist, in consultation with the individual, members of the Multidisciplinary Team where possible, and the individual's family/carer or chosen advocate, if appropriate.

3.12.1 The decision to admit shall be made after exploring alternative treatment options.

3.12.2 An individual shall be admitted to the unit most appropriate to his/ her needs, save in cases of emergency.

3.12.3 An individual shall be informed of the reasons why he/she is being admitted.

Decision not to Admit

3.13 A decision not to admit an individual following referral shall be documented and shall be communicated back to the individual's referring Registered Medical Practitioner or Community Mental Health Services and the individual's family/carer or chosen advocate, if appropriate.

3.13.1 The decision not to admit shall be made after exploring alternative treatment options.

3.13.2 Referral to a more appropriate service in accordance with the individual's existing needs shall be made, where necessary, and a record of this should be maintained.

3.13.3 An individual shall be informed of the reasons why he/she is not being admitted.

Assessment following Admission

3.14 A resident shall have an initial assessment on admission followed by a more comprehensive assessment as soon as possible.

3.14.1 Assessments shall be carried out in an area that ensures that the privacy and dignity of the resident, and the safety of the resident and staff, are preserved.

3.14.2 Assessment shall include, but is not limited to:

- current mental health state,
- risk assessment,
- the presenting problem,
- past psychiatric history,
- full physical examination,
- medical history,
- medication history and current medication,
- family history (where relevant),

- social and housing circumstances (where relevant),
- informational needs, and
- any other relevant information e.g. work situation, educational, dietary requirements.

3.15 All assessments shall be fully documented in the resident's clinical file.

Rights and Information

3.16 Information on a person's rights under the 2001 Act shall be readily available in the Approved Centre.

3.17 A resident shall be made fully aware of his/her rights upon admission.

3.17.1 Staff shall check that a resident understands his/her rights and his or her understanding of these rights shall be documented in the clinical file.

3.17.2 A resident's rights shall be revisited and discussed with him/her during his/her stay to ensure understanding.

3.18 Upon admission, a resident shall be orientated to staff and the unit to which he/ she is being admitted and supplied with a resident information booklet.

3.18.1 A booklet shall be written in plain understandable language and shall include, but is not limited to, information on the Approved Centre's policies and procedures.

3.18.2 The Approved Centre shall comply with Article 20 of the Regulations regarding the provision of information to the resident, which includes providing information relating to:

- details of the resident's Multidisciplinary Team;
- housekeeping practices, including arrangements for personal property, mealtimes, visiting
- times and visiting arrangements;
- verbal and written information on the resident's diagnosis and suitable written information
- relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition
- details of relevant advocacy and voluntary agencies;
- information on indications for use of all medications to be administered to the resident, including any possible side-effects. *(as per Regulation 20 Provision of Information – Judgement Support Framework)*

3.18.3 The provision of information to the resident shall be documented in the clinical file.

3.18.4 A resident and his/her family, carer or chosen advocate where appropriate (i.e. with the consent of the resident) shall have the opportunity to discuss with staff any issues arising from the information provided.

3.19 A resident shall be provided with individualised information in a timely manner upon admission including information on his/her initial care and treatment plan.

3.19.1 Information shall be adapted both in form and content to meet the needs of the resident.

3.19.2 Information shall be made available in both written and oral form. Interpretation services shall be made available, where necessary.

3.19.3 Information booklets shall be made available in other languages commonly seen in the Approved Centre, where possible.

3.19.4 Where a resident is unable to understand information given, such information shall be conveyed, where appropriate (i.e. with the consent of the resident), to a personal representative such as a family member, carer, chosen advocate, or the person best able and who is willing to represent the resident's interests.

Individual Care and Treatment Plan

3.20 Every resident shall have an Individual Care Plan in accordance with Article 15 of the Regulations, Individual Care Plan.

3.20.1 The plan shall focus on the individual's recovery. It shall also include a risk management plan and a preliminary discharge plan, outlining any possible obstacles to discharge e.g. social factors. (as per Regulation 15 Individual Care Plan – Judgement Support Framework)

Resident and Family/Carer/Advocate

Involvement

3.21 The resident shall be actively involved in the admission process and in the development of his/her care and treatment plan.

3.21.1 The resident shall be encouraged to involve his/her family/carer in his/her care and to inform them of the admission, where appropriate.

3.21.2 The resident's family/carer &/ or chosen advocate shall be involved in the admission process and in the development of the care and treatment plan with the resident's consent.

3.21.3 Advocacy services shall be made available to the resident as required.

Multidisciplinary Team Involvement

3.22 Where possible, Multidisciplinary involvement in the admission process shall occur.

3.23 The resident shall be introduced to the Multidisciplinary Team responsible for providing his/her care as soon as possible after admission.

Key Worker

3.24 There shall be a key worker system in place in the Approved Centre.

3.24.1 A resident shall be assigned the most appropriate person to be his/her key worker as soon as possible after admission and the name of the key worker shall be documented in the resident's clinical file.

3.24.2 The key worker shall make himself/herself known to the resident and his/her family, carer or chosen advocate, if appropriate (i.e. with the consent of the individual), as soon as possible in the resident's stay taking time to explain his/her role.

3.24.3 The key worker shall have responsibility for co-ordinating all stages of the resident's stay in the Approved Centre and shall serve as a point of contact for the resident and his or her family, carer or chosen advocate addressing their informational needs and informing them about what is happening and the likely proceeding steps in the inpatient process. He or she shall work with other members of the Multidisciplinary Team to ensure that liaison with relevant outside agencies takes place.

Collaboration with Primary health Care, Community Mental Health Services, Relevant Outside Agencies and Information Transfer

3.25 Staff in the Approved Centre shall establish verbal as well as written communication, where possible, with the relevant Registered Medical Practitioner/Community Mental Health staff upon referral of an individual, particularly in the case of urgent or self-referrals where information may be lacking.

3.26 Where the decision is made to admit an individual, his/her Registered Medical Practitioner/ Primary Care Team/ Community Mental Health Team shall be notified of the admission as soon as is practicable. This notification shall include information on the intended care to be provided to the resident, and the projected length of stay where possible.

Record keeping and Documentation

3.27 An integrated approach to record-keeping shall be adopted in the Approved Centre. All members of the Multidisciplinary Team shall work to one set of documentation. Records shall be accessible on a 24 hours basis.

3.28 It is considered good practice to use an admission form for voluntary patients which includes a general consent for admission. In the case of an involuntary admission, statutory forms shall be completed in accordance with the 2001 Act.

3.29 All assessments and examinations on admission shall be recorded in the resident's clinical file.

3.30 Documentary evidence of resident, and family/carer or chosen advocate involvement in admission, including the provision of information to these parties, shall be kept in the resident's file.

3.31 Approved Centres shall comply with Article 27 of the Regulation, Maintenance of Records.

3.32 Clinical files shall be well maintained (in accordance with Appendix 2 Code of Practice on Admission, Transfer and Discharge to and from Approved Centres for Excellence in Mental Health Records requirements and the relevant guidance documents of professional bodies).

3.32.1 Clinical files shall be legible, signed and dated.
3.32.2 Full names shall be provided as initials will not suffice.
3.32.3 Signature banks for all members of staff and students should be made available and be updated regularly. *(as per Regulation 27 Maintenance of Records – Judgement Support Framework)*

Day of Admission:
Personal Property and Clothing
3.33 Approved Centres shall comply with Article 7 and 8 of the Regulations in respect of personal property and possessions and clothing (as per Regulation 7 Clothing & Regulation 8: Residents' Personal Property and Possessions – Judgement Support Framework).
3.34 A resident's clothes, in general, shall not be taken from him/her on admission. Where clothes are taken, the rationale for this decision shall be clearly documented in the resident's clinical file.

Specific Groups:
3.35 A homeless person shall be identified on admission, and a record of his/her "no fixed abode" status recorded.
3.36 A homeless person with mental illness shall be admitted to an Approved Centre if in need of immediate inpatient care regardless of catchment area. Local policy shall take into consideration the importance of continuity of care for each homeless person.

TRANSFER
Transfer Criteria
3.37 The following criteria shall apply when considering the transfer of a resident:
- It is believed to be in the best interests of the resident to be transferred to another facility.
- The resident is in need of obtaining special treatment or care that can only be provided in another facility or is no longer in need of obtaining special treatment or care in another facility
- The resident requests to be transferred either to another Approved Centre, which may be closer to his/her home or to an independent facility for which he/she has health insurance cover. (as per Section 1.2, 1.3, 4.1, 4.2 & 4.3, Regulation 18 Transfer of Residents – Judgement Support Framework).

Decision to Transfer
3.38 The decision to transfer shall be made by a Registered Medical Practitioner or the Clinical Director whichever is appropriate, in consultation with the resident, members of the Multidisciplinary Team where possible, and the resident's family/carer or chosen advocate, if appropriate (i.e. with the consent of the resident) (as per Section 1.4, 1.10, 4.6, 4.7, 4.9, 4.11, Regulation 18 Transfer of Residents – Judgement Support Framework).
3.38.1 The decision to transfer shall be agreed with the receiving facility (as per Section, 1.7 & 4.4 Regulation 18 Transfer of Residents – Judgement Support Framework).

Assessment before Transfer
3.39 An assessment of the resident shall be carried out prior to transfer. This shall include a risk assessment (as per Section 1.2, 1.8 & 4.5 Regulation 18 Transfer of Residents – Judgement Support Framework).

Resident Involvement
3.40 Every effort shall be made to respect the resident's wishes regarding transfer and to obtain his/her consent before a transfer takes place, however there may be circumstances where it is not possible to obtain consent (as per Section 1.10 & 4.11 Regulation 18 Transfer of Residents – Judgement Support Framework).
3.41 A resident's family/carer &/or chosen advocate, where appropriate, (i.e. with the resident's consent) shall be involved in the transfer process (as per Section 1.10 & 4.9 Regulation 18 Transfer of Residents – Judgement Support Framework).
3.42 Transfer options available shall be discussed and any concerns or questions that the resident and/or his or her family/carer or chosen advocate may have about the transfer shall be addressed (as per Section 1.10 & 4.9 Regulation 18 Transfer of Residents – Judgement Support Framework).
3.42.1 Any relevant information conveyed by the resident or his or her family, carer or chosen advocate, particularly with regard to risk assessment and suicidal intent should be

documented and conveyed to the receiving facility (as per Section 4.5 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.42.2 Involvement shall be documented in the resident's clinical file (as per Section 4.9 Regulation 18 Transfer of Residents – Judgement Support Framework).

Multidisciplinary Team Involvement

3.43 Members of the Multidisciplinary Team shall be involved in the transfer process in so far as is practicable (as per Section 1.1 & 4.6 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.44 The key worker shall have responsibility for co-ordinating all stages of the resident's transfer to the receiving facility. He or she shall liaise with members of the Multidisciplinary Team in both facilities in preparation for transfer (as per Section 1.1, 1.5 & 4.7 Regulation 18 Transfer of Residents – Judgement Support Framework).

Communication between the Approved Centre and Receiving Facility and Information Transfer

3.45 The Approved Centre shall comply with Article 18 of the Regulations Transfer or Residents in respect of information transfer (as per Section 1.16 & 4.13 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.46 Direct verbal communication and liaison shall take place between the Approved Centre and the receiving facility prior to the transfer taking place.

3.46.1 This shall include a discussion of:

- the reasons for transfer,
- the resident's care and treatment plan (including needs and risk)
- and whether the resident requires accompaniment on transfer. (as per Section 1.6,1.7 & 4.4 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.46.2 Arrangements shall be made accordingly for the arrival of the resident at the receiving facility (as per Section 4.2 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.47 Full and complete written information regarding the resident shall be transferred when he or she moves from an Approved Centre to another facility.

3.47.1 This information shall be sent in advance or at least accompany the resident upon transfer.

3.47.2 The written information shall be sent to a named individual within the receiving facility and a record to this effect should be maintained.

3.47.3 Written information sent shall include the individual care and treatment plan and a brief referral letter addressing the reason(s) for the transfer (see Appendix 3 of the Code of Practice on Admission, Transfer and Discharge to and from the Approved Centre for a sample transfer form).

3.47.4 The information shall be checked by both the transferring Approved Centre and the receiving facility to ensure completeness. (as per Section 1.16, 4.15 & 4.18 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.48 Staff in the receiving facility shall familiarise themselves with all written information received in a timely fashion, particularly as it relates to risk assessment (as per Section 1.17 Regulation 18 Transfer of Residents – Judgement Support Framework).

Record keeping and Documentation

3.49 The decision to transfer a resident shall be documented in the resident's clinical file (as per Section 4.3 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.50 A copy of the referral letter shall be kept in the resident's clinical file (as per Section 4.15 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.51 Documentary evidence of the involvement of the resident and his or her family, carer or chosen advocate in the transfer process shall be kept (as per Section 4.11 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.52 Documentary evidence of the resident's consent to transfer shall be kept in the resident's file, where applicable.

3.52.1 Where consent has not been

obtained, the reasons for this shall be documented in the resident's clinical file (as per Section 4.11 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.52.2 In the case of the transfer of an involuntary patient, statutory forms shall be completed in accordance with the 2001 Act (as per Section 1.13 Regulation 18 Transfer of Residents – Judgement Support Framework).

Day of Transfer

3.53 A time shall be arranged for the transfer of the resident.

3.53.1 Planned transfers shall take place early in the day and before 17.00 hours in so far as is practicable.

3.53.2 If transfer takes place after 17.00 hours, the reason for it shall be clearly documented in the resident's clinical file. (as per Section 4.14 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.54 Transport shall be arranged for the transfer if required (as per Section 1.15 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.55 The return of property shall be in accordance with the Approved Centre's policy on personal property and possessions, with attention being paid to risk assessment (as per Section 1.12 & 4.12 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.56 The transferring Approved Centre shall maintain responsibility for the resident until care is accepted by the receiving facility (as per Section 4.17 Regulation 18 Transfer of Residents – Judgement Support Framework).

3.57 On arrival to a new unit, the admission policy of the receiving facility shall be implemented (see section above Admission).

Decision to Discharge

3.58 The decision to discharge shall be made by a Registered Medical Practitioner or the responsible Consultant Psychiatrist, in consultation with the resident, members of the Multidisciplinary Team where possible, and the resident's family/carer or chosen advocate, if appropriate (i.e. with the consent of the resident).

Discharge Planning

3.59 A comprehensive and structured discharge plan shall be developed as a component of the Individual Care Plan.

3.59.1 Discharge planning shall commence as soon as possible after admission. This plan shall be developed, reviewed and updated as per the Individual Care Plan.

3.60 The discharge plan shall focus on the resident's recovery and shall include, but is not limited to:

3.60.1 an estimated date of discharge,

3.60.2 documentary evidence of communication with the relevant Registered Medical Practitioner/ Primary Care Team or Community Mental Health Staff,

3.60.3 a follow-up plan,

3.60.4 early warning signs of relapse and risks.

3.61 Time periods shall be specified for each discharge action within the plan. Each discharge action shall be completed to ensure the timely implementation of various procedures within the discharge process. All Multidisciplinary Team members shall be aware of their roles and responsibilities as specified in the discharge plan.

3.62 A discharge meeting shall take place before discharge. This meeting shall be attended by:

- the resident,
- his/her key worker,
- relevant members of the Multidisciplinary Team
- the resident's family, carer or chosen advocate where appropriate (i.e. with the consent of the resident).

Pre-Discharge Assessment

3.63 A resident shall have a comprehensive assessment prior to discharge, which is multidisciplinary in so far as is practicable. It shall include:

- an assessment of psychiatric and psychological needs,
- a current mental state examination,
- comprehensive risk assessment and risk management plan,
- informational needs,
- any social and housing needs that the resident may have
- and any other relevant information.

3.64 Where necessary, suitable accommodation should be secured before a resident is discharged.

3.65 The assessment shall be documented in

the resident's clinical file.

Multidisciplinary Team Involvement

3.66 A Multidisciplinary Team approach to discharge planning shall be adopted and relevant members of the Multidisciplinary Team shall actively manage the discharge process.

Key Worker

3.67 The key worker shall co-ordinate the discharge process.

3.68 The key worker shall liaise with the resident, family, carer and/or chosen advocate, where appropriate (i.e. with the consent of the resident) and work with other members of the Multidisciplinary Team to ensure that liaison with the Registered Medical Practitioner /Primary Care Team and/or Community Mental Health Services and relevant outside agencies takes p lace.

3.69 The key worker shall check that all relevant documentation has been completed by relevant members of the Multidisciplinary Team.

Collaboration with Primary Health Care, Community Mental Health Services, Relevant Outside Agencies and Information Transfer

3.70 Community Mental Health staff shall be involved in the discharge process from an early stage. Where feasible, planned contact between a resident and the relevant Community Mental Health services/Registered Medical Practitioner/Primary Care Team shall be established prior to discharge.

3.71 The Registered Medical Practitioner/Primary Care Teams and/or Community Mental Health services shall always be informed by the Approved Centre of the discharge of a resident.

3.71.1 Every reasonable effort shall be made to inform them within 24 hours.

3.71.2 If not feasible, a record shall be made of the reason(s) and it shall be followed up as soon as possible.

3.72 When a resident is discharged, a discharge summary shall be sent by the Approved Centre to the Registered Medical Practitioner/Primary Care Team/Community Mental Health services responsible for follow up care within 3 days of discharge.

3.72.1 This may occur as follows:

- A comprehensive discharge summary is sent to the Registered Medical Practitioner/Primary Care Team/Community Mental Health services responsible on discharge or no later than 3 days, or
- 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.

3.73 Discharge summaries shall include information regarding:

- diagnosis,
- prognosis,
- medication,
- mental state at discharge,
- any outstanding health or social issues at discharge,
- follow up arrangements,
- the names and contact details of key people for follow-up,
- and risk issues such as signs of relapse.

Note: Appendix 4 of the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre includes a sample discharge summary for illustrative purposes only.

Resident and Family/Carer/Advocate Involvement and Information Provision

3.74 A resident and his/her family/carer and/or chosen advocate, where appropriate (i.e. with the resident's consent), shall be actively involved in the discharge process and a written record shall be made of any involvement in the resident's clinical file.

3.75 Involvement shall include the option:

- to attend and be involved in discharge meetings,
- ongoing discussion regarding the discharge plan with the Multidisciplinary Team and key worker,
- and the opportunity for the resident and his/her family/carer and/or chosen advocate to voice any concerns they may have regarding discharge.

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

3.77 Comprehensive information shall be provided by the key worker to the resident and his/her family/carer and/or chosen advocate, where appropriate (i.e. with the resident's consent), in plain understandable language upon discharge, which shall include generic

and individualised information.

3.77.1 Generic information shall include contact details of Community Mental Health services and 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).

3.77.2 Individualised information shall include information on the resident's medication and how to take medication, possible side effects, information on diagnosis and any follow up arrangements made prior to discharge.

3.78 The key worker shall discuss the information provided with the resident and his or her family/carer and/or chosen advocate, where appropriate (i.e. with the consent of the resident), prior to discharge to ensure that the resident understands the information given and to address any questions or concerns he/she may have prior to discharge

3.79 Discharge preparation groups shall be used, where feasible, to bridge the gap between inpatient and community care.

Notice of Discharge

3.80 An Approved Centre shall provide the resident, his/her family/carer and/or chosen advocate where appropriate (i.e. with the consent of the resident), with a minimum of 2 days' notice of discharge. If this does not occur, the reason(s) for it shall be clearly documented in the resident's clinical file.

Follow up and Aftercare

3.81 A timely post-discharge follow-up appointment with the relevant services shall be made prior to discharge.

3.81.1 The resident and his/her family, carer, or chosen advocate where appropriate (i.e. with the consent of the individual) shall be notified of the date of this appointment verbally and in writing. This shall be documented in the discharge plan.

3.81.2 The clinical judgement of the relevant members of the Multidisciplinary Team shall be used when deciding the appropriate time lapse between discharge and the date of the follow up appointment.

3.81.3 Individuals with severe mental illness and a history of deliberate self-harm within the previous three months or who are assessed as being at risk of suicide shall have a follow up appointment within one week of discharge.

Record Keeping and Documentation

3.82 All aspects of the discharge process shall be fully recorded in the resident's clinical file. This shall include the following:

- Documentary evidence that discharge planning commenced on admission where feasible, or as soon as possible thereafter;
- The individual's discharge plan.
- Evidence of review of discharge plan and consultation with resident and family/ carer/advocate if appropriate prior to discharge;
- The information given to resident and family/carers/advocates, where appropriate, (i.e. with the consent of the resident);
- The date of discharge;
- Necessary referrals undertaken;
- Follow up appointment dates and times;
- A copy of all discharge summaries

3.83 In the case of the discharge of an involuntary patient, statutory forms shall be completed in accordance with the 2001 Act.

Day of Discharge

3.84 Property shall be returned to the resident on the day of discharge in accordance with the centre's policy on personal property and possessions.

3.85 A medical certificate and prescription shall be furnished if required.

3.86 Transport arrangements shall be implemented in accordance with the individual's discharge plan.

Specific Groups: Homeless People

3.87 Before discharge, the Multidisciplinary Team shall endeavour to ensure that the resident has been referred to the appropriate housing authority where appropriate (i.e. with the consent of the

resident).

3.88 The key worker, or social worker, shall contact and liaise with relevant social, housing, and homeless services to arrange a supported community residence or suitable alternative accommodation for the resident. He/she shall work in partnership with the relevant statutory authorities and voluntary agencies to make arrangements for continuing support in the community.

3.89 A record shall be kept of the type of accommodation to which the person is discharged.

Specific Groups: Older Persons

3.90 When discharging an older person to continuing care in an independently managed nursing home or publicly funded and managed unit, the inspection reports of the facility for the past three years, where available, shall be reviewed to facilitate selection of the most appropriate facility for that person. This review shall include particular attention to:

- the programme of care and social activity in the facility,
- the availability of skilled and knowledgeable care and nursing staff,
- the availability of specialised services and facilities for those with dementia,
- the palliative care programme within the facility, and
- the Approved Centre's policies and procedures on such issues as the management of complaints, the use of restraint, and the management of allegations of abuse.

Scoring

4: Compliant - Excellent Achievement	1. Policies, procedures and protocols for the admission, transfer and discharge of residents to and from the Approved Centre are available. 2. Documented evidence is available of staff awareness of, or training in, the processes relating to the admission, transfer and discharge of residents to and from the Approved Centre. 3. Evidence is available of the processes relating to the admission, transfer and discharge of residents, and the related outputs, being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that all, or the vast majority (90-100%), of the requirements relating to the admission, transfer and discharge of residents are being implemented as per Section 4 of the Guidance for Compliance. 3: Compliant - Good Achievement
3: Compliant - Good Achievement	1. Standardised and agreed processes for the admission, transfer and discharge of residents to and from an Approved Centre are being utilised by staff, but the processes are not formally documented. 2. Documented evidence of staff awareness, or training, in the processes relating to the admission, transfer and discharge of residents is available for some staff only / Staff awareness, or training, regarding the processes relating to admission, transfer and discharge of residents is completed with all required staff but not formally documented. 3. Some evidence available of the processes relating to the admission, transfer and discharge of residents, and their related outputs, are being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence available that the majority (51-89%) of the requirements relating to the admission, transfer and discharge of residents are being implemented as per Section 4 of the Guidance for Compliance.
2: Non-Compliant - Poor Achievement	1. No defined processes are available in relation to the admission, transfer and discharge of residents to and from an Approved Centre, with limited evidence available of a standardised process being utilised by staff. 2. Limited evidence is available of staff awareness, or training, in relation to the admission, transfer and discharge of residents', either documented or informal. 3. Limited evidence available of admission, transfer and discharge of residents processes, or their related outputs, being monitored and continually reviewed, e.g. via resident record, review, audit, incident reporting, analysis and trending. 4. Evidence is available that a limited number (30-50%) of the admission, transfer and discharge of resident's requirements are being implemented as per Section 4 of the Guidance for Compliance.
1: Non-Compliant - Negligible Achievement	1. No standardised processes utilised in relation to the admission, transfer and discharge of residents to and from an Approved Centre. 2. No documented, or undocumented, evidence of staff awareness, or training, in relation to admission, transfer and discharge of residents. 3. No evidence available of the admission, transfer and discharge of residents processes, or their related outputs, being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that a negligible number (<30%) of the admission, transfer and discharge of residents requirements are being implemented as per Section 4 of the Guidance for Compliance.

PART 3: CODE OF PRACTICE FOR MENTAL HEALTH SERVICES ON NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Title

Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting (January 2008)

Purpose

The intention for this Code is that it will complement and support the existing incident reporting systems and will facilitate implementation of more robust risk management systems in mental health services. This section of the document will review the Code requirements in relation to their application within Approved Centres.

Approved Centres are required to report all deaths to the Mental Health Commission within 48 hours in accordance with the Regulations. The reporting of deaths to the Mental Health Commission is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

Approved Centres are no longer required to report incidents on an individual basis to the Commission. Incident summary reports are only required on a 6 monthly basis. This summary reporting of incidents to the Mental Health Commission is without prejudice to reporting requirements to other statutory agencies and external bodies such as the HSE, the Health and Safety Authority, the Clinical Indemnity Scheme, Irish Public Bodies and other Clinical Indemnifiers.

The Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting overlaps with a number of the legal and best practice requirements as reflected in the Judgement Support Framework. Where relevant, the corresponding Judgement Support Framework section is detailed in italics after the Code guidance. Relevant corresponding sections for this Code include:

- Regulation 14 – Care of the Dying
- Regulation 32 - Risk Management

Guidance for Compliance:

1. ***Defined processes in place:*** The Approved Centre shall have a Risk Management policy and procedure that addresses the following;
   - 1.1 The process for notification of deaths and incident reporting to the Mental Health Commission (as per Section 1.12, Regulation 14 Care of the Dying and Section 1.7, Regulation 32 Risk Management – Judgement Support Framework).
   - 1.2 The identity of the risk manager or person with responsibility for risk management within the mental health service (as per Section 1.1.1, Regulation 32 Risk Management – Judgement Support Framework).
   - 1.3 The roles and responsibilities of members of staff in relation to the reporting of deaths and incidents, including but not limited to,
     - 1.3.1 the completion of death notification forms,
     - 1.3.2 submission of forms to the Commission and
     - 1.3.3 the completion of six-monthly incident summary reports (as per Section 1.1, Regulation 14 Care of the Dying and Section 1.1.3, Regulation 32 Risk Management – Judgement Support Framework).

2. ***Training;*** Staff are aware, understand and, where required, are trained in all processes in relation to the notification of deaths and incident reporting. This training is documented.

3. ***Monitoring:*** The Approved Centre shall monitor the processes, and outputs, relating to the notification of deaths and incident reporting. This shall include:
   - 3.1 An annual audit is undertaken to determine compliance to the processes.
   - 3.2 Incident reports are recorded for non-compliances identified in relation to

the processes.

3.3 Analysis is completed to identify opportunities for improvement to the processes.

4. Evidence of Implementation:

NOTIFICATION OF DEATHS

4.1 All deaths of any resident of an Approved Centre shall be notified to the Commission within 48 hours of the death occurring (as per Section 4.7, Regulation 14 Care of the Dying – Judgement Support Framework).

4.2 A death notification form shall be completed and submitted to the Mental Health Commission within 48 hours of the death occurring (as per Section 4.7, Regulation 14 Care of the Dying – Judgement Support Framework). The form shall be in accordance to the Code of Practice on Notification of Deaths and Incident Reporting Addendum, Death Notification Form).

4.3 All Serious Reportable Events as defined by Appendix A below, shall be reported in a manner and timeframe specified by the Mental Health Commission.

4.4 All notifications shall be sent to mentalhealthdata@mhcirl.ie

INCIDENT REPORTING

4.5 Article 32 of the Regulations provides the statutory requirements for Approved Centres in relation to risk management procedures. The requirements include:

4.5.1 The registered proprietor shall ensure that an Approved Centre has a comprehensive written risk management policy in place and that it is implemented throughout the Approved Centre (as per Section 1 and Section 4 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.5.2 The Registered Proprietor shall ensure that Risk Management Policy covers, but is not limited to, the following:

4.5.2.1 The identification and assessment of risks throughout the Approved Centre (as per Section 1.2 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.5.2.2 The precautions in place to control the risks are identified (as per Section 1.2 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.5.2.3 The precautions are in place to control the following specified risks:
- resident absent without leave,
- suicide and self harm,
- assault,
- accidental injury to residents or staff;

(as per Section 1.4 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.5.2.4 Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents (as per Section 1.7 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.5.2.5 Arrangements for responding to emergencies (as per Section 1.8 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.5.2.6 Arrangements for the protection of children and vulnerable adults from abuse (as per Section 1.9 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.6 The Registered Proprietor shall ensure that an Approved Centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the Approved Centre with due regard to any relevant Codes of Practice issued by the Mental Health Commission from time to time which have been notified to the Approved Centre (as per Section 1.7.8 and 4.19 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.7 Approved Centres shall ensure effective systems are in place to implement Article 32 of the Regulations (as per Section 1, 2, 3 & 4 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.8 Approved Centres shall use existing local incident reporting systems and associated forms to report incidents within their service (Note: there is no longer a requirement to notify the Mental Health Commission/Inspector of Mental Health Services of individual incidents occurring in Approved Centres) (as per Section 4.14, 4.15 & 4.16 Regulation 32 Risk Management Procedures – Judgement Support Framework).

4.9 Approved Centres shall provide a six-monthly summary report of all incidents occurring in approved centres to the Mental Health Information Officer, Standards and Quality Assurance Division, Mental Health Commission, which includes details of how such incidents were managed, as per proforma.

4.9.1 Information on HSE incidents provided in the report should be drawn from local incident reporting management information systems, including but not limited to, the information reported to the Clinical Indemnity Scheme, Health and Safety Authority and Irish Public Bodies, to minimise duplication of work.

4.9.2 Information on Independent/ Voluntary mental health service provider incidents should be drawn from local incident reporting management information systems, including but not limited to, the information reported to the service provider's Clinical Indemnifier and other relevant statutory agencies, to minimise duplication of work. (as per Section 4.19 Regulation 32 Risk Management Procedures – Judgement Support Framework).

TREND ANALYSIS

4.10 Information provided in the six-monthly incident summary reports to the Commission should be anonymous at resident level (as per Section 4.19 Regulation 32 Risk Management – Judgement Support Framework).

Scoring

4: Compliant - Excellent Achievement	1. Defined policies and procedures are available addressing the notification of deaths and incident reporting of residents within the Approved Centre. 2. Documented evidence is available of staff awareness of, or training in, the processes relating to the notification of deaths and incident reporting of residents. 3. Evidence is available of the notification of deaths and incident reporting of residents processes, and the related outputs, being monitored and continually reviewed by the Approved Centre, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that all, or the vast majority (90-100%), of the notification of deaths and incident reporting of residents requirements are being implemented by the Approved Centre as per Section 4 of the Guidance for Compliance.
3: Compliant - Good Achievement	1. Standardised and agreed notification of deaths and incident reporting of residents processes are being utilised by staff of the Approved Centre, but process is not formally documented. 2. Documented evidence of notification of deaths and incident reporting of resident's staff awareness, or training, is available for some staff only / Staff awareness, or training, regarding the resident identification processes is completed with all required staff but not formally documented. 3. Some evidence available of notification of deaths and incident reporting of residents processes, and the related outputs, are being monitored and continually reviewed by the Approved Centre, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence available that the majority (51-89%) of the notification of deaths and incident reporting of residents requirements are being implemented by the Approved Centre as per Section 4 of the Guidance for Compliance.
2: Non-Compliant - Poor Achievement	1. No defined processes are available within the Approved Centre in relation to notification of deaths and incident reporting of residents, with limited evidence available of a standardised process being utilised by staff. 2. Limited evidence is available of staff awareness, or training, in relation to notification of deaths and incident reporting of residents, either documented or informal. 3. Limited evidence available of notification of deaths and incident reporting of residents processes, and the related outputs, being monitored or continually reviewed by the Approved Centre, e.g. via resident record, review, audit, incident reporting, analysis and trending. 4. Evidence is available that a limited number (30-50%) of the notification of deaths and incident reporting of residents requirements are being implemented by the Approved Centre as per Section 4 of the Guidance for Compliance.
1: Non-Compliant - Negligible Achievement	1. No standardised processes utilised in relation to the notification of deaths and incident reporting of residents within the Approved Centre. 2. No documented, or undocumented, evidence of staff awareness, or training, in relation to notification of deaths and incident reporting of residents. 3. No evidence available of the notification of deaths and incident reporting of residents processes, and the related outputs, being monitored and continually reviewed by the Approved Centre, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that a negligible number (<30%) of the notification of deaths and incident reporting of residents requirements are being implemented by the Approved Centre as per Section 4 of the Guidance for Compliance.

PART 4: GUIDANCE FOR PERSONS WORKING IN MENTAL HEALTH SERVICES WITH PEOPLE WITH INTELLECTUAL DISABILITIES

Title

Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People in Intellectual Disabilities. Issues Pursuant to Section 33(3)(e) of the Mental Health Act, 2001 (September, 2009).

Purpose

People with intellectual disabilities have the same rights as the general population and are protected by the Constitution, national legislation and international human rights law as it applies to all persons, including the entitlement to receive a mental health service in the most appropriate setting for him/her. The resident's additional needs, including possible communication difficulties and/or limited capacity may impact on the treatment received. Therefore this Code was developed to provide guiding principles and good practice guidance for mental health professionals on the issues relating to the provision of care and treatment to residents with intellectual disabilities. This document presents this guidance as it relates to relevant staff of an Approved Centre.

Four guiding principles are highlighted in this Code that are particularly important in the delivery of care and treatment to residents with intellectual disabilities, those being:

1. Best interests
2. Person-centred approach
3. The presumption of capacity
4. Least restrictive intervention

The consideration of the use of restrictive practices within an Approved Centre is addressed within this Code. The Code clarifies that examples of restrictive practice includes mechanical restraint, physical restraint, psychotropic medication as a restraint and seclusion. Where the Code reflects requirements detailed within the Judgement Support Framework in relation to the use of seclusion and mechanical restraint this shall be cross referenced.

This Code overlaps with a number of the legal and best practice requirements as reflected in the Judgement Support Framework. Where relevant, the corresponding Judgement Support Framework section is detailed in italics after the Code guidance. Relevant corresponding sections for this Code include:

- Regulation 15 Individual Care Plan
- Regulation 18 Transfer of Residents
- Regulation 20 Provision of Information to Residents
- Regulation 22 Premises
- Regulation 29 Operating Policies and Procedures
- Regulation 26 Staffing
- Use of Seclusion Rule
- Use of Mechanical Restraint Rule
- Mental Health Act, 2001; Part 4: Consent to Treatment
- Part 7: Code of Practice on the Use of Physical Restraint in Approved Centres (see page 38)

Guidance for Compliance

1. ***Defined processes in place:*** The Approved Centre shall have policies, procedures and protocols that address the following:
   - 1.1 The principles contained in the Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities are reflected in the Approved Centres policies and procedures (as per Section 1.2 Regulation 29 Operating Policies and Procedures – Judgement Support Framework).
   - 1.2 The process for the delivery of person-centred mental health care and treatment. This policy and procedure shall include:
     - 1.2.1 The timeframes for assessment, planning and implementation.
     - 1.2.2 The roles and responsibilities of Multidisciplinary Team members. (as per Section 1.0 & 4.0 Regulation 15 Individual Care Plan – Judgement Support Framework).

1.3 The process for the use of restrictive practices (as per Use of Seclusion Rule & Use of Mechanical Restraint Rule - Judgement Support Framework). These shall only be used in the context of a comprehensive policy and procedures on the management of problem behaviours consistent with the law.

1.4 The process for management of problem behaviour.

1.5 The process for staff training. This policy and procedure shall include, but is not limited to, the following:

1.5.1 Induction training for all new staff, including induction training for those new to working with people with intellectual disabilities (as per Section 1.2.7 Regulation 26 Staffing - Judgement Support Framework).

1.5.2 Details of who should receive training based on identified needs of residents' and staff (as per Section 1.2.5 Regulation 26 Staffing - Judgement Support Framework).

1.5.3 The areas to be addressed within the training programme with emphasis on areas of mandatory training (as per Section 1.2.8 Regulation 26 Staffing - Judgement Support Framework).

1.5.4 The frequency of training (as per Section 1.2.8 Regulation 26 Staffing - Judgement Support Framework).

1.5.5 Identifying appropriately qualified person(s) to give the training (as per Section 1.2.10 Regulation 26 Staffing - Judgement Support Framework).

1.5.6 Evaluation of training programmes to ensure they are evidence informed and up to date (as per Section 1.2.11 Regulation 26 Staffing - Judgement Support Framework).

1.5.7 A robust communication protocol shall be in place between the Approved Centre and the relevant external agencies to ensure appropriate and relevant communication and close liaison regarding people with intellectual disabilities (as per section 1.6 and 4.8 Regulation 18 Transfer of Residents- Judgement Support Framework).

Applicable to Approved Centres providing mental health services for children with intellectual disabilities and mental illness.

1.6 The processes relating to child protection. These shall be in line with relevant legislation and regulations made thereunder, such as:

1.6.1 Child Care Act 1991

1.6.2 Children Act 2001 and Amendment 2006

1.6.3 Children First Guidelines 2011

1.7 The process to address staff training in relation to child protection (as per Section 4.16.18 Regulation 26 Staffing - Judgement Support Framework).

2. ***Training:*** Relevant staff of the Approved Centre shall be aware, understand and, where required, trained on the policies, procedures and processes relating to working with people with intellectual disabilities. Training shall be documented.

2.1 The Approved Centre shall ensure that evidence informed education and training (accredited programmes, where possible) are made available to staff in the following areas:

2.1.1 Person-centred approaches to mental health care and treatment (as per Section 4.16.8 Regulation 26 Staffing - Judgement Support Framework).

2.1.2 Relevant human rights principles (as per Section 4.16.6 Regulation 26 Staffing - Judgement Support Framework).

2.1.3 Training that focuses on both preventative and responsive strategies to problem behaviours (as per Section 4.16.9 Regulation 26 Staffing - Judgement Support Framework).

3. ***Monitoring:*** The Approved Centre shall monitor the processes relating to working with people with intellectual disabilities. This shall include:

3.1 An annual audit is undertaken to determine compliance to the processes relating to working with people with intellectual disabilities.

3.2 Incident reports are recorded for non-compliances identified against the processes relating to working with people with intellectual disabilities.

3.3 Analysis is completed to identify opportunities for improvement relating to working with people with intellectual disabilities.

4. Evidence of Implementation:

Problem Behaviour

4.1 The Approved Centre shall ensure that restrictive practices are only used in the context of a comprehensive policy and procedure on the management of problem behaviour that is consistent with the law (as per Rules: Use of Seclusion & Use of Mechanical Restraint Rule - Judgement Support Framework and Code of Practice on the Use of Physical Restraint in Approved Centres).

4.2 Parents and guardians are informed of the Approved Centre's policies on the management of problem behaviours. A written confirmation of same shall be signed by the parents or guardians.

Inter-Agency Collaboration

4.3 Inter-agency collaboration shall take place to ensure a smooth transition from one service to another (as per Section 4.8 Regulation 18 Transfer of Residents- Judgement Support Framework).

4.4 The key worker shall be ideally placed to facilitate inter-agency collaboration (as per section 4.7 Regulation 18 Transfer of Residents- Judgement Support Framework).

Individual Care and Treatment Plan

4.5 Each resident shall have an individual care and treatment plan (as per Section 1.0 and 4.0, Regulation 15 Individual Care Plan- Judgement Support Framework).

4.6 A comprehensive assessment shall form the basis of the plan. This may include reference to an Independent Assessment of Need where one has been carried out. The assessment shall include, but is not limited to:

- 4.6.1 Medical psychiatric and psychosocial history;
- 4.6.2 Medical history and current medications;
- 4.6.3 Current mental health assessment;
- 4.6.4 Detailed risk assessment;
- 4.6.5 Social, interpersonal and physical environment related issues;
- 4.6.6 Communication difficulties, if not elsewhere;
- 4.6.7 Performance capabilities and difficulties, if not assessed elsewhere. (as per Section 4.4 Regulation 15 Individual Care Plan- Judgement Support Framework)

4.7 The individual care and treatment plan shall describe the levels of support and treatment required to support the resident's journey to recovery, which are in line with the resident's assessed needs and in consideration of his/her environment, available resources and supports (as per section 4.6, 4.6.4 Regulation 15 Individual Care Plan – Judgement Support Framework).

4.8 A key worker shall be identified within the Approved Centre to ensure continuity in the implementation of the resident's individual care and treatment plan and close collaboration between services. The key worker shall make himself/herself known to the resident and relevant others (as per section 4.7 Regulation 15 Individual Care Plan – Judgement Support Framework).

Communication Issues

4.9 The resident's preferred ways of receiving and giving information should be established (as per Section 1.4 & 4.7 Regulation 20 Provision of Information to Residents – Judgement Support Framework).

4.10 It shall be agreed how the information is given and received. Information shall be made appropriate and accessible. Non-verbal communication approaches such as sign language, picture exchange communication systems and easy to read forms shall be provided, where necessary (as per Section 1.5 & 4.16 Regulation 20 Provision of Information to Residents – Judgement Support Framework).

4.11 The types of environment in which the resident communicates best shall be identified (as per Section 4.7 Regulation 20 Provision of Information to Residents – Judgement Support Framework).

4.12 The resident's previous experience of giving and receiving information shall be considered (as per Section 4.7 Regulation 20 Provision of Information to Residents – Judgement Support Framework).

4.13 The information the resident needs to know, when he/she needs to know it, and the rationale for providing such information shall be agreed (as per Section 4.4 (including 4.4.1 – 4.4.4) Regulation 20 Provision of Information to Residents – Judgement Support Framework).

4.14 A resident's understanding of the

information given shall be documented (as per Section 4.5 Regulation 20 Provision of Information to Residents – Judgement Support Framework).

4.15 It shall be decided who is the best person to give or receive information (as per Section 1.7 Regulation 20 Provision of Information to Residents – Judgement Support Framework).

4.16 The involvement of the resident's family, carer or advocate shall be actively encouraged to facilitate communication, particularly for those with reduced decision making capacity (as per Section 1.9 & 4.11 Regulation 20 Provision of Information to Residents – Judgement Support Framework).

Environmental Considerations

4.17 All mental health care and treatment shall be provided in the least restrictive environment consistent with the resident's needs (as per Section 4.13 Regulation 22 Premises – Judgement Support Framework). This may require a creative and flexible approach to adapt a restrictive environment to meet a resident's needs.

4.18 The design of the physical environment shall offer a maximum opportunity to maintain and improve mental and general health status. The design and layout of environments can reduce the need for restrictive practices (as per Section 4.4 Regulation 22 Premises – Judgement Support Framework). Environmental factors to consider include:

- 4.18.1 Access to personal space (as per Section 4.4.1 Regulation 22 Premises – Judgement Support Framework)
- 4.18.2 Temperature(as per Section 4.4.2 Regulation 22 Premises – Judgement Support Framework)
- 4.18.3 Noise levels/acoustics (as per Section 4.4.4 Regulation 22 Premises – Judgement Support Framework)
- 4.18.4 Lighting (as per Section 4.4.5 Regulation 22 Premises – Judgement Support Framework)
- 4.18.5 Orientation aids (as per Section 4.4.6 Regulation 22 Premises – Judgement Support Framework)
- 4.18.6 Sufficient spaces to move including outdoor spaces-enclosed gardens/patios (as per Section 4.4.7 Regulation 22 Premises – Judgement Support Framework)
- 4.18.7 Ease of observation (as per Section 4.1 Regulation 22 Premises – Judgement Support Framework)
- 4.18.8 Ratio of people within an environment (as per Section 4.1 Regulation 22 Premises – Judgement Support Framework)
- 4.18.9 Opportunities for privacy (as per Section 4.4.9 Regulation 22 Premises – Judgement Support Framework)
- 4.18.10 Safety avoiding large open spaces, steps and stairs, slippery floors, hard and sharp edges, hard and rough surfaces, things to trip over (as per Section 4.4.10 Regulation 22 Premises – Judgement Support Framework).

4.19 Environments shall create and provide opportunities for engagement in meaningful activities (as per Section 4.4.8 Regulation 22 Premises – Judgement Support Framework).

Considering the Use of Restrictive Practices

4.20 Restrictive practices shall only be used where a resident poses an immediate threat or serious harm to self or others (as per Section 4.22.2 Rules: Use of Mechanical Restraint – Judgement Support Framework & Section 4.1 Code of Practice on the Use of Physical Restraint in Approved Centres).

4.21 The use of restrictive practices shall only be considered as a last resort when all alternative interventions to manage the resident's problem behaviours have been considered (as per Section 1.5, 2.1 & 4.5 Rules: Use of Seclusion & Section 4.5 & 4.22.4 Rules: Use of Mechanical Restraint – Judgement Support Framework).

4.22 A multi-disciplinary assessment shall be carried out, where feasible, which looks at both reasons within the resident for the problem behaviours as well as service issues that may be contributing to the behaviour, This can include:

- 4.22.1 Past assessment of the resident (as per Section 4.2 & 4.17 Rules: Use of Seclusion & Section 1.2 & 4.2 Rules: Use of Mechanical Restraint – Judgement Support Framework);
- 4.22.2 Risk assessment and risk management plan for the resident (as per Section 1.4 & 4.12 Rules:

Use of Mechanical Restraint, Section 1.3, 4.14, 4.20.1 & 4.20.2 Rules: Use of Seclusion – Judgement Support Framework);

4.22.3 Physical illness, discomfort or pain; effects of drugs; psychological distress (as per Section 4.6 & 4.20.9 Rules: Use of Seclusion – Judgement Support Framework);

4.22.4 Environmental factors (as per Section 4.4 Regulation 22 Premises & Section 4.15 Rules: Use of Seclusion – Judgement Support Framework);

4.22.5 Staffing levels and the approach utilised by staff (as per Section 2.1 – 2.6 Rules: Use of Seclusion & Section 1.19 & 2.1-2.6 Rules: Use of Mechanical Restraint – Judgement Support Framework);

4.22.6 The assessment shall also attempt to predict and understand how the resident is likely to feel if a restrictive practice is used. A resident shall not be restricted in a way that causes greater distress than the original problem (as per Section 4.17 Rules: Use of Seclusion – Judgement Support Framework).

4.23 Any intervention employed affecting a resident's liberty shall be the least restrictive and safest intervention to manage the situation and should be in proportion to the risk posed (as per Section 4.13 Regulation 22 Premises & 4.4, 4.20.4 Rules: Use of Seclusion, Section 1.6, 4.4 & 4.5, Rules: Use of Mechanical Restraint – Judgement Support Framework).

4.24 The use of a restrictive practice shall be for as short a time as possible.

4.25 Restrictive practices shall never be to ameliorate operational difficulties such as where staff shortages or defects in the environment.

Decision Making & Capacity to Consent

4.26 The presumption of capacity; every adult shall be presumed to have capacity to make a decision affecting him/her unless the contrary is established (as per Section 1.2 & 4.1 Part 4: Consent to Treatment, Mental Health Act (2001) - Judgement Support Framework).

4.27 If a resident's capacity is in doubt, an assessment shall be carried out and documented. A clear and transparent method of assessing capacity shall be used that promotes the facilitation of people to use the decision making capabilities they have (as per Section 1.2 & 4.5 Part 4: Consent to Treatment, Mental Health Act (2001) - Judgement Support Framework).

4.28 A functional approach to assessing a resident's capacity to make choices regarding his/her treatment within the Approved Centre shall be adopted. This is where the capacity is determined following an 'issue specific' and 'time specific' assessment of a resident's decision-making ability. This approach is related to the resident's ability to make a particular decision at the time it is to be made. The more important the decision, the more thorough the assessment of capacity to make such a decision should be (as per Section 1.2 Part 4: Consent to Treatment, Mental Health Act (2001) - Judgement Support Framework).

4.29 A resident shall be given assistance to make his/her own decisions where possible (as per Section 4.5.4 Part 4: Consent to Treatment, Mental Health Act (2001) and as per Section 4.11 Regulation 20 Provision of Information - Judgement Support Framework).

4.30 Advocacy services shall be made available to residents to facilitate the decision-making process (as per Section 4.11 Regulation 20 Provision of Information – Judgement Support Framework).

4.31 Family and carers shall be involved as advocates for a resident with reduced decision making capacity (as per Section 4.11 Regulation 20 Provision of Information – Judgement Support Framework). However, family, carers and advocates have no automatic legal authority to make decisions on behalf of adults with mental illness and intellectual disabilities.

4.32 The more important the decision, the wider the consultation, where appropriate, on what might be in the resident's best interests.

4.33 Before and act is carried out or the decision made, regard shall be had as to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive to the resident's right and freedom of action.

4.34 A resident shall not be treated as unable to make a decision merely because he/she makes an unwise or

unconventional decision (as per Section 4.1 Part 4: Consent to Treatment, Mental Health Act (2001) - Judgement Support Framework).

Scoring

4: Compliant - Excellent Achievement	1. Defined policies, procedures and protocols for the guidance for persons working with people with intellectual disabilities are available within the Approved Centre. 2. Documented evidence is available of staff awareness of, or training in, the processes relating to the guidance for persons with people with intellectual disabilities. 3. Evidence is available of the processes relating to the guidance of persons working with people with intellectual disabilities, and their related outputs, being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that all, or the vast majority (90-100%), of the requirements relating to the guidance for persons working with people with intellectual disabilities are being implemented as per Section 4 of the Guidance for Compliance.
3: Compliant - Good Achievement	1. Standardised and agreed processes relating to the guidance for persons working with people with intellectual disabilities are being utilised by staff of the Approved Centre, but processes are not formally documented. 2. Documented evidence of staff awareness, or training, in the processes relating to the guidance for persons working with people with intellectual disabilities is available for some staff only / Staff awareness, or training, regarding the processes is completed with all required staff but not formally documented. 3. Some evidence available of the processes relating to the guidance for persons working with people with intellectual disabilities, and their related outputs, being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence available that the majority (51-89%) of the requirements relating to the guidance for persons working with people with intellectual disabilities are being implemented as per Section 4 of the Guidance for Compliance.
2: Non-Compliant - Poor Achievement	1. No defined processes are available in relation to the guidance for persons working with people with intellectual disabilities, with limited evidence available of a standardised process being utilised by staff. 2. Limited evidence is available of staff awareness, or training, in relation to the guidance for persons with people with intellectual disabilities, either documented or informal. 3. Limited evidence available of the processes relating to the guidance for persons working with people with intellectual disabilities, and their related outputs, being monitored or continually reviewed, e.g. via resident record, review, audit, incident reporting, analysis and trending. 4. Evidence is available that a limited number (30-50%) of the requirements relating to the guidance for persons working with people with intellectual disabilities are being implemented as per Section 4 of the Guidance for Compliance.
1: Non-Compliant - Negligible Achievement	1. No standardised processes utilised in relation to the guidance for persons working with people with intellectual disabilities within the Approved Centre. 2. No documented, or undocumented, evidence of staff awareness, or training, in relation to the guidance for persons working with people with intellectual disabilities. 3. No evidence available of the processes relating to the guidance for persons working with people with intellectual disabilities, and their related outputs, being monitored or continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that a negligible number (<30%) of the requirements relating to the guidance for persons working with people with intellectual disabilities are being implemented as per Section 4 of the Guidance for Compliance.

PART 5: CODE OF PRACTICE RELATING TO ADMISSION OF CHILDREN UNDER THE MENTAL HEALTH ACT 2001

Title

Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act 2001 (1st November 2006). Ref:COP-S33)s)/01/2006 &
Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act 2001 Addendum (1st July 2009).

Purpose

The purpose of this Code is to provide guidance on the admission of children to Approved Centres and, where necessary, on the admission of children to an adult unit. For the purpose of the Code, and of this document, a child shall mean a person under the age of 18 years other than a person who is or has been married.

The Code guidance requires that the best interest of the child shall be the principle and overarching consideration in its application. All children admitted to the Approved Centre shall receive care and treatment pursuant to the legal requirements and are involved, consistent with their identified needs and wishes, in the planning, implementation and evaluation of their care and treatment.

The Code of Practice relating to the Admission of Children under the Mental Health Act (2001), and it's supporting Addendum, overlaps with a number of the legal and best practice requirements as reflected in the Judgement Support Framework. Where relevant, the corresponding Judgement Support Framework section is detailed in italics after the Code guidance. Relevant corresponding sections for this Code include:

- Regulation 11 Visits
- Regulation 17: Children's Education
- Regulation 20: Provision of Information to Residents

Guidance for Compliance

1. ***Defined processes in place:*** The Approved Centre shall make available the following policies, procedures and protocols that detail the following:
   - 1.1 The processes for the admission of a child to the Approved Centre, including:
     - 1.1.1 Where admission is voluntary
     - 1.1.2 Where the admission is involuntary
     - 1.1.3 Where the Approved Centre is for adults and is used as a matter of necessity, including:
       - Age-appropriate facilities and a programme of activities;
       - Child provisions;
       - Child protection measures;
       - Continuance of education;
       - Advocacy support available;
       - Visiting arrangements;
       - Notification responsibilities, when children are admitted and discharged from Approved Centres for Adults.
   - 1.2 The process to ensure each child to be individually risk assessed.
   - 1.3 The process to provide care and treatment to residents of the Approved Centre.
   - 1.4 The processes in place for family liaison, parental or guardian consent and resident confidentiality for children for Approved Centres for Audits that admit children.

2. ***Training:*** Relevant staff of the Approved Centre shall be aware, understand and, where required, trained on the policies, procedures and processes relating to the admission of children to the Approved Centre. Training shall be documented.
   - 2.1 Staff shall receive training relating to the care of children.
   - 2.2 Staff shall receive training in applicable legislation and guidelines, including
     - Child Care Act 1991
     - Children Act 2001 and amendment 2006
     - Children First Guidelines, 2011

3. ***Monitoring:*** The Approved Centre shall monitor the processes relating to the admission of children under the 2001 Act. This shall include:
   - 3.1 An annual audit is undertaken to determine compliance to the processes relating to the admission of children under the 2001 Act.
   - 3.2 Incident reports are recorded for non-compliances identified against the ~ processes relating to the admission of children under the 2001 Act.
   - 3.3 Analysis is completed to identify opportunities for improvement in relation to the admission of children under the 2001 Act.

4. ***Evidence of Implementation***

Admission to Approved Centre

- 4.1 In respect of the admission of a child, no child under 18 shall be admitted to an Approved Centre for Adults, unless in exceptional circumstances.
- 4.2 If Approved Centres for Adults are used of necessity the following shall apply:
  - 4.2.1 Age-appropriate facilities and a programme of activities appropriate to age and ability shall be provided.
  - 4.2.2 Provisions shall be in place to:
    - Ensure the safety of the child.
    - Respond to the child's special needs as a young person in an adult setting.
    - Ensure the right of the child to have his/her views heard.
  - 4.2.3 Child protection issues:
    - Staff having contact with the child shall have undergone Garda Síochána / police vetting.
    - Copies of the Child Care Act 1991, Children Act 2001 and amendment 2006, and Children First Guidelines shall be available to relevant staff.
    - Appropriate accommodation shall be designated which should include segregated (age and gender) sleeping and bathroom areas.
    - Staff observation shall acknowledge gender sensitivity. Observation arrangements, including the provision of a designated member of staff, shall be provided as considered clinically appropriate.
  - 4.2.4 Arrangements shall be made for the continuation of the child's education if under 16 years and from 16 – 18 years if in receipt of education prior to admission to in-patient care, as considered clinically appropriate (as per Regulation 17 Children's Education – Judgement Support Framework).
  - 4.2.5 Children shall have access to age-appropriate advocacy services.
  - 4.2.6 Children shall have his/her rights explained and information about the ward and facilities provided in a form and language that can be understood by the child. The clinical file shall record his/her understanding of the explanation given (as per Section 1.9 & 4.3 (4.3.5) Regulation 20 Provision of Information to Residents – Judgement Support Framework).
  - 4.2.7 Advice from the Child and Adolescent Mental Health Service shall be available, when necessary, to the Approved Centre.
  - 4.2.8 Appropriate visiting arrangements for families shall be available, including children (as per Section 1.5, 4.1, 4.4 and 4.5 Regulation 11 Visits – Judgement Support Framework).
  - 4.2.9 The Commission shall be notified of all children admitted to an Approved Centre for Adults within 72 hours of admission and also notified of the discharge of all children from an Approved Centre for Adults within 72 hours of discharge using the associated clinical practice forms, those being:
    - 4.2.9.1 Admission: Notification to the Mental Health Commission of the Admission of a Child to an Adult Unit in an Approved Centre.
    - 4.2.9.2 Discharge: Notification to the Mental Health Commission of the Discharge of a Child to an Adult Unit in an Approved Centre. (see Code of Practice Relating to Admission of Children under the Mental Health Act 2001 Addendum for form templates)

Voluntary Admission of a Child

4.3 In order for treatment to be administered to a child who is a voluntary patient, a valid consent must have been obtained on the child's behalf from one or both parents or guardians.

4.4 The views of 16 and 17 year olds as to their treatment shall be sought as a matter of course.

Voluntary Admission to Involuntary Admission

4.5 A change of status from voluntary to involuntary must be in accordance with Mental Health Act 2001, Section 23(2) and Section 25. The associated Clinical Practice Form shall be completed and retained in the child's clinical file (Mental Health Act 2001 Section 23(2) and 23(3): Power to Detail Voluntary Patient (Child) in an Approved Centre - see Code of Practice Relating to Admission of Children under the Mental Health Act 2001 for form template).

4.6 In changing the child's status, the following shall be considered:

- Best interest
- Risk assessment
- Attempts to encourage the child and parents or guardians to agree to stay voluntary.

Involuntary Admission of a Child

4.7 An application for an involuntary admission of a child shall be made by the HSE under the Mental Health Act 2001, Section 25(1).

Treatment: Voluntary Admission of Children

4.8 Parental or guardian consent shall be required before a child can be treated while admitted as a voluntary patient. The three key components of consent – provision of adequate information, decisional capacity and voluntarism should apply (as per Section 4.7 & 4.9 Part 4: Consent to Treatment – Judgement Support Framework).

4.9 In accordance with the Code of Practice guidance, irrespective of whether a 16 or 17 year old is capable, as a matter of law or fact, of providing an effective consent to treatment, his or her views as to their treatment shall be sought as a matter of course. It will then be a matter for the treating Health Professional to judge the weight (if any) to be accorded to such views in all the circumstances.

Treatment: Involuntary Admission of Children

4.10 A child shall be involuntarily admitted to an Approved Centre for treatment pursuant to Mental Health Act 2001, Section 25 and the provisions of Section 61 is adhered to (as per Section 4.7 & 4.9 Part 4: Consent to Treatment – Judgement Support Framework).

Absence with Leave

4.11 The Consultant Psychiatrist responsible for the care and treatment of a child detained pursuant to a Section 25 order may grant permission in writing to the child to be absent from the Approved Centre for a specified period of time. The permission shall be for a period of less than the unexpired period provided for under the Section 25 order (for example, if there are 10 days of the order remaining the period of absence with leave must be for less than 10 days). The Consultant Psychiatrist shall attach any condition(s) he or she considers appropriate. Any such conditions shall be specified in writing.

4.12 The Consultant Psychiatrist may withdraw permission for absence with leave if he or she is of the opinion that this is in the child's best interests and direct the child in writing to return to the Approved Centre.

Absence without Leave

4.13 Where a child, the subject of a Mental Health Act 2001, Section 25 Order:

4.13.1 leaves an Approved Centre without permission obtained under Mental Health Act 2001, Section 26, or 4.13.2 fails to return to the Approved Centre in accordance with any direction given under Mental Health Act 2001, Section 26 or, on the expiration of the period for which absence or leave was permitted under Section 26, or

4.13.3 fails in the opinion of the Consultant Psychiatrist responsible for the care and treatment of the child to comply with any condition specified in Mental Health Act 2001, Section 26, the Clinical Director of the Approved Centre concerned shall arrange for members of staff of the Approved Centre to bring the child back to the Approved Centre. If they are unable to do so, and the Clinical

Director is of the opinion that there is a serious likelihood of the child concerned causing immediate and serious harm to himself/herself or the other persons, the Clinical Director or Consultant Psychiatrist acting on his/her behalf may, if necessary, shall request the Garda Síochána to assist the members of the staff of the Approved Centre in the removal of the person to that Approved Centre and the Garda Síochána shall comply with any such request. The HSE and the child's parent(s) or guardian(s) shall be immediately notified if the child absconds.

Scoring

4: Compliant - Excellent Achievement	1. Defined policies, procedures and processes for the admission of children under the 2001 Act are available within the Approved Centre. 2. Documented evidence is available of staff awareness of, or training in, the processes relating to the admission of children under the 2001 Act. 3. Evidence is available of the admission of children under the 2001 Act processes, and the related outputs, being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that all, or the vast majority (90-100%), of the admission of children under the 2001 Act requirements are being implemented as per Section 4 of the Guidance for Compliance.
3: Compliant - Good Achievement	1. Standardised and agreed processes relating to the admission of children under the 2001 Act are being utilised by staff of the Approved Centre, but processes are not formally documented. 2. Documented evidence of staff awareness, or training, in relation to the admission of children under the 2001 Act processes is available for some staff only / Staff awareness, or training, regarding the processes is completed with all required staff but not formally documented. 3. Some evidence available of the admission of children under the 2001 Act processes, and the related outputs, are being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that the majority (51-89%) of the admission of children under the 2001 Act requirements are being implemented as per Section 4 of the Guidance for Compliance.
2: Non-Compliant - Poor Achievement	1. No defined processes are available in relation to the admission of children under the 2001 Act, with limited evidence available of a standardised process being utilised by staff. 2. Limited evidence is available of staff awareness, or training, in relation to the admission of children under the 2001 Act processes, either documented or informal. 3. Limited evidence available of the admission of children under the 2001 Act processes, or the related outputs, being monitored and continually reviewed, e.g. via resident record, review, audit, incident reporting, analysis and trending. 4. Evidence is available that a limited number (30-50%) of the admission of children under the 2001 Act requirements are being implemented as per Section 4 of the Guidance for Compliance.
1: Non-Compliant - Negligible Achievement	1. No standardised processes are utilised in relation to the admission of children under the 2001 Act within the Approved Centre. 2. No documented, or undocumented, evidence of staff awareness, or training, in relation to the admission of children under the 2001 Act. 3. No evidence available of the admission of children under the 2001 Act processes, or the related outputs, being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that a negligible number (<30%) of the admission of children under the 2001 Act requirements are being implemented as per Section 4 of the Guidance for Compliance.

PART 6: CODE OF PRACTICE ON THE USE OF ELECTRO-CONVULSIVE THERAPY FOR VOLUNTARY PATIENTS

Title

Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients Issued Pursuant to Section 33(3)(e) of the Mental Health Act, 2001 (October 2009).

Purpose

This Code is intended as guidance for individuals working in Approved Centres, and in particular for staff involved in Electro-convulsive therapy (ECT) to voluntary patients. The Code's intention is to provide practical guidance to relevant Health Professionals on the delivery of ECT, addressing areas as consent, information provision, administration and resources. The purpose of the Code is to ensure that the rights of the voluntary patient are respected and that the Approved Centre provides voluntary patients with ECT in a safe and appropriate environment.

Guidance for Compliance

1. ***Defined processes in place:*** Policies and procedures are available within the Approved Centre in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policies and procedures shall include:
   - 1.1 The roles and responsibilities and authorities in relation to the use of ECT.
   - 1.2 The provision of information to a voluntary patient regarding the use of ECT to a voluntary patient.
   - 1.3 The process to assess the voluntary patient's capacity to consent to ECT.
   - 1.4 The process to receive voluntary patient's consent to ECT, with consideration of the requirements detailed in Part 4, section 59 of the Mental Health Act, 2001.
   - 1.5 The process to be applied where the voluntary patient is unable or unwilling to consent to ECT.
   - 1.6 The requirements for the formal identification of the voluntary patient prior to ECT.
   - 1.7 The voluntary patient observation requirements during ECT.
   - 1.8 The medical review requirements for voluntary patients during ECT.
   - 1.9 The voluntary patients record requirements for ECT.
   - 1.10 The ECT Register requirements.
   - 1.11 The processes for the management of:
     - Cardiac arrest;
     - Anaphylaxis;
     - Malignant hypothermia.
   - 1.12 The processes for the storage of dantrolene and sterile water, where available.
   - 1.13 The required ECT suite facilities.
   - 1.14 The maintenance and service programme in place for ECT machines.
   - 1.15 The storage and checking requirements for resuscitation and emergency drugs by the ECT nurse.
   - 1.16 The required staff training on ECT.
   - 1.17 The external reporting requirements in relation to the use of ECT.

2. ***Training:*** Relevant staff of the Approved Centre shall be aware, understand and, where required, trained on the policies, procedures, protocols and processes relating to use of ECT for voluntary patients. All training will be documented.
   - 2.1 For staff involved in the use of ECT, stating they have read and understood the policy on the use of ECT.
   - 2.2 Designated ECT nursing staff are appropriately trained and competent to fulfil their role in the provision of ECT.
   - 2.3 All Registered Nurses involved in the administration of ECT treatment shall be trained in Basic Life Support (BLS).

3. ***Monitoring:*** The Approved Centre shall monitor the policies and procedures, processes and outputs relating to the use of Electro-Convulsive Therapy for voluntary patients. This shall include:
   - 3.1 Regular ECT audits are scheduled, conducted and reported by

appropriately trained auditors.

3.2 An annual audit shall be undertaken to determine compliance to the ECT policies and procedures and associated processes.

3.3 Incident reports shall be recorded for non-compliances identified in relation to the ECT processes or where issues arise during the provision of ECT.

3.4 Analysis shall be completed to identify opportunities for improvement in relation to the use of ECT for voluntary patients.

4. Evidence of Implementation

Consent

4.1 ECT shall only be administered to a voluntary patient following his/her consent.

4.2 A voluntary patient shall be considered capable of giving informed consent for ECT, including anaesthesia, unless there is evidence to the contrary.

4.3 The Consultant Psychiatrist responsible for the care and treatment of the voluntary patient shall be satisfied that the voluntary patient has capacity to provide consent before he or she obtains consent for a programme of ECT, including anaesthesia, from the voluntary patient.

4.4 Capacity to consent shall ensure that the voluntary patient can:

- Understand the nature of ECT;
- Understand why ECT is being proposed;
- Understand the benefits, risks and alternatives to receiving ECT;
- Understand and believe the broad consequences of not receiving ECT;
- Retain the information long enough to make a decision to receive or not receive ECT;
- Make a free choice to receive or refuse ECT;
- Communicate the decision to consent to ECT.

4.5 A written record of assessments of capacity to consent to ECT shall be kept in the voluntary patient's clinical file.

4.6 Consent shall be voluntary, therefore a voluntary patient shall be aware that he/she can refuse to give consent or withdraw consent for ECT at any time.

4.7 No relative, carer or guardian shall give consent for ECT on behalf of the voluntary patient.

4.8 Consent shall not be obtained through coercion or threats.

4.9 Consent for each programme of ECT, including anaesthesia, shall be obtained in written form. Consent shall also be obtained in writing for each ECT treatment session, including anaesthesia. It shall be obtained by a Registered Medical Practitioner under the supervision of the Consultant Psychiatrist responsible for the care of the voluntary patient prior to each ECT treatment session. It shall be recorded in the voluntary patient's clinical file.

4.10 The consent form for ECT shall include, as a minimum, all the particulars included in the Consent Form for ECT Programme (in accordance to Appendix 1:Consent Form for ECT Programme, Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients).

4.11 Specific consent for maintenance/ continuation ECT shall be obtained and renewed after 6 months.

Information

4.12 Appropriate information about ECT shall be given to the voluntary patient by the Consultant Psychiatrist responsible for the care and treatment of the voluntary patient to enable him/ her to give informed consent.
Information shall include the following:

- The nature of the treatment of ECT;
- Description of process of ECT;
- Purpose of treatment with ECT;
- Intended benefits of treatment with ECT;
- Possible consequences of not having ECT;
- Treatment alternatives to ECT;
- Confirmation that the voluntary patient will be offered alternative treatment to ECT if he/she decides to withhold consent.

4.13 Information shall also be provided on the likely adverse effects of ECT, including the risk of cognitive impairment and the risk of amnesia and other potential side effects.

4.14 Information shall be provided in both oral and written forms.

4.15 Information shall be clearly and simply written.

4.16 Information shall be available in languages other than English if necessary and/or an interpreter provided including Irish sign langue interpreters for any voluntary patient who is deaf.

4.17 Subject to the urgency of the clinical circumstances, the voluntary patient shall be given at least 24 hours to reflect on the information, should he or she wish.
4.18 The voluntary patient shall be informed that he/she may have access to an advocate of his/her choosing at any stage.
4.19 The voluntary patient shall be given an opportunity to raise questions and these questions shall be answered. A record of these discussions shall be maintained in the voluntary patient's clinical file.

Prescription of ECT

4.20 A programme of ECT shall only be prescribed by the Consultant Psychiatrist responsible for the care and the treatment of the voluntary patient.
4.21 The Consultant Psychiatrist responsible for the care and the treatment of the voluntary patient shall record the decision to prescribe ECT in the voluntary patient's clinical file.
The record shall include:
4.21.1 The reason for the decision to use ECT;
4.21.2 Alternative therapies that have been considered or proved ineffective;
4.21.3 Documentation of the discussion with the voluntary patient, and, where appropriate, the voluntary patient's next of kin or representative; and
4.21.4 Current mental state examination.
4.22 The initial stimulus dose of electricity to be delivered to each voluntary patient shall be discussed and considered by the treating Consultant Psychiatrist and the Consultant Psychiatrist responsible for the administration of ECT in advance of ECT and prescribed accordingly.

Assessment of Voluntary Patient

4.23 A cognitive assessment shall be completed for the voluntary patient before each programme of ECT.
4.24 The voluntary patient's clinical status shall be assessed before and following each ECT treatment session.
4.25 The voluntary patient's cognitive functioning shall be monitored on an ongoing basis throughout the programme of ECT.
4.26 A cognitive assessment shall be completed for the voluntary patient after each programme of ECT.
4.27 The Consultant Psychiatrist in consultation with the voluntary patient shall review the voluntary patient's progress and the need for continuation of the programme of ECT. In the event of a programme of ECT being terminated, reasons for this termination shall be documented in the voluntary patient's clinical file.

Anaesthesia

4.28 Anaesthesia for ECT shall be given by an Anaesthetist who has experience in providing anaesthesia for ECT. Where the Anaesthetist is not a Consultant Anaesthetist, he or she shall be under the supervision of a Consultant Anaesthetist.
4.29 Formal identification of the voluntary patient shall be confirmed to the Anaesthetist.
4.30 The Anaesthetist shall ensure that a pre-anaesthetic assessment has been carried out and recorded in the voluntary patient's clinical file. The assessment shall include the following:
4.30.1 A detailed medical history and a full physical examination shall be performed before ECT and recorded.
4.30.2 Any physical problem shall be recorded and the Anaesthetist notified.
4.30.3 A detailed medication history, including allergies or previous anaesthetic difficulties shall be taken and recorded.
4.30.4 The presence or absence of dental problems and/or dentures shall be noted.
4.30.5 The length of time the voluntary patient has been fasting shall be recorded.
4.30.6 Investigations such as full blood count, urea and electrolytes, urine testing for blood glucose and protein shall be performed. Voluntary patients at risk for sickle-cell anaemia shall have blood tests for this condition.
4.30.7 An ECG for voluntary patients with cardiovascular disease or who have risk factors for cardiovascular disease shall be performed.
4.30.8 A chest X-Ray will be required if the voluntary patient has cardio-respiratory problems.
4.30.9 Any other relevant information.
4.31 The anaesthetic risk of the voluntary patient shall be assessed by the Anaesthetist and recorded in the

voluntary patient's clinical file. Any variation in the ASA grade of the voluntary patient shall be recorded before the ECT treatment session.

4.32 The designated ECT nurse shall be responsible for checking that the pre-anaesthetic assessment is completed and made available to the anaesthetist.

4.33 The voluntary patient's consent form, clinical file, medication prescription chart and record of administered drugs shall be made available to the Anaesthetist.

4.34 The anaesthetic induction agent used for the voluntary patient shall remain consistent throughout the duration of his/her programme of ECT unless such an approach is contraindicated.

4.35 The doses of all anaesthetic agents used, the voluntary patient's response and the monitor recordings before and immediately after treatment and recovery shall be recorded, dated and the record signed by the Anaesthetist.

Administration of ECT

4.36 ECT shall be administered by a constant current, brief pulse ECT machine capable of delivering a wide range of electrical dose, from 25 millicoulombs to 1000 millicoulombs or more.

4.37 ECT shall be administered to a voluntary patient using the same ECT machine throughout his/her programme of ECT, unless in exceptional circumstances. Where the same machine is not used, the rationale for this shall be clearly documented in the voluntary patient's clinical file.

4.38 There shall be a facility for EEG monitoring on two channels.

4.39 All machines shall have a regular programme of maintenance and service. Records of maintenance shall be kept safe by the approved centre and confirmation of the service shall be identifiable from the machine, as is appropriate.

4.40 Stimulus dosing or using recommended starting dose regimes (per age/sex) as per the Royal College of Psychiatrists' Guidelines shall be used and recorded in the ECT record.

ECT Suite

4.41 ECT shall only be carried out in a dedicated ECT suite in an Approved Centre or where deemed appropriate, in a specified location in a critical care area in a general hospital or maternity hospital.

4.42 An ECT suite shall have a private waiting area, an adequately equipped treatment room and an adequately equipped recovery room.

4.43 High risk voluntary patients shall be treated in an environment allowing rapid intervention should complications occur, for example, a theatre suite or its recovery area.

4.44 The recovery room shall be of sufficient size to accommodate the number of people receiving ECT at each treatment session.

Materials and Equipment

4.45 Protocols relating to the management of cardiac arrest, anaphylaxis and malignant hyperthermia shall be prominently displayed.

4.46 If nitrous oxide is ever used, then the treatment room shall be equipped with scavenging equipment.

4.47 There shall be one tipping trolley or bed, with cot sides, per voluntary patient which can comfortably accommodate a reclining adult, with braked wheels and which can rapidly be tipped into a head down position.

4.48 There shall be a fully equipped emergency trolley with adequate resuscitation equipment including a defibrillator.

4.49 There shall be means of measuring temperature, blood pressure, oxygen saturation, ECG and end-tidal carbon dioxide.

4.50 Provision shall be made for positive pressure respiration: oxygen cylinder, mask and self-inflating bag and at least one full spare cylinder in both the treatment and recovery areas.

4.51 There shall be two suction machines, one in the treatment room and one in the recovery room.

4.52 The following drugs shall be available in the ECT suite:
- An anaesthetic induction agent;
- A neuro-muscular blocking agent; and
- Oxygen.

4.53 There shall be a standard tray of drugs for use in the event of cardiac arrest. The emergency tray shall contain drugs and equipment agreed with the local pharmacy or resuscitation committee.

4.54 Dantrolene and sterile water shall be available. These shall be stored under the direction of the Anaesthetist. Where

Dantrolene and sterile water are stored, the relevant protocol shall be available in the ECT suite.

Staffing

4.55 There shall be a named Consultant Psychiatrist with overall responsibility for the management of ECT.

4.56 ECT shall only be administered by a Registered Medical Practitioner. Where the Registered Medical Practitioner is not a Consultant Psychiatrist, he or she shall be under the supervision of a Consultant Psychiatrist.

4.57 There shall be a named Consultant Anaesthetist with overall responsibility for anaesthesia.

4.58 An anaesthetic shall only be administered by an Anaesthetist. Where the Anaesthetist is not a Consultant Anaesthetist, he or she shall be under the supervision of a Consultant Anaesthetist.

4.59 The Anaesthetist shall have responsibility for anaesthesia and recovery of the voluntary patient. He/she shall be satisfied that the voluntary patient is fully recovered prior to leaving the ECT suite.

4.60 There shall be a minimum number of two registered nursing staff in the ECT suite at all times to safely meet the needs of voluntary patients, one of whom shall be trained in ECT and shall be known as "a designated ECT nurse".

4.61 The designated ECT nurse is responsible for ensuring that before each ECT treatment session, emergency resuscitation equipment is tested and checked in the ECT suite, and the emergency drugs tray has been recently checked and stocked. All such checks shall be recorded.

4.62 The designated ECT nurse shall be in the treatment room while ECT is being administered.

Documentation

4.63 The ECT Register shall be completed for the voluntary patient on conclusion of a programme of ECT and a copy filed in the voluntary patient's clinical file (in accordance to Appendix 2: ECT Register, Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients). A copy of the form shall be made accessible to the Inspector or Mental Health Services and/or the Mental Health Commission upon request.

4.64 Pre-ECT assessments (capacity to consent, consent, pre-anaesthetic assessment, anaesthetic risk, mental state) shall be completed and filed in the voluntary patient's clinical file.

4.65 A record of ECT shall be completed after each ECT treatment session and filed in the voluntary patient's clinical file. The record shall include:

- Session Number;
- Laterality;
- Dose (set and received);
- Duration and quality of seizure;
- Any/all complications experienced; and
- Signature of registered medical practitioner(s) administering ECT.

4.66 A record of anaesthesia shall be completed after each ECT session and filed in the voluntary patient's clinical file.

4.67 Post-ECT assessments (clinical status, voluntary patient progress) shall be recorded after each ECT treatment session in the voluntary patient's clinical file. Reasons for continuing or discontinuing further ECT shall be outlined. Any adverse events during or following ECT shall be addressed in full and recorded.

4.68 A copy of all cognitive assessments that are completed shall be filed in the voluntary patient's clinical file.

ECT During Pregnancy

4.69 All pregnant voluntary patients shall be assessed by an obstetrician prior to receiving ECT.

4.70 Facilities administering ECT to pregnant voluntary patients shall have resources for managing obstetric and neonatal emergencies.

4.71 If foetal gestation age is past first trimester, foetal monitoring shall be required.

Scoring

4: Compliant - Excellent Achievement	1. Defined processes for the use of ECT for voluntary patients are available within the Approved Centre. 2. Documented evidence is available of staff awareness of, or training in, the processes relating to the use of ECT for voluntary patients. 3. Evidence is available of the processes relating to the use of ECT for voluntary patient, and the related outputs, being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that all, or the vast majority (90-100%) of the requirements relating to the use of ECT for voluntary patients are being implemented as per Section 4 of the Guidance for Compliance.
3: Compliant - Good Achievement	1. Standardised and agreed processes relating to the use of ECT for voluntary patients are being utilised by staff of the Approved Centre, but the processes are not formally documented. 2. Documented evidence of staff awareness, or training, is available for some staff only in relation to the use of ECT for voluntary patients / Staff awareness, or training, regarding the processes is completed with all required staff but not formally documented. 3. Some evidence is available of the processes, and the related outputs, relating to the use of ECT for voluntary patients are being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence available that the majority (51-89%) of the requirements relating to the use of ECT for voluntary patients are being implemented as per Section 4 of the Guidance for Compliance.
2: Non-Compliant - Poor Achievement	1. No defined processes are available in relation to the use of ECT for voluntary patients, with limited evidence available of a standardised process being utilised by staff. 2. Limited evidence is available of staff awareness, or training, in relation to the use of ECT for voluntary patients, either documented or informal. 3. Limited evidence available of the processes, or the related outputs, relating to the use of ECT for voluntary patients being monitored and continually reviewed, e.g. via resident record, review, audit, incident reporting, analysis and trending. 4. Evidence is available that a limited number (30-50%) of the requirements relating to the use of ECT for voluntary patients are being implemented as per Section 4 of the Guidance for Compliance.
1: Non-Compliant - Negligible Achievement	1. No standardised processes utilised in relation to the use of ECT for voluntary patients within the Approved Centre. 2. No documented, or undocumented, evidence of staff awareness, or training, in relation to the use of ECT for voluntary patients. 3. No evidence available of the processes, or the related outputs, in relating to the use of ECT for voluntary patients are being monitored or continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that a negligible number (<30%) of the requirements relating to the use of ECT for voluntary patients are being implemented as per Section 4 of the Guidance for Compliance.

PART 7: CODE OF PRACTICE ON THE USE OF PHYSICAL RESTRAINT IN APPROVED CENTRES

Title

Mental Health Commission Code of Practice on the use of Physical Restraint in Approved Centres Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001 (October 2009)

Purpose

The Code is intended as guidance for staff involved in the use of physical restraint in Approved Centres. It provides clarification on how physical restraint practices should be used in an Approved Centre for the purpose of treatment or to prevent a resident from injuring themselves or others.

Guidance for Compliance

1. ***Defined processes in place:*** Policies and procedures shall be available within the Approved Centre in relation to the use of physical restraint. The policies and procedures shall address the following:
   - 1.1 The training requirements in relation to physical restraint, including:
     - 1.1.1 identification of who will receive training based on the identified needs of residents and staff;
     - 1.1.2 the areas to be added within the training programme;
     - 1.1.3 the required frequency of training;
     - 1.1.4 identifying appropriately qualified person(s) to give the training;
     - 1.1.5 the mandatory nature of training for those involved in physical restraint;
     - 1.1.6 where appropriate, the training requirements for staff in relation to child protection.
   - 1.2 The provision of information to the resident.
   - 1.3 Who may initiate and who may carry out physical restraint.
   - 1.4 Where appropriate, the child protection processes in place where staff physically restrain a child. These shall be in line with relevant legislation and regulations.

2. ***Training:***
   - 2.1 All health professionals working in an Approved Centre are familiar with the content of the physical restraint policies and procedures and adhere to the processes outlined in them.
   - 2.2 The physical restraint staff training programme shall be provided by appropriately qualified individuals and shall include:
     - 2.2.1 The use of physical restraint involving residents in the "prone" down" position.
     - 2.2.2 The prevention and management of violence (including "breakaway" techniques)
     - 2.2.3 The alternatives to physical restraint;
   - 2.3 A record of attendance at training shall be maintained.
   - 2.4 There shall be a written record that all staff involved in physical restraint have read and understand the policies and procedures relating to physical restraint. The record relating to staff training shall be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

3. ***Monitoring:*** The Approved Centre shall monitor the processes relating to the use of physical restraint. This shall include:
   - 3.1 An annual audit shall be undertaken to determine compliance to the physical restraint policies and procedures to ensure they are being fully and effectively implemented and adhered to in clinical practice.
   - 3.2 An Approved Centre shall review its policy and procedure on the use of physical restraint as required but at minimum on an annual basis.
   - 3.3 Incident reports shall be recorded for non-compliances identified in relation to the processes for the use of physical restraint.

3.4 Analysis shall be completed to identify opportunities for improvement to the physical restraint processes.
3.5 All information gathered by the Approved Centre regarding the use of physical restraint shall be used to compile an annual report on the use of physical restraint. This report shall be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

4. Evidence of Implementation:

Principles Underpinning the Use of Physical Restraint

4.1 Physical restraint shall be used in rare and exceptional circumstances and only in the best interests of the resident when he/she poses an immediate threat of serious harm to self or others.
4.2 Physical restraint shall only be used after all alternatives interventions to manage the resident's unsafe behaviour have been considered.
4.3 Physical restraint shall not be prolonged beyond the period which is strictly necessary to prevent immediate and serious harm to the resident or others.
4.4 The use of physical restraint shall be proportional and minimal force shall be applied.
4.5 Physical restraint shall be used in a professional manner and shall be based within an ethical and legal framework.
4.6 Physical restraint shall be used in settings where the safety of residents, staff and visitors are regarded as being essential and equal.
4.7 The use of physical restraint shall be based on a risk assessment.
4.8 The use of physical restraint shall be based on best available evidence and contemporary practice.
4.9 Cultural awareness and gender sensitivity shall be demonstrated when considering the use of and when using physical restraint.

Orders for Physical Restraint

4.10 Physical restraint shall only be initiated and ordered by Registered Medical Practitioners, Registered Nurses or other members of the Multidisciplinary Care Team in accordance with the Approved Centre's policy and procedure on physical restraint.
4.11 A designated member of staff shall be responsible for leading the physical restraint of a resident and for monitoring the head and airway of the resident.
4.12 The Consultant Psychiatrist responsible for the care and treatment of the resident or the duty Consultant Psychiatrist shall be notified by the person who initiated the use of physical restraint as soon as is practicable and this shall be recorded in the residents' clinical file.
4.13 As soon as is practicable, and no later than 3 hours after the start of an episode of physical restraint, a medical examination of the resident by a Registered Medical Practitioner shall take place.
4.14 An order of physical restraint shall last for a maximum of 30 minutes.
4.15 An episode of physical restraint may be extended by a renewal order made by a Registered Medical Practitioner following an examination, for a further period not exceeding 30 minutes.
4.16 The episode of physical restraint shall be recorded in the resident's clinical file.
4.17 The relevant section of the Clinical Practice Form for Physical Restraint (in accordance to Appendix 2 of the Code of Practice on the use of Physical Restraint in Approved Centres) shall be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than 3 hours after the episode of physical restraint.
4.18 The clinical practice for physical restraint shall also be signed by the Consultant Psychiatrist responsible for the care and treatment of the resident or the duty Consultant Psychiatrist as soon as is practicable and in any event within 24 hours.
4.19 The resident shall be informed of the reasons for, likely duration of and the circumstances which will lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial to the resident's mental health, wellbeing or emotional condition. In the event that this communication does not occur, a record explaining why it has not occurred shall be entered in the resident's clinical file.
4.20 As soon as is practicable, and with the resident's consent or where the resident lacks capacity and cannot consent, the resident's next of kin or representative shall be informed of the resident's

restraint and a record of this communication shall be placed in the resident's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred shall be entered in the resident's clinical file.

4.21 Where a resident has capacity, and does not consent to informing his or her next of kin or representative of his or her restraint, no such communication shall occur outside the course of that necessary to fulfil legal and professional requirements. This shall be recorded in the resident's clinical file.

Resident Dignity & Safety

4.22 Staff involved in the use of physical restraint shall be aware of, and have considered, any relevant entries in the resident's care and treatment plan, pertaining to his or her specific requirements/needs in relation to the use of physical restraint. This may include "advance directives".

4.23 Special consideration shall be given when restraining a resident who is known, by the staff involved in restraining him/her, to have experienced physical or sexual abuse.

4.24 Where practicable, the resident shall have a same sex member of staff present at all times during the episode of physical restraint.

4.25 The resident shall be continually assessed throughout the use of restraint to ensure his/her safety.

4.26 The use of holds intended to deliberately inflict pain shall be prohibited.

4.27 The following shall be avoided:

4.20.1 Neck holds;

4.20.2 The application of heavy weight to the resident's chest or back.

4.28 Limited use of physical restraint involving the resident in the "prone", face down position shall be permitted in exceptional circumstances by staff who have received appropriate training. A record of the use of prone restraints shall be entered in the resident's clinical file.

Ending the Use of Physical Restraint

4.29 The use of physical restraint may be ended at any time by the person responsible for leading the physical restraint of the resident and monitoring the head and airway of the resident.

4.30 Following physical restraint, the resident concerned shall be afforded the opportunity to discuss the episode with members of the Multidisciplinary Team involved in his or her care and treatment as soon as is practicable.

Recording the Use of Physical Restraint:

4.31 All uses of physical restraints shall be clearly recorded in the resident's clinical file.

4.32 All uses of physical restraint shall be clearly recorded on the Clinical Practice Form for Physical Restraint (in accordance to Appendix 2 of the Code of Practice on the use of Physical Restraint in Approved Centres).

4.33 The completed form shall be placed in the resident's clinical file and a copy shall be available to the Inspector of Mental Health Services and/or the Mental Health Commission on request.

Clinical Governance:

4.34 Physical restraint shall never be used to ameliorate operational difficulties including where there are staff shortages.

4.35 Each episode of physical restraint shall be reviewed by members of the Multidisciplinary Team involved in the resident's care and treatment and documented in the residents clinical file as soon as is practicable and in any event no later than 2 normal working days (i.e. days other than Saturday/ Sunday and bank holidays) after the episode of restraint.

Child Residents:

4.36 An Approved Centre physically restraining a child shall ensure the child's parent or guardian is informed as soon as possible of the child's physical restraint.

Scoring

4: Compliant - Excellent Achievement	1. Defined processes are available in relation to the use of physical restraint of residents within the Approved Centre. 2. Documented evidence is available of staff awareness of, or training in, the processes relating to the use of physical restraint of residents. 3. Evidence is available of the processes relating to the use of physical restraint of residents, and the related outputs, are being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence is available that all, or the vast majority (90-100%), of the requirements relating to the use of physical restraint of residents are being implemented as per Section 4 of the Guidance for Compliance.
3: Compliant - Good Achievement	1. Standardised and agreed of processes relating to the use of physical restraint of residents are being utilised by staff of the Approved Centre, but processes are not formally documented. 2. Documented evidence of staff awareness, or training, in relation to the use of physical restraint of residents is available for some staff only / Staff awareness, or training, regarding the processes is completed with all required staff but not formally documented. 3. Some evidence available of the processes relating to the use of physical restraint of residents, and the related outputs, are being monitored and continually reviewed, e.g. via resident record review, audit, incident reporting, analysis and trending. 4. Evidence available that the majority (51-89%) of the requirements relating to the use of physical restraint of residents are being implemented as per Section 4 of the Guidance for Compliance.
2: Non-Compliant - Poor Achievement	1. No defined processes are available in relation to the use of physical restraint of residents, with limited evidence available of standardised processes being utilised by staff. 2. Limited evidence is available of staff awareness, or training, in relation to the use of physical restraint of residents, either documented or informal. 3. Limited evidence available of the processes relating to the use of physical restraint of residents, or the related outputs, are being monitored or continually reviewed, e.g. via resident record, review, audit, incident reporting, analysis and trending. 4. Evidence is available that a limited number (30-50%) of the requirements relating to the use of physical restraint of residents are being implemented as per Section 4 of the Guidance for Compliance.
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APPENDICES

Appendix A: List of Serious Reportable Events (SRE) – To be reported within 48 hours.

NOTES

Mental Health Commission

Mental Health Commission
Coimisiún Meabhair-Shláinte
St. Martin's House,
Waterloo Road,
Dublin 4

Tel: +353 1 6362400
Fax: +353 1 6362440
Email: info@mhcirl.ie
Website: www.mhcirl.ie

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