Contents

Introduction ......................................................................................................................... 6
Purpose ............................................................................................................................... 6
Background ......................................................................................................................... 6
Structure of the Framework ................................................................................................. 6
Rules and Codes of Practice ............................................................................................... 6
Inspection process ............................................................................................................. 6
Scoring and assessment ..................................................................................................... 7
Risk level of non-compliance ............................................................................................ 7
Inspection report ............................................................................................................... 7
Our Values ......................................................................................................................... 8
Our Vision ........................................................................................................................ 8
Our Mission ....................................................................................................................... 8
Disclaimer ........................................................................................................................ 8
Regulation 4: Identification of Residents ........................................................................... 9
Regulation 5: Food and Nutrition ....................................................................................... 9
Regulation 6: Food Safety .................................................................................................. 11
Regulation 7: Clothing ....................................................................................................... 13
Regulation 8: Residents’ Personal Property and Possessions ........................................... 15
Regulation 9: Recreational Activities ................................................................................ 17
Regulation 10: Religion ..................................................................................................... 19
Regulation 11: Visits ......................................................................................................... 21
Regulation 12: Communication ........................................................................................ 23
Regulation 13: Searches ................................................................................................... 25
Regulation 14: Care of the Dying ...................................................................................... 27
Regulation 15: Individual Care Plan .................................................................................. 29
Regulation 16: Therapeutic Services and Programmes ...................................................... 31
Regulation 17: Children’s Education ................................................................................ 33
Regulation 18: Transfer of Residents ............................................................................... 35
Regulation 19: General Health ......................................................................................... 37
Regulation 20: Provision of Information to Residents ....................................................... 40
Regulation 21: Privacy ...................................................................................................... 42
Regulation 22: Premises .................................................................................................. 44
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines ............ 47
Regulation 24: Health and Safety ...................................................................................... 51
Regulation 25: Use of Closed Circuit Television .............................................................. 53
Regulation 26: Staffing ..................................................................................................... 55
Regulation 27: Maintenance of Records.................................................................58
Regulation 28: Register of Residents ......................................................................61
Regulation 29: Operating Policies and Procedures.........................................................62
Regulation 30: Mental Health Tribunals ....................................................................65
Regulation 31: Complaints Procedures .....................................................................67
Regulation 32: Risk Management Procedures .............................................................70
Regulation 33: Insurance ..........................................................................................73
Regulation 34 Certificate of Registration ..................................................................74
Part 4 of the Mental Health Act 2001: Consent to Treatment .....................................75
Introduction

Purpose

The Judgement Support Framework (“the Framework”) has been developed as a guidance document to assist approved centres to comply with the Mental Health Act 2001 (Approved Centre) Regulations 2006 (“the Regulations”). The Framework also promotes the continuous improvement of the quality of services provided to residents of approved centres.

The introduction to the Framework provides information on: the scope of the Framework; the inspection process; compliance ratings; the inspection report; corrective and preventative action plans (CAPAs), and enforcement actions.

Background

The Framework was first published in July 2015. A major review was conducted at the end of 2015, and minor and technical reviews in October 2015, December 2016 and December 2017.

The scope of the latest minor and technical review was to correct errors, address duplications and clarify points of ambiguity.

The date of commencement of the revised Framework is 12 February 2018.

Structure of the Framework

The Framework provides detailed guidance to assist approved centres to comply with regulatory requirements and to improve the quality of services provided to residents. For each regulation, the Framework sets out the following: the purpose of the regulation; the processes and training that should be in place to support the regulation; the monitoring requirements to ensure the regulation is being implemented appropriately; and the type of evidence that should be available to the Inspector of Mental Health Services (“the Inspector”).

PURPOSE: This section details the primary reason for implementing the regulation.

PROCESSES: This section details supports and systems in place to ensure the consistent implementation of the regulation e.g. policies, protocols and procedures.

TRAINING AND EDUCATION: This section details the staff training and education requirements in place to ensure relevant staff understand the processes needed to implement the regulation. The service should identify who is a ‘relevant person’ for each regulation based on their discipline, role and activities.

MONITORING: This section details the way the approved centre monitors and measures the implementation of the regulation and identifies opportunities for improvement e.g. review, audit and analysis.

EVIDENCE OF IMPLEMENTATION: This section details the evidence that should be available to the Inspector, illustrating that the approved centre is effectively implementing the relevant regulation.

The Framework also includes guidance on attaining compliance with Part 4 of the Mental Health Act 2001: Consent to Treatment.

Rules and Codes of Practice

The Framework does not cover any rules or codes of practice made under the Mental Health Act 2001 (“the Act”). The rules and codes of practice will be inspected against during inspection and should be referred to directly for guidance.

The rules and codes of practice will be assessed for compliance against all of the requirements of the relevant rule or code; as the requirements are set out exhaustively, the Inspector will not undertake a separate quality assessment.

Inspection process

The Inspector will look for evidence of implementation with each regulation, rule, code of practice and Part 4 of the Act (together referred to as “the legislative requirements”), through the following:
• Documentary evidence, including the examination of policies, protocols, meeting minutes, training logs, complaints logs, risk register(s), clinical files and individual care plans;
• Interviews with staff and residents; and
• Observations of the premises, facilities and operational practices in the approved centre.

Scoring and assessment

COMPLIANCE

Compliance is assessed against the strict wording of the legislative requirements. The ‘Evidence of Implementation’ sections provide guidance on the interpretation of the regulations.

An approved centre will not be found non-compliant with a regulation where they have failed to meet a point in the Framework which is not a strict requirement of the relevant regulation.

QUALITY ASSESSMENT

The Inspector will also assess the quality of services provided against the requirements of the Framework.

The Inspector will assess whether the approved centre has the appropriate systems and structures in place to support the implementation and purpose of the regulation.

For each regulation, the following criteria are used to determine whether an approved centre is:

• Compliant – Excellent achievement;
• Compliant – Satisfactory;
• Non-compliant – Needs improvement; or
• Non-compliant – Inadequate.

Compliant – Excellent achievement

The approved centre complies with all aspects of the regulation and there is evidence of the following:

• An up-to-date written policy on the processes relating to the regulation;
• Staff training as detailed under the Training and Education section;
• Ongoing monitoring as detailed under the Monitoring section; and
• All points under the Evidence of Implementation section, as applicable.

Compliant – Satisfactory

The approved centre complies with all aspects of the regulation.

Non-compliant – Needs improvement

The approved centre does not comply with all aspects of the regulation.

Non-compliant – Inadequate

The approved centre does not comply with all aspects of the regulation and there is evidence (or a lack thereof) of the following:

• No written up-to-date policy on the processes relating to the regulation;
• No staff training as detailed under the Training and Education section;
• No monitoring as detailed under the Monitoring section; and
• The approved centre has not met applicable requirements under the Evidence of Implementation section.

Risk level of non-compliance

When an approved centre has been found to be non-compliant with a regulation, the risk of the non-compliance is assessed by the Inspector. The risk level is calculated by assessing the impact of the non-compliance against the likelihood of the non-compliance reoccurring.

Inspection report

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre.

COMMENTS AND REVIEW

The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report, as appropriate.

CORRECTIVE AND PREVENTATIVE ACTION (CAPA) PLANS
The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report, as appropriate.

Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART).

The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

PUBLICATION

Following completion of this process, the final inspection report is issued to the registered proprietor and is subsequently published by the Mental Health Commission on the Mental Health Commission website.

ONGOING MONITORING

Following receipt of the final inspection report by the registered proprietor, the Mental Health Commission monitors the implementation of the approved centre’s CAPAs on an ongoing basis.

Our Values
ACCOUNTABILITY AND INTEGRITY

We will operate at all times in a fair and transparent manner and take responsibility for our actions.

RESPECT AND DIGNITY

We will show respect and dignity for those using services and those providing them.

CONFIDENTIALITY

We will handle confidential and personal information with the highest level of professionalism and we will take due care not to disclose information outside of the course of that required by law.

EMPOWERMENT

Our goal is to empower stakeholders (service users, families, carers, service providers and general public) through our work.

QUALITY

We aim to provide a quality service to all our stakeholders through the use of evidence informed practices and by adopting a responsive regulatory approach.

RECOVERY

Our work will be at all times oriented towards recovery, encouraging and focusing on strong, equal partnerships between service users, families, and carers and service providers.

Our Vision

Our vision is a quality mental health service that is founded on the provision of recovery based care, dignity and autonomy for service users.

Our Mission

Our Mission is to safeguard the rights of service users, to encourage continuous quality improvement, and to report independently on the quality and safety of mental health services in Ireland.

Disclaimer

“The following is a guidance document for approved centres regarding the matters which the office of 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.”
Regulation 4
Identification of Residents

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

Purpose

Appropriate resident identification assists to ensure resident safety when administering medication and providing treatment and services. The approved centre continuously improves the accuracy of resident identification within the service.

Guidance for Compliance:

1. PROCESSES:

A written policy is available in relation to the identification of residents in the approved centre. The policy includes the processes and procedures for:

1.1. The roles and responsibilities in relation to the identification of residents.
1.2. The required use of two appropriate resident identifiers prior to the administration of medications, medical investigations or other services.
1.3. The required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.
1.4. The process of identification applied for same/similar name residents.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on identification of residents. This is documented.
2.2. Relevant staff can articulate the processes for identifying residents as set out in the policy.

3. MONITORING:

The implementation of the resident identification policy is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. An annual audit undertaken to ensure appropriate resident identifiers are used.
3.2. Analysis completed to identify opportunities to improve the resident identification process. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy being implemented throughout the approved centre, including, but not limited to:

4.1. There are a minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs. The preferred identifiers to be used for each resident are detailed within the residents’ clinical files.
4.2. The identifiers used are person specific (e.g. do not include room number or physical location).
4.3. The identifiers used are appropriate to the residents’ communication abilities.
4.4. Two appropriate resident identifiers are used when administering medication, medical investigations and providing other healthcare services.
4.5. An appropriate resident identifier is used prior to the provision of therapeutic services and programmes.
4.6. The use of appropriate identifiers and alerts for same/similar name residents.
## Scoring

<table>
<thead>
<tr>
<th>Compliant – Excellent achievement</th>
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<tbody>
<tr>
<td>The approved centre complies with all aspects of Regulation 4: Identification of Residents; and there is evidence of the following:</td>
</tr>
<tr>
<td>- An up-to-date written policy on the processes for the identification of residents; and</td>
</tr>
<tr>
<td>- Staff training as detailed under Section 2: Training and Education; and</td>
</tr>
<tr>
<td>- Ongoing monitoring as detailed under Section 3: Monitoring; and</td>
</tr>
<tr>
<td>- All points under Section 4: Evidence of implementation, as applicable.</td>
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<tr>
<td>The approved centre complies with all aspects of Regulation 4: Identification of Residents.</td>
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<tr>
<th>Non-compliant – Needs improvement</th>
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<tbody>
<tr>
<td>The approved centre does not comply with all aspects of Regulation 4: Identification of Residents.</td>
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<tr>
<th>Non-compliant – Inadequate</th>
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<tbody>
<tr>
<td>The approved centre does not comply with all aspects of Regulation 4: Identification of Residents; and there is evidence (or a lack thereof) of the following:</td>
</tr>
<tr>
<td>- No written up-to-date policy on the processes for the identification of residents; and</td>
</tr>
<tr>
<td>- No staff training as detailed under Section 2: Training and education; and</td>
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<tr>
<td>- No monitoring as detailed under Section 3: Monitoring; and</td>
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<tr>
<td>- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.</td>
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</table>
Regulation 5
Food and Nutrition

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.
(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident’s individual care plan.

Purpose

All residents receive a nutritious and varied diet, which is appropriate to their needs and is provided in pleasant surroundings at appropriate times to promote health and well-being.

Residents are provided with a menu that offers choice and caters for specific diets that are considerate of the resident’s age, cultural and dietary requirements and preferences, physical condition and individual care plan.

Guidance for Compliance:

1. PROCESSES:

A written policy is available in relation to the provision of appropriate food and nutrition to residents by the approved centre. The policy includes the processes and procedures for:

1.1. The roles and responsibilities for food and nutrition within the approved centre.
1.2. The management of food and nutrition for each resident within the approved centre.
1.3. Assessing the dietary and nutritional needs of residents.
1.4. Monitoring food and water intake.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on food and nutrition. This is documented.
2.2. Relevant staff can articulate the processes for food and nutrition as set out in the policy.

3. MONITORING:

The implementation of the food and nutrition policy is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. A systematic review of menu plans to ensure residents are provided with wholesome and nutritious food in line with their needs.
3.2. Analysis completed to identify opportunities to improve the processes for food and nutrition. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy relating to food and nutrition being implemented throughout the approved centre, as appropriate:

For all residents:

4.1. Approved centre menus are approved by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs.
4.2. Residents are provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid.
4.3. Residents have at least two choices for meals.
4.4. Food, including modified consistency diets, is presented in a manner that is attractive and appealing in terms of texture, flavour and appearance, in order to maintain appetite and nutrition.
4.5. Hot and cold drinks are offered regularly to residents.
4.6. There is a source of safe, fresh drinking water made available to residents at all times in easily accessible locations throughout the approved centre.
4.7. Hot meals are provided on a daily basis.

For residents with special dietary requirements (e.g. malnutrition, eating disorder etc)

4.8. An evidence-based nutrition assessment tool is used.
4.9. Weight charts are implemented, monitored and acted upon for residents, where appropriate.
4.10. Residents, their representatives, family and next-of-kin are educated about the residents' diets, where appropriate, specifically in relation to any contraindications with medication.

4.11. Nutritional and dietary needs are assessed, where necessary, and addressed in the resident's individual care plan.

4.12. The needs of residents identified as having special nutritional requirements are regularly reviewed by a dietician.

4.13. Intake and output charts are maintained for residents, where appropriate.

Scoring

**Compliant – Excellent achievement**

The approved centre complies with all aspects of Regulation 5: Food and Nutrition; and there is evidence of the following:

- An up-to-date written policy on the processes for food and nutrition; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

**Compliant – Satisfactory**

The approved centre complies with all aspects of Regulation 5: Food and Nutrition.

**Non-compliant – Needs improvement**

The approved centre does not comply with all aspects of Regulation 5: Food and Nutrition.

**Non-compliant – Inadequate**

The approved centre does not comply with all aspects of Regulation 5: Food and Nutrition; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for Regulation 5: Food and Nutrition; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
**Regulation 6**

**Food Safety**

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

**Purpose**

Food preparation, handling, storage, distribution and disposal are appropriately managed to ensure safety and compliance with relevant legislation and current best practice. The use of appropriate equipment reduces the risk of contamination and infection in the Approved Centre.

**Guidance for Compliance:**

1. **PROCESSES:**

   A written policy is available in relation to food safety in the approved centre. The policy includes the processes and procedures for:

   1.1. The roles and responsibilities in relation to food safety within the approved centre.

   1.2. Food preparation, handling, storage, distribution and disposal controls.

2. **TRAINING AND EDUCATION:**

   2.1. Relevant staff have read and understood the policy on food safety. This is documented.

   2.2. Relevant staff can articulate the processes for food safety as set out in the policy.

   2.3. All staff handling food have up-to-date training in food safety/hygiene, commensurate with their role. This training is documented and evidence of certification is available, where appropriate.

3. **MONITORING:**

   The implementation of the food safety policy is monitored and continuously improved. Monitoring requirements include, but are not limited to:

   3.1. Evidence of food safety audits periodically completed.

   3.2. Food temperatures recorded in line with food safety recommendations. A log sheet is maintained and monitored.

   3.3. Analysis completed to identify opportunities to improve food safety processes. This is documented.

4. **EVIDENCE OF IMPLEMENTATION:**

   There is evidence of the policy on food safety being implemented throughout the approved centre including, but not limited to:

   4.1. Appropriate hand-washing areas are provided for catering services.

   4.2. Appropriate protective equipment (including Personal Protective Equipment (PPE), where required) is used during the catering process.

   4.3. There is suitable and sufficient catering equipment.

   4.4. There are proper facilities for the refrigeration, storage, preparation, cooking and serving of food.

   4.5. Hygiene is maintained to support food safety requirements.

   4.6. Catering areas, and associated catering and food safety equipment, are appropriately cleaned.

   4.7. Food is prepared in a manner that reduces risk of contamination, spoilage, and infection.

   4.8. Residents are provided with crockery and cutlery that is suitable and sufficient to address their specific needs.
### Scoring

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<td>The approved centre complies with all aspects of Regulation 6: Food Safety; and there is evidence of the following:</td>
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<tr>
<td>• An up-to-date written policy on the processes for food safety; and</td>
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<td>• Staff training as detailed under Section 2: Training and Education; and</td>
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<td>• No written up-to-date policy on the processes for Regulation 6: Food Safety; and</td>
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**Regulation 7**  
**Clothing**

The registered proprietor shall ensure that:

1. when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
2. night clothes are not worn by residents during the day, unless specified in a resident’s individual care plan.

**Purpose**

Residents are encouraged to keep and use personal clothing. Where a resident is unable to provide personal clothing, appropriate and sufficient clothing will be provided by the approved centre, with consideration of the resident’s preferences, dignity and their religious and cultural practices. In line with resident needs, residents are encouraged to use different sets of clothing during day and night hours.

**Guidance for Compliance:**

1. **PROCESSES:**
   
   A written policy is available in relation to residents’ clothing in the approved centre. The policy includes the processes and procedures for:
   
   1.1. The responsibility of the approved centre to provide new clothing to residents where necessary, with consideration of the residents’ preferences, dignity, bodily integrity, religious and cultural practices.
   1.2. The use of night and day clothes.
   1.3. Recording the use of night clothes worn during the day in the resident’s individual care plan.

2. **TRAINING AND EDUCATION:**

   2.1. Relevant staff have read and understood the policy on residents’ clothing. This is documented.

   2.2. Relevant staff can articulate the processes for residents’ clothing as set out in the policy.

3. **MONITORING:**

   The implementation of the policy relating to resident clothing will be reviewed and updated in response to identified resident needs.
   
   3.1. The availability of an emergency supply of clothing for residents is monitored on an ongoing basis. This is documented.
   3.2. A record of residents wearing night clothes during the day, as indicated by their individual care plan, is kept and monitored.

4. **EVIDENCE OF IMPLEMENTATION:**

   There is evidence of the processes relating to resident clothing being implemented throughout the approved centre including, but not limited to:
   
   4.1. Residents are supported to keep and use personal clothing.
   4.2. Resident clothing is clean and appropriate to the residents’ needs.
   4.3. Residents are provided with emergency personal clothing that is appropriate to the resident and considers the residents’ preferences, dignity, bodily integrity, religious and cultural practices.
   4.4. Residents change out of night clothes during day time hours unless specified otherwise in the resident’s individual care plan.
   4.5. Residents have an adequate supply of individualised clothing.
## Scoring

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<th>Compliant – Excellent achievement</th>
<th>The approved centre complies with all aspects of Regulation 7: Clothing; and there is evidence of the following:</th>
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<tbody>
<tr>
<td>• An up-to-date written policy on the processes for clothing; and</td>
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<td>• Staff training as detailed under Section 2: Training and Education; and</td>
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<td>• Ongoing monitoring as detailed under Section 3: Monitoring; and</td>
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<td>• All points under Section 4: Evidence of implementation, as applicable.</td>
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| Compliant – Satisfactory | The approved centre complies with all aspects of Regulation 7: Clothing. |

| Non-compliant – Needs improvement | The approved centre does not comply with all aspects of Regulation 7: Clothing. |

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<tr>
<th>Non-compliant – Inadequate</th>
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<td>• The approved centre has not met applicable requirements under Section 4: Evidence of implementation.</td>
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Regulation 8
Residents’ Personal Property and Possessions

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents’ personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident’s personal property and possessions and is available to the resident in accordance with the approved centre’s written policy.

(4) The registered proprietor shall ensure that records relating to a resident’s personal property and possessions are kept separately from the resident’s individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident’s individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

Purpose
Residents are supported in the management of their personal property and possessions at the Approved Centre.

Guidance for Compliance:

1. PROCESSES:

A written operational policy is available in relation to residents’ personal property and possessions in the approved centre. The policy includes the processes and procedures for:

1.1. The roles and responsibilities of the approved centre to support residents to manage their personal property and possessions.

1.2. The communications with the resident, and their representatives, regarding the resident’s entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.

1.3. The process to record, secure and manage the personal property and possessions of the resident, including money.

1.4. The process to allow a resident access to, and control over, their personal property and possessions, unless this poses a danger to the resident, or others, as indicated under an individual risk assessment and the resident’s individual care plan.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on residents’ personal property and possessions. This is documented.

2.2. Relevant staff can articulate the processes for residents’ personal property and possessions as set out in the policy.

3. MONITORING:

The implementation of the residents’ personal property and possessions policy is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. Personal property logs are monitored.

3.2. Analysis is completed to identify opportunities to improve the processes for residents’ personal property and possessions. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy relating to residents’ personal property and possessions being implemented throughout the approved centre, including, but not limited to:

4.1. A resident’s personal property and possessions are safeguarded when the approved centre assumes responsibility of them.
4.2. Secure facilities are provided for the safe-keeping of the resident’s monies, valuables, personal property and possessions, as necessary.

4.3. The resident is entitled to bring personal possessions with him/her, the extent of which is agreed at admission.

4.4. The approved centre compiles a detailed property checklist with each resident on admission, listing their personal property and possessions. The checklist is updated on an ongoing basis, in line with the approved centre’s policy.

4.5. The property checklist is kept separate to the resident’s individual care plan and is available to the resident.

4.6. The access to and use of resident monies is overseen by two members of staff and the resident or their representative.

4.7. Where any money belonging to the resident is handled by staff, signed records of the staff issuing the money is retained. Where possible, this is counter-signed by the resident or their representative.

4.8. Residents are supported to manage their own property, unless this poses a danger to the resident or others, as indicated in their individual care plan, and/or in accordance with the approved centre’s policy.

Scoring

Compliant – Excellent achievement

The approved centre complies with all aspects of Regulation 8: Residents’ Personal Property and Possessions; and there is evidence of the following:

- An up-to-date written policy on the processes for residents’ personal property and possessions; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

Compliant – Satisfactory

The approved centre complies with all aspects of Regulation 8: Residents’ Personal Property and Possessions.

Note: A written operational policy is required to attain compliance with this Regulation.

Non-compliant – Needs improvement

The approved centre does not comply with all aspects of Regulation 8: Residents’ Personal Property and Possessions.

Non-compliant – Inadequate

The approved centre does not comply with all aspects of Regulation 8: Residents’ Personal Property and Possessions; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for residents’ personal property and possessions; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
**Regulation 9**

**Recreational Activities**

*The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.*

**Purpose**

All residents are provided, where possible, with activities that are beneficial, enjoyable and improve the residents’ quality of life and wellbeing within the approved centre.

**Guidance for Compliance:**

1. **PROCESSES:**

   A written policy is available in relation to the provision of recreational activities in the approved centre. The policy includes the processes and procedures for:

   1.1. The roles and responsibilities relating to the provision of recreational activities within the approved centre.
   1.2. Determining resident needs, likes and dislikes in relation to activities.
   1.3. The process applied to risk assess residents for recreational activities, including outdoor activities.
   1.4. The process applied for the development of recreational activity programmes.
   1.5. The methods of communicating recreational activities and individual activities programmes with the residents.
   1.6. The facilities available for recreational activities, including identification of suitable locations for recreational activities within and external to the approved centre.
   1.7. The process to support resident involvement in planning and reviewing recreational activities.

2. **TRAINING AND EDUCATION:**

   2.1. Relevant staff have read and understood the policy on recreational activities. This is documented.
   2.2. Relevant staff can articulate the processes for recreational activities as set out in the policy.

3. **MONITORING:**

   The implementation of the recreational activities policy is monitored and continuously improved. Monitoring requirements include, but are not limited to:

   3.1. A record of the occurrence of planned recreational activities, including a record of resident uptake/attendance.
   3.2. Analysis is completed to identify opportunities to improve the processes for recreational activities. This is documented.

4. **EVIDENCE OF IMPLEMENTATION:**

   There is evidence of the processes relating to the provision of recreational activities being implemented throughout the approved centre including, but not limited to:

   4.1. The approved centre provides access to recreational activities appropriate to the resident group profile.
   4.2. The approved centre provides access to recreational activities on weekdays and during the weekend.
   4.3. Information is provided to residents in an accessible format, which is appropriate to his/her individual needs. The information includes the types and frequency of appropriate recreational activities available within the approved centre.
   4.4. Recreational activities programmes are developed, implemented and maintained for residents, with resident involvement.
   4.5. Individual risk assessments are completed for residents, where deemed appropriate, in relation to the selection of appropriate activities.
   4.6. Resident decisions on whether or not to participate in activities are respected and documented, as appropriate.
   4.7. The recreational activities provided by the approved centre are appropriately resourced.
   4.8. Opportunities are provided for indoor and outdoor exercise and physical activity.
   4.9. Communal areas are provided that are suitable for recreational activities.
   4.10. Documented records of attendance are retained for recreational activities in group records or within the resident’s clinical file, as appropriate.
## Scoring

### Compliant – Excellent achievement

The approved centre complies with all aspects of Regulation 9: Recreational Activities; and there is evidence of the following:

- An up-to-date written policy on the processes relating to recreational activities; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

### Compliant – Satisfactory

The approved centre complies with all aspects of Regulation 9: Recreational Activities.

### Non-compliant – Needs improvement

The approved centre does not comply with all aspects of Regulation 9: Recreational Activities.

### Non-compliant – Inadequate

The approved centre does not comply with all aspects of Regulation 9: Recreational Activities; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes relating to recreational activities; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 10
Religion

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

Purpose

The approved centre provides residents with spiritual care and support in accordance with their religious affiliations, where possible.

Guidance for Compliance:

1. PROCESSES:

A written policy is available in relation to the approved centre’s facilitation of religious practice by residents. The policy includes the processes and procedures for:

1.1. Identifying the residents’ religious beliefs.
1.2. The roles and responsibilities in relation to the support of residents’ religious practices.
1.3. Facilitating residents in the practice of their religion, insofar as is practicable.
1.4. Respecting religious beliefs during the provision of services, care and treatment.
1.5. Respecting a resident’s religious beliefs and values within the routines of daily living, including resident choice regarding their involvement in religious practice.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on religion. This is documented.
2.2. Relevant staff can articulate the processes for facilitating residents in the practice of their religion as set out in the policy.

3. MONITORING:

The implementation of the policy to support residents’ religious practices is reviewed to ensure it reflects the identified needs of the residents. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy relating to the facilitation of residents’ religious practices being implemented throughout the approved centre including, but not limited to:

4.1. Residents’ rights to practice religion are facilitated within the approved centre insofar as is practicable.
4.2. There are facilities provided within the approved centre for residents’ religious practices, insofar as is practicable.
4.3. Residents have access to multi-faith chaplains.
4.4. Residents have access to local religious services and are supported to attend, if deemed appropriate following a risk assessment.
4.5. Care and services that are provided within the approved centre are respectful of the residents’ religious beliefs and values.
4.6. Any specific religious requirements relating to the provision of services, care and treatment are clearly documented.
4.7. The resident is facilitated to observe or abstain from religious practice in accordance with his/her wishes.
## Scoring

### Compliant – Excellent achievement

The approved centre complies with all aspects of Regulation 10: Religion; and there is evidence of the following:

- An up-to-date written policy on the processes relating to religion; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

### Compliant – Satisfactory

The approved centre complies with all aspects of Regulation 10: Religion.

### Non-compliant – Needs Improvement

The approved centre does not comply with all aspects of Regulation 10: Religion.

### Non-compliant – Inadequate

The approved centre does not comply with all aspects of Regulation 10: Religion; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes relating to religion; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 11
Visits

1. The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

2. The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

3. The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

4. The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.

5. The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

6. The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

Purpose
Appropriate arrangements are in place for residents to receive visitors within the approved centre.

Guidance for Compliance:
1. PROCESSES:

Written operational policies and procedures are available within the approved centre in relation to visits. The policies and procedures include requirements in relation to:

1.1. The roles and responsibilities for visiting the approved centre and its residents.

1.2. The process for restricting visitors based on a resident request, an identified risk to resident, an identified risk to others or an identified health and safety risk.

1.3. The availability of appropriate locations for resident visits.

1.4. The arrangements and appropriate facilities for children visiting a resident.

1.5. The required visitor identification methods.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on visits. This is documented.

2.2. Relevant staff can articulate the processes for visits as set out in the policy.

3. MONITORING:

The implementation of the policy on visits is reviewed to ensure it is appropriate to the identified needs of residents.

3.1. Restrictions on residents’ rights to receive visitors are monitored and reviewed on an ongoing basis.

3.2. Analysis is completed to identify opportunities to improve visiting processes. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policies and procedures on visits being implemented throughout the approved centre including, but not limited to:

4.1. Visiting times are publicly displayed.

4.2. Visiting times are appropriate and reasonable.

4.3. Justifications for visiting restrictions implemented for a resident are documented in the clinical file.

4.4. The clinical file documents the names of visitors the resident does not wish to see and those who pose a risk to the resident.

4.5. A separate visitor room or visiting area is provided where residents can meet visitors in private, unless there is an identified risk to the resident, an identified risk to others or a health and safety risk.

4.6. Appropriate steps are taken to ensure the safety of residents and visitors during visits.

4.7. Children visiting are accompanied at all times to ensure their safety. This is communicated to all relevant individuals publicly.

4.8. The visiting room/area is suitable for visiting children.
### Scoring

<table>
<thead>
<tr>
<th>Compliant – Excellent achievement</th>
<th>The approved centre complies with all aspects of Regulation 11: Visits; and there is evidence of the following:</th>
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<tbody>
<tr>
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<td>- An up-to-date written policy on the processes for visits; and</td>
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<th>The approved centre does not comply with all aspects of Regulation 11: Visits.</th>
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| Non-compliant – Inadequate       | The approved centre does not comply with all aspects of Regulation 11: Visits; and there is evidence (or a |
|                                  | lack thereof) of the following:                                                                       |
|                                  | - No written up-to-date policy on the processes for visits; and                                        |
|                                  | - No staff training as detailed under Section 2: Training and education; and                          |
|                                  | - No monitoring as detailed under Section 3: Monitoring; and                                           |
|                                  | - The approved centre has not met applicable requirements under Section 4: Evidence of implementation.|


Regulation 12
Communication

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation “communication” means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

Purpose
Residents are free to communicate externally at all times unless a risk assessment has been completed and is otherwise indicated in their individual care plan.

Guidance for Compliance:
1. PROCESSES:

Written operational policies and procedures are available within the approved centre in relation to resident communication. The policies and procedures include requirements in relation to:

1.1. The roles and responsibilities for resident communication processes.
1.2. The communication services available to the resident (including: mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods).
1.3. The assessment of resident communication needs.
1.4. The circumstances in which resident communications may be examined by a senior member of staff.

1.5. The individual risk assessment requirements in relation to limiting resident communication activities.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on communication. This is documented.
2.2. Relevant staff can articulate the processes for communication as set out in the policy.

3. MONITORING:

The implementation of the resident communication policy is monitored and continuously improved by the approved centre.

3.1. Resident communication needs and restrictions on communication are monitored on an ongoing basis.
3.2. Analysis is completed to identify opportunities to improve communication processes. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the resident communication policies and procedures implemented throughout the approved centre including:

4.1. Residents have access to mail, fax, email, internet (where available), telephone or any device for the purposes of sending or receiving messages or goods unless otherwise risk assessed with due regard to the residents’ wellbeing, safety and health.
4.2. Individual risk assessments are completed for residents as deemed appropriate in relation to any risks associated with their external communication and documented in the individual care plan.
4.3. The clinical director, or a senior member of staff designated by the clinical director, only examines incoming and outgoing resident communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.
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<td>• No written up-to-date policy on the processes for resident communication; and</td>
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<td>• The approved centre has not met applicable requirements under Section 4: Evidence of implementation.</td>
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Regulation 13
Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident’s dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

Purpose

Where there are concerns for the safety of residents, staff or visitors within the approved centre, searches of a resident, including his or her belongings and the environment in which he or she is accommodated in, may be carried out in certain circumstances.

Guidance for Compliance:

1. PROCESSES:

Documented policies and procedures are available in relation to the implementation of resident searches by the approved centre. The policies and procedures include requirements relating to:

1.1. The management and application of searches of a resident, his or her belongings and the environment in which he or she is accommodated.

1.2. The roles and responsibilities in relation to the implementation of resident searches.

1.3. The application of individual risk assessment in relation to resident searches.

1.4. The processes for communicating the approved centre’s search policies and procedures to residents and staff.

1.5. The consent requirements of a resident regarding searches.

1.6. The process for carrying out searches in the absence of consent.

1.7. The processes for informing the resident being searched of what is happening and why.

1.8. The considerations to be provided to the resident in relation to their dignity, privacy and gender during searches.

1.9. The requirement to record searches, including the reason for the search.

1.10. The process for the finding of illicit substances during a search.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on searches. This is documented.

2.2. Relevant staff can articulate the searching processes as set out in the policy.

3. MONITORING:

The implementation of the resident search policy is monitored and continuously improved.

3.1. A log of searches is maintained. Each search record is systematically reviewed to ensure the requirements of the regulation have been complied with.
3.2. Analysis is completed to identify opportunities for improvement of search processes. This is documented.

4. **EVIDENCE OF IMPLEMENTATION:**

There is evidence of the resident search policies and procedures being appropriately implemented throughout the approved centre including, but not limited to:

4.1. Risk is assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken.

4.2. Resident consent is sought prior to all searches. The request for consent, and the received consent, is documented for every search of a resident and every property search.

4.3. General written consent is sought for routine environmental searches.

4.4. Where consent is not received, this is documented and the process relating to searches without consent is implemented.

4.5. The resident search policy and procedure is communicated to all residents.

4.6. Residents are informed by those implementing the search of what is happening during a search and why.

4.7. There is a minimum of two clinical staff in attendance at all times when searches are being conducted.

4.8. Searches are implemented with due regard to the resident’s dignity, privacy and gender; at least one of the staff members conducting the search is the same gender as the resident being searched.

4.9. A written record of every search of a resident and every property search is available, which includes the reason for the search, the names of both staff members who undertook the search and details of who was in attendance for the search.

4.10. A written record is kept of all environmental searches.

4.11. Policy requirements are implemented when illicit substances are found as a result of a search.

**Scoring**

**Compliant – Excellent achievement**

The approved centre complies with all aspects of Regulation 13: Searches; and there is evidence of the following:

- An up-to-date written policy on the processes for searches; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

**Compliant – Satisfactory**

The approved centre complies with all aspects of Regulation 13: Searches:

Note: A written operational policies on the following are required to attain compliance with this Regulation:

- Searches of a resident, their property and their environment
- Searches with and without the consent of a resident
- Finding illicit substances

**Non-compliant – Needs improvement**

The approved centre does not comply with all aspects of Regulation 13: Searches.

**Non-compliant – Inadequate**

The approved centre does not comply with all aspects of Regulation 13: Searches; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for searches; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 14
Care of the Dying

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

Purpose

The approved centre affords residents all appropriate care and dignity at the final stages of their life.

Guidance for Compliance:

1. PROCESSES:

Written operational policies and protocols are available in relation to the care of the dying in the approved centre. The policies and protocols include requirements relating to:

1.1. The roles and responsibilities for the care of the dying.

1.2. The identification and implementation of the resident's physical, emotional, social, psychological, spiritual and pain management needs in relation to end of life care.

1.3. Advance directives in relation to end of life care, Do Not Attempt Resuscitation orders (DNARs), and residents' religious and cultural end of life preferences.

1.4. The privacy, propriety and dignity requirements of residents to be implemented as part of care of the dying.

1.5. The required communication with the resident and their representatives, family, next-of-kin and friends during end of life care.

1.6. The involvement, accommodation and support provided to resident representatives, family, next-of-kin and friends during the end of life care of a resident.

1.7. The process for managing the sudden death of a resident.

1.8. The supports available to other residents and staff following a resident's death.

1.9. The process and the responsibility for reporting the death of a resident to the required external bodies.

1.10. The process for the notification to the Mental Health Commission of deaths of residents within 48 hours.

1.11. The process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy and protocols on care of the dying. This is documented.

2.2. Relevant staff can articulate the processes for end of life care as set out in the policy.

3. MONITORING:

The implementation of the care of the dying policy and protocols are monitored and continuously improved.
3.1. End of life care provided to residents is systematically reviewed to ensure Section 2 of the Regulation is complied with.

3.2. Systems analysis is undertaken in the event of a sudden or unexplained death in the approved centre.

3.3. Analysis is completed to identify opportunities to improve the processes for the care of the dying. This is documented.

4. **EVIDENCE OF IMPLEMENTATION:**

There is evidence of the processes relating to the care of the dying being implemented throughout the approved centre including, but not limited to:

4.1. The end of life care provided is appropriate to the resident’s physical, emotional, social, psychological and spiritual needs. This is documented in the resident’s individual care plan.

4.2. Religious and cultural practices are respected, insofar as is practicable.

4.3. The privacy and dignity of residents is protected, e.g. provision of a single room within the approved centre during the provision of end of life care.

4.4. Representatives, family, next-of-kin and friends are involved, supported and accommodated during end of life care.

4.5. Pain management is prioritised and managed during end of life care.

4.6. Advance directives relating to end of life care, as well as DNAR orders and associated documentation, are evidenced in the clinical file.

4.7. The sudden death of a resident is managed in accordance with legal requirements.

4.8. The sudden death of a resident is managed in accordance with the resident's religious and cultural practices, with dignity and propriety and in a way that accommodates the resident representatives, family, next-of-kin and friends.

4.9. Support is given to other residents and staff following a resident’s death.

4.10. All deaths of any resident of an approved centre, including a resident transferred to a general hospital for care and treatment, are notified to the Mental Health Commission as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

**Scoring**

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<tr>
<td>• An up-to-date written policy on the processes relating to the care of the dying; and</td>
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<td>• The approved centre has not met applicable requirements under Section 4: Evidence of implementation.</td>
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Regulation 15
Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.

“Individual care plan” means a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation. (S.I. 551 of 2006)

Purpose

Every resident has an individual care plan that meets the definition in the Regulations.

Guidance for Compliance:

1. **PROCESSES:**

A written policy is available in relation to the development, use and review of individual care plans by the approved centre. The policy includes the processes for:

1.1. The roles and responsibilities relating to individual care planning.
1.2. The comprehensive assessment of residents at admission and on an ongoing basis.
1.3. The required content in the set of documentation making up the individual care plan.
1.4. The implementation of individual care plan reviews and updates.
1.5. The required resident involvement in individual care planning.
1.6. The timeframes for assessment planning, implementation and evaluation of the individual care plan.
1.7. Resident access to their individual care plan.

2. **TRAINING AND EDUCATION:**

2.1. All clinical staff have read and understood the policy on individual care planning. This is documented.

2.2. All clinical staff can articulate the processes relating to individual care planning as set out in the policy.

2.3. All multi-disciplinary team (MDT) members are trained in individual care planning.

3. **MONITORING:**

The implementation of the individual care planning processes, are monitored and continuously improved.

3.1. Individual care plans are audited on a quarterly basis to assess compliance with the Regulation.

3.2. Analysis is completed to identify opportunities to improve the individual care planning process. This is documented.

4. **EVIDENCE OF IMPLEMENTATION:**

There is evidence of the policy relating to individual care plans being implemented throughout the approved centre including, but not limited to:

4.1. The individual care plan must be a composite set of documents. The composite set of documentation should:

4.1.1. Include allocated space/sections for goals, treatment, care and resources required;
4.1.2. Include allocated space/sections for reviews;
4.1.3. Be stored within the clinical file;
4.1.4. Be identifiable and uninterrupted; and
4.1.5. It should not be amalgamated with progress notes.

4.2. Each resident is initially assessed at admission. An initial care plan is completed by the admitting clinician to address the immediate needs of the resident.

4.3. An individual care plan is developed by the MDT following a comprehensive assessment within seven days of admission.

4.4. The comprehensive assessment may include, but is not limited to, the following:

4.4.1. Medical, psychiatric and psychosocial history.
4.4.2. Medication history and current medications.
4.4.3. Current physical health assessment.
4.4.4. Detailed risk assessment.
4.4.5. Social, interpersonal and physical environment related issues including resilience and strengths.

4.4.6. Communication abilities.

4.4.7. Educational, occupational and vocational history.

4.5. Evidence-based assessments are used where possible.

4.6. The individual care plan is discussed, agreed where practicable and drawn up with the participation of the resident and their representative, family and next-of-kin, as appropriate.

4.7. The individual care plan identifies the resident’s assessed needs.

4.8. The individual care plan identifies appropriate goals for the resident.

4.9. The individual care plan identifies the care and treatment required to meet the goals identified including the frequency and responsibilities for implementing the care and treatment.

4.10. The individual care plan identifies the resources required to provide the care and treatment identified.

4.11. A key worker is identified to ensure continuity in the implementation of a resident’s individual care plan.

4.12. The individual care plan includes an individual risk management plan.

4.13. The individual care plan includes a preliminary discharge plan, where deemed appropriate.

4.14. The individual care plan is reviewed by the MDT in consultation with the resident; weekly in an acute setting and at least every 6 months for residents in a continuing care facility.

4.15. The individual care plan is updated following review as indicated by the resident’s changing needs, condition, circumstances and goals.

4.16. The resident has access to the individual care plan and is kept informed of any changes. The resident is offered a copy of their individual care plan, including any reviews; this is documented.

4.17. When a resident declines or refuses a copy of their individual care plan, this is recorded, including the reason, if given.

4.18. The individual care plan of a child resident must include their educational requirements.

### Scoring

**Compliant – Excellent achievement**

The approved centre complies with all aspects of Regulation 15: Individual Care Plan; and there is evidence of the following:

- An up-to-date written policy on the processes for individual care planning; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

**Compliant – Satisfactory**

The approved centre complies with all aspects of Regulation 15: Individual Care Plan.

**Non-compliant – Needs improvement**

The approved centre does not comply with all aspects of Regulation 15: Individual Care Plan.

**Non-compliant – Inadequate**

The approved centre does not comply with all aspects of Regulation 15: Individual Care Plan; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for individual care planning; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 16
Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

Purpose
Therapeutic services and programmes, which are based on a resident’s assessed needs, are made available by the approved centre. They are specified in residents’ individual care plans.

Guidance for Compliance:

1. PROCESSES:
   A written policy is available in relation to the provision of therapeutic services and programmes to residents in the approved centre. This policy includes the processes and procedures for:
   1.1. The roles and responsibilities in relation to the provision of therapeutic services and programmes.
   1.2. The planning and provision of therapeutic services and programmes within the approved centre.
   1.3. Assessing residents as to the appropriateness of services and programmes (including risk).
   1.4. The resource requirements of the therapeutic services and programmes.
   1.5. The recording requirements for therapeutic services and programmes.
   1.6. The review and evaluation of therapeutic services and programmes.
   1.7. The facilities for the provision of therapeutic services and programmes.
   1.8. The provision of therapeutic services and programmes by external providers in external locations.

2. TRAINING AND EDUCATION:

2.1. All clinical staff have read and understood the policy on therapeutic services and programmes. This is documented.

2.2. All clinical staff can articulate the processes for therapeutic services and programmes as set out in the policy.

3. MONITORING:

The implementation of the therapeutic services and programmes policy is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. Ongoing monitoring of the range of services and programmes provided to ensure they meet the assessed needs of residents.

3.2. Analysis is completed to identify opportunities to improve the processes for therapeutic services and programmes. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy relating to therapeutic services and programmes being implemented throughout the approved centre including, but not limited to:

4.1. The therapeutic services and programmes provided by the approved centre are appropriate and meet the assessed needs of the residents, as documented in residents’ individual care plans.

4.2. The therapeutic services and programmes provided by the approved centre are evidence-based.

4.3. The therapeutic services and programmes provided by the approved centre are directed towards restoring and maintaining optimal levels of physical and psychosocial functioning.

4.4. A list of all the therapeutic services and programmes provided within the approved centre is available to the residents.

4.5. Where a resident requires a therapeutic service or programme that is not provided internally, the approved centre arranges for the service to be provided by an approved, qualified health professional in an appropriate location.

4.6. Adequate and appropriate resources and facilities are available to provide therapeutic services and programmes.
4.7. Therapeutic services and programmes are provided in a separate dedicated room, containing facilities and space for individual and group therapies.

4.8. A record is maintained of participation, engagement and outcomes achieved in therapeutic services or programmes, within the resident's individual care plan or clinical file.

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Regulation 17
Children’s Education

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

Purpose

The fulfilment of the educational needs of children is important to the provision of comprehensive care and treatment by an approved centre. All children in approved centres receive educational services that meet their educational requirements as appropriate.

Guidance for Compliance:

1. PROCESSES:

A written policy is available in relation to the provision of education to child residents in the approved centre. The policy includes the processes and procedures for:

1.1. The roles and responsibilities relating to the provision of educational services for child residents by the approved centre.
1.2. The planning, provision, documentation and review of educational provisions to child residents.
1.3. The assessment of the educational needs of child residents.
1.4. The information provided to child residents, and their representatives, on the educational services available.
1.5. The facilities and resources available to support education of child residents. This considers facilities and support for education provided by the approved centre and support for child residents that access external educational services.
1.6. The methods of assessment of child residents’ progress within the educational provisions of the approved centre.
1.7. The management of the transition of child residents between educational services.

2. TRAINING AND EDUCATION:

Relevant staff are trained on the policy relating to children’s education and its implementation throughout the approved centre.

2.1. Individual providers of educational services on behalf of the approved centre are appropriately qualified in line with their role and responsibilities.
2.2. Relevant staff are appropriately trained in the relevant legislation relating to working with children and their educational needs.

3. MONITORING:

The implementation of the children’s education policy within the approved centre is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. A record is kept of attendance at internal and external educational services.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy relating to children’s education being implemented throughout the approved centre including, but not limited to:

4.1. Child residents are assessed regarding their individual educational requirements with consideration of their individual needs and age on admission.
4.2. Where appropriate, the approved centre links with educational authorities and local education providers to ensure that each child resident is appropriately assessed in relation to education needs.
4.3. Where appropriate to the needs and age of the child resident, the education provided by the approved centre is reflective of the required educational curriculum.
4.4. Appropriate facilities are available for the provision of education to child residents within the approved centre.
4.5. Sufficient personnel resources are available for the provision of education to child residents within the approved centre.
4.6. Sufficient personnel and resources are available to support child residents to access external educational services.
4.7. The educational provisions available within the approved centre are effectively communicated to child residents and their representatives.
4.8. A daily activity timetable for schooling is available for each child resident receiving educational services within the approved centre.
4.9. Attendance by child residents at the educational services of the approved centre is documented, including reasons for non-attendance.

4.10. Attendance by child residents at external educational services is documented.

4.11. The approved centre maintains comprehensive records of each resident’s educational history, for example: schools attended, reports obtained, certificates awarded, assessment reports and any remedial assistance provided.

4.12. Where child residents are managing a transition, such as changing school or entering a higher level of education, they are given additional support and appropriate assistance by the approved centre, if appropriate.

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Regulation 18
Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

Purpose

Where a resident has care needs that cannot be addressed by the approved centre, a resident may be transferred to another approved centre, hospital or facility. The purpose of this regulation is to ensure that all relevant information is transferred with the resident in order to provide continuity of care when a resident is received by another facility.

This regulation relates to residents who have been transferred for care and treatment, but remain a resident of the approved centre. It does not apply to residents who have been discharged to another facility.

Guidance for Compliance:

1. PROCESSES:

A written policy and procedures are available within the approved centre in relation to the transfer of residents. The policy and procedures include requirements in relation to:

1.1. The roles and responsibilities for the resident transfer process, including the responsibility of the approved centre’s multi-disciplinary team and the resident’s key worker.

1.2. The planning and management of the resident transfer process in a safe and timely manner, including controls to ensure the continuity of care.

1.3. The criteria for transfer.

1.4. The process for making a decision to transfer to, or from, the approved centre.

1.5. The interagency involvement in transfer process.

1.6. The communication requirements with the receiving facility including the provision of all relevant information about the resident.

1.7. The resident assessment requirements prior to transfer from the approved centre, including the individual risk to be assessed.

1.8. The process for managing resident medications during transfer from the approved centre.

1.9. The resident and/or their representative’s involvement in, and consent to, the transfer process.

1.10. The process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.

1.11. The process for managing resident property during the transfer process.

1.12. The process for ensuring the safety of the resident and staff during the resident transfer process.

1.13. The process for emergency transfers.

1.14. The processes for ensuring the safety of the resident and staff during the resident transfer process.

1.15. The record keeping and documentation requirements for the resident transfer process.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the policy on transfers. This is documented.

2.2. Relevant staff can articulate the processes for transfer of residents as set out in the policy.

3. MONITORING:

3.1. A log of transfers is maintained.

3.2. Each transfer record is systematically reviewed to ensure all relevant information was provided to the receiving facility.

3.3. Analysis is completed to identify opportunities to improve information provision during transfers. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the resident transfer policy and procedures being implemented throughout the approved centre, including:

4.1. Communication records with the receiving facility are documented and available on inspection, including
agreement of resident receipt prior to transfer. Verbal communication and liaison takes place between the approved centre and the receiving facility prior to the transfer taking place. These shall include a discussion of:

- the reasons for transfer;
- the resident’s care and treatment plan (including needs and risk); and
- if the resident requires accompaniment on transfer.

4.2. Documented consent of the resident to transfer is available or a justification as to why consent was not received.

4.3. An assessment of the resident completed prior to transfer, including an individual risk assessment relating to the transfer and the resident’s needs. This is documented and provided to the receiving facility.

4.4. Full and complete written information regarding the resident is transferred when he or she moves from an approved centre to another facility. This information is sent in advance, or at least accompanies the resident upon transfer, to a named individual.

4.5. The following information is issued (with copies retained) as part of the transfer of resident documentation:

- letter of referral, including a list of current medications;
- resident transfer form; and
- required medication for the resident during the transfer process.

4.6. In the case of an emergency transfer, communications between the approved centre and the receiving facility are documented and followed up with a written referral.

4.7. A checklist is completed by the approved centre to ensure comprehensive resident records have been transferred to the receiving facility.

4.8. Copies of all records relevant to the resident transfer process are retained in the resident’s clinical file.

**Scoring**

**Compliant – Excellent achievement**

The approved centre complies with all aspects of Regulation 18: Transfer of Residents; and there is evidence of the following:

- An up-to-date written policy on the processes for transferring residents; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

**Compliant – Satisfactory**

The approved centre complies with all aspects of Regulation 18: Transfer of Residents.

Note: A written policy is required to attain compliance with this Regulation.

**Non-compliant – Needs improvement**

The approved centre does not comply with all aspects of Regulation 18: Transfer of Residents.

**Non-compliant – Inadequate**

The approved centre does not comply with all aspects of Regulation 18: Transfer of Residents; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for transferring residents; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 19
General Health

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

Purpose

The approved centre provides services, care and treatment to promote the general health of residents, including medical emergencies.

Guidance for Compliance:

1. PROCESSES:

Policies, procedures and defined processes are available in the approved centre regarding the provision of general health services and for responding to medical emergencies.

Responding to Medical Emergencies

Written operational policies and procedures are available for responding to medical emergencies. The policies and procedures include requirements relating to:

1.1. The roles and responsibilities for responding to medical emergencies.

1.2. The management, response and documentation of a medical emergency, including cardiac arrest.

1.3. The staff training requirements in relation to Basic Life Support (BLS).

1.4. The management of emergency response equipment, including resuscitation trolley and Automated External Defibrillator (AED).

Provision of General Health Services

A written policy is available in relation to the provision of general health services to residents in the approved centre. The policy includes the processes for:

1.5. The roles and responsibilities in relation to the provision of general health services to residents.

1.6. Resident access to a registered medical practitioner.

1.7. The ongoing assessment of residents’ general health needs.

1.8. The resource requirements for general health services, including equipment needs.

1.9. The protection of resident privacy and dignity during general health assessments.

1.10. The incorporation of general health needs into the resident individual care plan.

1.11. The referral process for general health needs of residents.

1.12. The documentation requirements in relation to general health assessments.

1.13. Access to national screening programmes available for residents through the approved centre.

2. TRAINING AND EDUCATION:

2.1. All clinical staff have read and understood the policies on the provision of general health services and for responding to medical emergencies. This is documented.

2.2. All clinical staff can articulate the processes for the provision of general health services and for responding to medical emergencies, as set out in the policies.

3. MONITORING:

The implementation of the policies on the provision of general health services and responding to medical emergencies is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. Resident take-up of national screening programmes is recorded and monitored, where applicable.

3.2. A systematic review undertaken to ensure six-monthly reviews of general health needs take place.

3.3. Analysis is completed to identify opportunities to improve general health processes.
4. **EVIDENCE OF IMPLEMENTATION:**

There is evidence of the policies on the provision of general health services and responding to medical emergencies being implemented throughout the approved centre.

**Responding to Medical Emergencies**

4.1. The approved centre has an emergency trolley and staff have access at all times to an AED.
4.2. Weekly checks are completed on the resuscitation trolley/tray and on the AED, if located in the approved centre.
4.3. Records are available of any medical emergency that occurred within the approved centre and the care implemented.

**Provision of General Health Services**

4.4. Registered medical practitioners assess residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care.
4.5. Residents receive appropriate general health care interventions in line with their individual care plans.
4.6. Residents’ general health needs are monitored and assessed as indicated by the residents’ specific needs, but not less than every six months.
4.7. At a minimum, the six monthly general health assessment documents the following:
   4.7.1. Physical examination
   4.7.2. Family/Personal history
   4.7.3. BMI, weight and waist circumference
   4.7.4. Blood pressure
   4.7.5. Smoking status
   4.7.6. Nutritional status (diet and physical activity, incl. sedentary lifestyle)
   4.7.7. Medication review (per prescriber guidelines)
   4.7.8. Dental health
4.8. For residents on antipsychotic medication, there must be an annual assessment of the following, unless more regular review is indicated by physical examination:
   4.8.1. Glucose regulation (Fasting glucose / HbA1c)
   4.8.2. Blood lipids
   4.8.3. ECG
   4.8.4. Prolactin
4.9. Adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required.
4.10. Records are available demonstrating the residents’ completed general health checks and the associated results, including records of any clinical testing, e.g. lab results.
4.11. Residents have access to national screening programmes that are available according to age and gender. These include, but are not limited to, the following as applicable to resident needs:
   - Breast check
   - Cervical screening
   - Retinal check (for diabetics only)
   - Bowel Screening
4.12. Information is provided to residents regarding the national screening programmes available through the approved centre.
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<td>• No written up-to-date policy on the processes for relating to general health services; and</td>
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Regulation 20
Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident’s multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) 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;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

Purpose

Residents are provided with all relevant information regarding the approved centre, the services, care and treatment provided in a format that they understand.

Guidance for Compliance:

1. PROCESSES:

Policies and procedures are available within the approved centre in relation to the provision of information to residents. The policies and procedures include requirements relating to:

1.1. The roles and responsibilities for the provision of information to residents.
1.2. The information provided to residents at admission.
1.3. The information provided to residents on an ongoing basis.
1.4. The process for identifying the residents’ preferred ways of receiving and giving information.

1.5. The methods for providing information to residents with specific communication needs.
1.6. The interpreter and translation services available within the approved centre.
1.7. The process in place to manage the provision of information to resident representatives, family and next-of-kin, as appropriate.
1.8. The advocacy arrangements.

2. TRAINING AND EDUCATION:

2.1. All staff have read and understood the policy on the provision of information to residents. This is documented.
2.2. All staff can articulate the processes for providing information to residents as set out in the policy.

3. MONITORING:

The implementation of the policy on the provision of information to residents is monitored and continuously improved:

3.1. The provision of information to residents is monitored on an ongoing basis to ensure the information is appropriate and accurate, particularly where information changes e.g. information on medication and housekeeping practices.
3.2. Analysis is completed to identify opportunities to improve the processes for providing information to residents. This is documented.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy relating to the provision of information to residents being implemented throughout the approved centre, including, but not limited to:

4.1. Required information is provided to residents and/or their representatives at admission, including the approved centre’s Information Booklet that details the care and services provided. The booklet is available in the required formats to support resident needs and information is clearly and simply written. The booklet contains:
4.1.1. housekeeping arrangements, including arrangements for personal property and mealtimes;
4.1.2. complaints procedure;
4.1.3. visiting times and arrangements;
4.1.4. details of relevant advocacy and voluntary agencies; and
4.1.5. residents’ rights.

4.2. Residents are provided with the details of their multi-disciplinary team.

4.3. Residents are provided with written and verbal information regarding their 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. The justification for restricting information regarding a resident’s diagnosis is documented in their clinical file.

4.4. Information is provided to the resident on the likely adverse effects of treatments, including the risks and other potential side effects.

4.5. Medication information sheets, as well as verbal information, are provided in a format that is appropriate to the resident’s needs.

4.6. The content of the medication information sheets includes information on indications for use of all medications to be administered to the resident, including any possible side-effects.

4.7. The information in the documents provided by, or within, the approved centre is evidence-based.

4.8. Information documents provided by, or within, the approved centre are appropriately reviewed and approved prior to use.

4.9. Residents have access to interpretation and translation services as required.

**Scoring**

**Compliant – Excellent achievement**

The approved centre complies with all aspects of Regulation 20: Provision of Information to Residents; and there is evidence of the following:

- An up-to-date written policy on the processes for providing information to residents; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

**Compliant – Satisfactory**

The approved centre complies with all aspects of Regulation 20: Provision of Information to Residents.

Note: A written operational policy is required to attain compliance with this Regulation.

**Non-compliant – Needs improvement**

The approved centre does not comply with all aspects of Regulation 20: Provision of Information to Residents.

**Non-compliant – Inadequate**

The approved centre does not comply with all aspects of Regulation 20: Provision of Information to Residents; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for providing information to residents; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 21
Privacy

The registered proprietor shall ensure that the resident’s privacy and dignity is appropriately respected at all times.

Purpose

Care and treatment is provided to residents, having due regard to the right to privacy and dignity.

Guidance for Compliance:

1. PROCESSES:

A written policy is available in relation to resident privacy within the approved centre. The policy includes the processes and procedures for:

1.1. The roles and responsibilities for the provision of resident privacy and dignity.
1.2. The method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.
1.3. The approved centre layout and furnishing requirements to support resident privacy and dignity.
1.4. The approved centre’s process to be applied where resident privacy and dignity is not respected by staff.

2. TRAINING AND EDUCATION:

2.1. All staff have read and understood the policy relating to resident privacy. This is documented.
2.2. All staff can articulate the processes for ensuring resident privacy and dignity as set out in the policy.

3. MONITORING:

The implementation of the policy relating to resident privacy and dignity within the approved centre is monitored and continuously improved.

3.1. An annual review (e.g. observational audit, walk-through review) is undertaken to check that the policy is being implemented, and that the premises and facilities in the approved centre are conducive to resident privacy. This is documented.

3.2. Analysis is completed to identify opportunities to improve the processes relating to residents’ privacy and dignity.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policy relating to resident privacy and dignity being implemented throughout the approved centre, including, but not limited to:

4.1. Residents are called by their preferred name.
4.2. The general demeanour of staff.
4.3. The manner in which staff address and communicate with residents.
4.4. Staff appearance and dress.
4.5. Staff ensuring that no ageist, racist, sexist or other inappropriate comments or “jokes” are made.
4.6. Staff discretion when discussing the resident’s condition or treatment needs.
4.7. Staff seeking the resident’s permission before entering their room, as appropriate.
4.8. All residents wearing clothes that respect their privacy and dignity, e.g. no soiled clothing, inappropriate size or type of emergency clothing.

Approved centre layout and furnishings

The layout and furnishings of the approved centre are conducive to resident privacy and dignity, including:

4.9. All bathrooms, showers, toilets and single bedrooms have locks on the inside of the door, unless there is an identified risk to a resident. Locks should have an override function.
4.10. Where the resident shares a room, the bed screening ensures that their privacy is not compromised.
4.11. All observation panels on doors of treatment rooms and bedrooms have blinds, curtains or opaque glass.
4.12. Rooms are not overlooked by public areas. If so, the windows have opaque glass.
4.13. Noticeboards do not detail resident names or other identifiable information.
4.14. Residents are facilitated to make private phone calls.
Compliant – Excellent achievement
The approved centre complies with all aspects of Regulation 21: Privacy; and there is evidence of the following:
- An up-to-date written policy on the processes for respecting residents’ privacy; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

Compliant – Satisfactory
The approved centre complies with all aspects of Regulation 21: Privacy.

Non-compliant – Needs improvement
The approved centre does not comply with all aspects of Regulation 21: Privacy.

Non-compliant – Inadequate
The approved centre does not comply with all aspects of Regulation 21: Privacy; and there is evidence (or a lack thereof) of the following:
- No written up-to-date policy on the processes for respecting residents’ privacy; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 22
Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.


Purpose

The location, design, layout and furnishings of the approved centre is appropriate to the number and needs of the residents. The approved centre is accessible, safe, hygienic, spacious, well maintained and meets residents’ individual and collective needs.

Guidance for Compliance:

1. **PROCESSES:**

A written policy is available in relation to the approved centre’s premises. The policy includes the processes and procedures for:

1.1. The roles and responsibilities for the maintenance of the approved centre’s premises and related processes.

1.2. The legislative requirements to which the approved centre premises must conform.

1.3. The approved centre’s premises maintenance programme.

1.4. The approved centre’s cleaning programme.

1.5. The approved centre’s utility controls and requirements.

1.6. Providing adequate and suitable furnishings in the approved centre.

1.7. Identifying hazards and ligature points in the premises.

2. **TRAINING AND EDUCATION:**

2.1. Relevant staff have read and understood the premises policy. This is documented.

2.2. Relevant staff can articulate the processes relating to the maintenance of the premises as set out in the policy.

3. **MONITORING:**

The implementation of the premises policy is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. A hygiene audit.

3.2. A ligature audit, using a validated tool (e.g. Manchester Audit Tool).

3.3. Analysis is completed to identify opportunities to improve the premises. This is documented.

4. **EVIDENCE OF IMPLEMENTATION:**

There is evidence of the premises policy being implemented throughout the approved centre, including, but not limited to:

**Physical environment**
The design of the physical environment offers maximum opportunity to maintain and improve mental and general health status. Environmental requirements include the following:

4.1. Access to personal space.
4.2. Appropriately sized communal rooms provided.
4.3. Temperature: There is suitable and sufficient heating with a minimum temperature of 18°C (65°F) in bedroom areas and 21°C (70°F) in day areas and in bedrooms where residents sit during the day.
4.4. Rooms are ventilated.
4.5. Noise levels/acoustics: Private and communal areas are suitably sized and furnished to remove excessive noise/acoustics.
4.6. The lighting in communal rooms suits the needs of residents and staff. It is sufficiently bright and positioned to facilitate reading and other activities.
4.7. Appropriate signage and sensory aids are provided to support resident orientation needs.
4.8. Sufficient spaces are provided for residents to move about, including outdoor spaces.
4.9. Hazards, including large open spaces, steps and stairs, slippery floor, hard and sharp edges, hard or rough surfaces are minimised in the approved centre.
4.10. Minimisation of ligature points, to the lowest practicable level, based on risk assessment.

**Facilities and furnishings**

4.19. There is a sufficient number of toilets and showers for residents in the approved centre.
4.20. Toilets are accessible and clearly marked.
4.21. Toilets are close to day and dining areas.
4.22. Toilet facilities that are wheelchair accessible are identified for use by visitors who require such facilities.
4.23. There is at least one assisted toilet per floor.
4.24. The approved centre has a designated sluice room, as appropriate.
4.25. The approved centre has a designated cleaning room, as appropriate.
4.26. The approved centre has a designated laundry room, as appropriate.
4.27. The approved centre has appropriately sized lifts, where applicable.
4.28. The approved centre has dedicated therapy/examination rooms, as appropriate.
4.29. All resident bedrooms are appropriately sized to address the resident needs.
4.30. The approved centre provides suitable furnishings to support resident independence and comfort.
4.31. The approved centre provides assisted devices and/or equipment available to address resident needs.
4.32. Where substantial changes are required to the approved centre premises, this is appropriately assessed for possible impact to the current residents and staff prior to implementation. The Mental Health Commission is informed prior to the commencement of works.
4.33. Remote or isolated areas of the approved centre are monitored.
## Scoring

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Regulation 23
Ordering, Prescribing, Storing and Administration of Medicines

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.


Purpose
Medication within the approved centre is ordered, prescribed, stored, administered and disposed of in a safe and legal manner to maximise resident safety and wellbeing.

Guidance for Compliance:

1. PROCESSES:

Policies and procedures are available within the approved centre in relation to the ordering, prescribing, storing and administration of medicines. The policies and procedures include requirements relating to:

1.1. The roles and responsibilities for the ordering, prescribing, storing and administration of medication.
1.2. The legislative requirements and professional codes of practice to be complied with during the ordering, prescribing, storing and administration of medication.
1.3. The process for prescribing resident medication.
1.4. The process for ordering resident medication.
1.5. The process for storing resident medication.
1.6. The process for the administration of resident medication, including routes of medication.
1.7. The process for administering controlled drugs, including checks and records required.
1.8. The process for self-administration of medication.
1.9. The process for crushing medications.
1.10. The process for withholding medication.
1.11. The process to be applied when medication is refused by the resident.
1.12. The processes for medication management at admission, transfer, and discharge.
1.13. The process for medication reconciliation.
1.14. The process to review resident medication.
1.15. The process for the management of medication errors and/or adverse effects, including external reporting requirements.

2. TRAINING AND EDUCATION:

2.1. All nursing and medical staff, as well as pharmacy staff, where applicable, have read and understood the policies relating to ordering, prescribing, storing and administering medicines. This is documented.
2.2. All nursing and medical staff, as well as pharmacy staff, where applicable, can articulate the processes for ordering, prescribing, storing and administering medicines, as set out in the policy.

2.3. Staff have access to comprehensive, up-to-date information on all aspects of medication management.
2.4. All nursing, medical and pharmacy staff, where applicable, receive training on the importance of reporting medication incidents, errors or near misses. This is documented.

3. MONITORING:

The implementation of the ordering, prescribing, storing and administration of medication policies is monitored and continuously improved. Monitoring requirements include, but are not limited to:

3.1. Quarterly audits of Medication Prescription and Administration Records (MPARs) are undertaken to determine compliance with the policies and procedures and with the applicable legislation and guidelines.
3.2. Incident reports are recorded for medication incidents, errors and near misses.

3.3. Analysis is completed to identify opportunities for improvement of medication management processes.

4. **EVIDENCE OF IMPLEMENTATION:**

There is evidence that the ordering, prescribing, storing and administration of medication policies are being implemented throughout the approved centre, including, but not limited to:

**Prescription and Administration – MPAR**

A Medication Prescription and Administration Record (MPAR) is maintained for each resident that details the following:

4.1. Two appropriate resident identifiers.

4.2. A record of any allergies or sensitivities to any medications, including if the resident has no allergies.

4.3. The generic name of the medication and preparation (where applicable).

4.4. Names of medications and preparations written in full - unofficial abbreviations are not used.

4.5. Dedicated space for routine medications.

4.6. Dedicated space for once-off medications.

4.7. Dedicated space for “as required” (PRN) medications.

4.8. The frequency of administration, including the minimum dose interval for “as required” (PRN) medication.

4.9. The dose/amount to be given.

4.10. Micrograms written in full - not abbreviated

4.11. The administration route for the medication.

4.12. A record of all medications administered to the resident.

4.13. A record of any medications refused by the resident.


4.15. A clear record of the date of discontinuation of each medication.

4.16. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident. The MCRN does not need to be included on every entry in the MPAR, but must be present within the resident’s MPAR.

4.17. The Nursing and Midwifery Board of Ireland (NMBI) registration number (also known as Personal Identification Number (PIN)) of every nurse prescriber prescribing medication to the resident.

4.18. The signature of the medical practitioner/nurse prescriber for each entry.

**Prescription and Administration – General**

4.19. All entries on the MPAR are legible.

4.20. All entries on the MPAR are written in black indelible ink.

4.21. Medication is reviewed and re-written at least six-monthly, or more frequently where there is a significant change in the resident’s care or condition. This is documented in the clinical file.

4.22. A prescription is not altered where a change is required. Where there is any alteration in the medication order, the medical practitioner rewrites the prescription.

4.23. All medicines, including scheduled controlled drugs (except those for self-administration) are administered by a registered nurse or registered medical practitioner.

4.24. Medicinal products are administered in accordance with:

4.24.1. Directions of the prescriber.

4.24.2. Any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

4.25. The expiration date of the medication is checked prior to administration; expired medications are not administered.

4.26. Good hand hygiene techniques are implemented during the dispensing of medications.

4.27. When a resident’s medication is withheld, the justification is noted in the MPAR and also documented in the clinical file.

4.28. Where the resident refuses the medication, this is documented in the MPAR and the clinical file and communicated to medical staff.

4.29. Schedule 2 controlled drugs are checked by two staff members (one of which must be a registered nurse) against the delivery form and details are entered on the controlled drug book. The controlled drug balance available corresponds with the balance recorded in the controlled drug book.
Following administration, the details are entered in the controlled drug book and signed by both staff members.

4.30. The resident may self-administer medications where the risks have been assessed and his/her competence to self-administer is confirmed. Any change to the initial risk assessment is recorded and arrangements for self-administering medicines are kept under review.

4.31. Direction to crush medication is only accepted from the resident’s medical practitioner. The medical practitioner gives a documented reason why the medication is to be crushed. The pharmacist is consulted about the type of preparation to be used. The medical practitioner documents within the MPAR that the medication is to be crushed.

Ordering and Storage

4.32. Medication is stored in the appropriate environment as indicated on the label or packaging of the medication, or as advised by the pharmacist.

4.33. Where medication requires refrigeration, a log of the temperature of the refrigeration storage unit is taken daily.

4.34. Medication storage areas are free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage.

4.35. Medication storage areas are incorporated in the cleaning and housekeeping schedules.

4.36. Food and drink is not stored in areas used for the storage of medication.

4.37. Medications for self-administration should be labelled individually by a pharmacist with the resident name, MRN and appropriate directions for use, and stored appropriately for use only by that resident.

4.38. Medication dispensed or supplied to the resident is stored securely in a locked storage unit (e.g. drugs trolley or drawers), with the exception of medication which is recommended to be stored elsewhere (e.g. refrigerator).

4.39. The medication trolley and/or medication administration cupboard remains locked at all times and secured in a locked room.

4.40. Schedule 2 and 3 controlled drugs are locked in a separate cupboard from other medicinal products to ensure further security.

4.41. A system of stock-rotation is implemented, to avoid accumulation of old stock.

4.42. An inventory of medications is conducted on a monthly basis, checking:
   4.42.1. Name and dose of medication.
   4.42.2. Quantity of medication.
   4.42.3. Expiry date.

4.43. Medications that are no longer required, which are past their expiry date or have been dispensed to a resident but are no longer required are stored in a secure manner, segregated from other medication, and are returned to the pharmacy for disposal.
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Regulation 24
Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

Purpose
The registered proprietor takes all reasonable steps to ensure the health and safety of residents, staff and visitors.

Guidance for Compliance:
1. **PROCESSES:**

Written operational policies and procedures are available in relation to health and safety within the approved centre. The policies and procedures include requirements relating to:

1.1. The roles and responsibilities for ensuring the health and safety of staff, residents and visitors.

1.2. Specific roles are allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

1.3. Safety representative roles are allocated and documented.

1.4. The approved centre’s compliance with health and safety legislation including the reporting requirements.

1.5. The content of the Health and Safety Statement.

1.6. The health and safety risk management process.

1.7. The fire management plan.

1.8. Infection control measures, including:

   1.8.1. Provision and required use of Personal Protective Equipment (PPE)

   1.8.2. Safe handling and disposal of healthcare risk waste

   1.8.3. Management of spillages

   1.8.4. Raising awareness of residents and their visitors to infection control measures

   1.8.5. Hand washing

   1.8.6. Linen handling

1.8.7. Covering of cuts and abrasions

1.8.8. Response to sharps or needle stick injuries

1.8.9. Availability of staff vaccinations and immunisations

1.8.10. Management and reporting of an infection outbreak

1.8.11. Support provided to staff following exposure to infectious diseases

1.8.12. Specific infection control measures in relation to infection types, e.g. C.diff, MRSA, Norovirus

1.9. First aid response requirements.

1.10. Falls prevention initiatives.

1.11. Vehicle controls.

1.12. The staff training requirements in relation to health and safety.

1.13. The monitoring and continuous improvement requirements implemented for the health and safety processes.

2. **TRAINING AND EDUCATION:**

2.1. All staff have read and understood the health and safety policy. This is documented.

2.2. All staff can articulate the processes relating to health and safety as set out in the policy.

3. **MONITORING:**

The health and safety policy is monitored pursuant to Regulation 29: Operational Policies and Procedures.

4. **EVIDENCE OF IMPLEMENTATION:**

This Regulation is only assessed against the approved centre’s written policies and procedures and does not assess health and safety practices within the approved centre.
## Scoring

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<td>The approved centre complies with all aspects of Regulation 24: Health and Safety.</td>
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<tr>
<td>Note: A written operational policy relating to staff, residents and visitors is required to attain compliance with this Regulation.</td>
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<td>The approved centre does not comply with all aspects of Regulation 24: Health and Safety.</td>
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Regulation 25
Use of Closed Circuit Television

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
(b) it shall be clearly labelled and be evident;
(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

Purpose

The approved centre may use CCTV cameras for the purpose of monitoring resident health and well-being. The Regulation does not apply to places of access for the general population (e.g. reception area), where cameras are used for security; i.e. for the purposes of crime prevention and prosecution.

 Guidance for Compliance:

1. **PROCESSES:**

   Policies and procedures are available within the approved centre in relation to the use of CCTV or other monitoring equipment. The policies and procedures include requirements in relation to:

   1.1. The roles and responsibilities for the use of CCTV within the approved centre.
   1.2. The purpose and function of using CCTV for observing residents in the approved centre.
   1.3. The measures used to ensure the privacy and dignity of residents where the approved centre uses CCTV cameras or other monitoring equipment.
   1.4. The maintenance of CCTV cameras by the approved centre.
   1.5. The disclosure of the existence and usage of CCTV or other monitoring devices to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.
   1.6. Ensuring the use of CCTV in the approved centre is overt and clearly identifiable through the use of signage and communication with residents and/or their representatives.
   1.7. The process to cease monitoring a resident using CCTV in certain circumstances.

2. **TRAINING AND EDUCATION:**

   2.1. Relevant staff have read and understood the policy on CCTV. This is documented.
   2.2. Relevant staff can articulate the processes relating to the use of CCTV as set out in the policy.

3. **MONITORING:**

   The implementation of the policies and procedures on the use of CCTV is monitored and continuously improved.

   3.1. The CCTV equipment is checked regularly to ensure it is operating appropriately. This is documented.
   3.2. Analysis is completed to identify opportunities for improvement of the use of CCTV.
4. **EVIDENCE OF IMPLEMENTATION:**

There is evidence of the implementation of the policies, procedures for the use of CCTV in the approved centre including, but not limited to:

4.1. Clear signs in prominent positions where CCTV cameras or other monitoring systems are located throughout the approved centre.

4.2. A resident is monitored solely for the purposes of ensuring the health, safety and welfare of that resident.

4.3. The usage of CCTV, or other monitoring systems, has been disclosed to the Mental Health Commission and/or the Inspector of Mental Health Services.

4.4. CCTV cameras or other monitoring systems used to observe a resident must be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form.

4.5. CCTV cameras or other monitoring systems used to observe a resident must not transmit images other than to a monitor that is viewed solely by the health professional responsible for the resident.

4.6. CCTV is not used to monitor a resident if they start to act in a way which compromises their dignity.

**Scoring**

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<td>The approved centre complies with all aspects of Regulation 25: Use of Closed Circuit Television; and there is evidence of the following:</td>
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Regulation 26
Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

Purpose

The approved centre employs a sufficient number of suitably qualified, competent and experienced staff to enable them to meet the care and treatment needs of residents at all times.

Guidance for Compliance:

1. PROCESSES:

Written policies and procedures are in place in relation to the approved centre’s staffing requirements. The policies and procedures include requirements relating to:

Staffing

1.1. The roles and responsibilities for the recruitment, selection, vetting and appointment processes for all staff within the approved centre.

1.2. The recruitment, selection and appointment process of the approved centre, including the Garda vetting requirements.

1.3. The roles and responsibilities in relation to staffing processes within the approved centre.

1.4. The organisational structure of the approved centre, including lines of responsibility.

1.5. The job description requirements.

1.6. The staff planning requirements to address the number and skill mix of staff appropriate to the assessed needs of residents as well as the size and layout of the approved centre.

1.7. The staff rota and the methods applied for its communication to staff.

1.8. The staff performance and evaluation requirements.

1.9. The use of agency staff.

1.10. The process for reassignment of staff in response to changing resident needs or staff shortages.

1.11. The process for transferring responsibility from one staff member to another.

Training

1.12. The roles and responsibilities in relation to staff training processes within the approved centre.

1.13. The orientation and induction training for all new staff.

1.14. The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.

1.15. The required qualifications of training personnel.

1.16. The evaluation of training programmes.

2. TRAINING AND EDUCATION:

2.1. Relevant staff have read and understood the staffing policies. This is documented.

2.2. Relevant staff can articulate the processes relating to staffing as set out in the policies.

3. MONITORING:

The implementation of staffing policies and procedures, processes and outputs, is monitored and continuously improved,
including:

3.1. The implementation and effectiveness of the staff training plan is reviewed on an annual basis. This is documented.

3.2. The numbers and skill mix of staff is reviewed against the levels recorded in the approved centre’s registration.

3.3. Analysis is completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policies, procedures and defined processes for staffing being implemented throughout the approved centre.

Staffing

4.1. There is an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff.

4.2. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, is maintained in the approved centre.

4.3. The numbers and skill mix of staffing is sufficient to meet resident needs.

4.4. Staff are recruited and selected in accordance to the approved centre’s policy and procedure for recruitment, selection and appointment.

4.5. All staff, including permanent, contract and volunteers, are vetted in accordance with the approved centre’s recruitment, selection and appointment policy and procedure. Information from referees is sought and documented.

4.6. Staff have the appropriate qualifications to do their job.

4.7. An appropriately qualified staff member is on duty and in charge at all times. This is documented.

4.8. There is a written staffing plan for the approved centre. The staffing plan addresses the following:

4.8.1. The skill mix, competencies, number and qualifications of staff.

4.8.2. The staffing plan takes into consideration the assessed needs of the resident group profile of the approved centre through the following:

   • Size and layout of the approved centre

   • Level of acuity of psychiatric illness

   • Age profile of residents

   • The length of stay of residents

   • The physical care needs of the residents

   • Challenging behaviour exhibited by residents

   • Level of dependency and need for supervision of the residents

   • The number of beds available

4.8.3. The required number of staff on duty at night to ensure safety of residents in the event of a fire or other emergency.

4.9. Where agency staff are used, there is a comprehensive contract between the approved centre and any registered/licensed staffing agency used that sets out the agency’s responsibilities in relation to:

4.9.1. vetting of staff, including Garda vetting and references and vetting from other jurisdictions as appropriate;

4.9.2. confirmation of registration/validation of status (where applicable);

4.9.3. confirmation of identity;

4.9.4. professional indemnity;

4.9.5. confirmation of staff training; and

4.9.6. arrangements for responding to concerns/complaints.

Training

4.10. Annual staff training plans are completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile.

4.11. Orientation training is completed for staff.

4.12. Induction training is completed for staff.

4.13. All healthcare professionals are trained in the following:


4.13.2. Basic Life Support.

4.13.3. Management of violence and aggression (e.g. Therapeutic Crisis Intervention (TCI)/Professional Management of Aggression and Violence (PMAV)).


4.13.5. Children First

4.14. All staff in a CAMHS unit are trained in Children First.

4.15. Staff are trained in accordance with the assessed needs of the resident group.
profile, and assessed needs of individual residents, as detailed in the staff training plan. Training may include, but is not limited to:

4.15.2. Infection control and prevention (including sharps, hand hygiene techniques and use of PPE).
4.15.3. Dementia care.
4.15.4. Care for residents with an intellectual disability.
4.15.5. End of life care.
4.15.6. Resident rights.
4.15.7. Risk management – individual, organisational and care and treatment provision as appropriate to the staff role.
4.15.9. Incident reporting.
4.15.10. Protection of children and vulnerable adults.

4.16. All staff training is documented.
4.17. Staff training logs are maintained.

4.18. Opportunities are made available to staff by the approved centre for further education. These opportunities are effectively communicated to all relevant staff and are supported through tuition support, scheduled time away from work, or recognition for achievement.

4.19. In-service training is completed by appropriately trained and competent individuals.

4.20. There are facilities and equipment available for staff in-service education and training.

Mental Health Act 2001

4.21. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance are made available to staff throughout the approved centre.

Scoring

Compliant – Excellent achievement
The approved centre complies with all aspects of Regulation 26: Staffing; and there is evidence of the following:

- An up-to-date written policy on the processes for staffing and staff training; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

Compliant – Satisfactory
The approved centre complies with all aspects of Regulation 26: Staffing.
Note: A written policy on the recruitment, selection and vetting of staff is required to attain compliance with this Regulation.

Non-compliant – Needs Improvement
The approved centre does not comply with all aspects of Regulation 26: Staffing.

Non-compliant – Inadequate
The approved centre does not comply with all aspects of Regulation 26: Staffing; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for staffing and staff training; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 27

Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.


Purpose

The approved centre maintains comprehensive records to support the provision of safe and effective health care.

Guidance for Compliance

1. PROCESSES:

Written policies and procedures are available in relation to the maintenance of records in the approved centre. The policies and procedures include requirements relating to:

1.1. The roles and responsibilities for the creation of, access to, retention of and destruction of records.
1.2. The records required to be created for each resident.
1.3. The required content for each resident record.
1.4. Those authorised to access and make entries in the residents’ records.
1.5. Record review requirements.
1.6. Privacy and confidentiality of resident record and content.
1.7. Residents’ access to resident records.
1.8. Record retention periods.
1.9. The destruction of records.

1.10. The relevant legislative requirements relating to record maintenance; the implementation of the Data Protection Acts, Freedom of Information Acts and associated controls for records.
1.11. How entries in the residents’ records are made, corrected and overwritten.
1.12. The process for making a retrospective entry in residents’ records.
1.14. Retention of inspection reports relating to food safety, health and safety and fire inspections.

2. TRAINING AND EDUCATION:

2.1. All clinical staff and other relevant staff have read and understood the policies relating to maintenance of records. This is documented.
2.2. All clinical staff and other relevant staff can articulate the processes for the creation of, access to, retention of and destruction of records as set out in the policies.
2.3. All clinical staff are trained in best-practice record keeping.

3. MONITORING:

The implementation of policies and procedures relating to the maintenance of records is monitored and continuously improved, including:

3.1. Resident records are audited to ensure their completeness, accuracy and ease of retrieval. This is documented. The records of transferred and discharged residents are included in the review process, insofar as is practicable.
3.2. Analysis is completed to identify opportunities to improve the maintenance of records processes.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the policies and procedures for the maintenance of records being implemented throughout the approved centre, including, but not limited to:

4.1. All residents’ records are secure, up to date, in good order and are constructed, maintained and used in accordance with national guidelines and legislative requirements.
4.2. All resident records are physically stored together, where possible.

4.3. A record is initiated for every resident assessed or provided with care and/or services by the approved centre.

4.4. Resident records are reflective of the residents’ current status and the care and treatment being provided.

4.5. Resident records are maintained through the use of an identifier that is unique to the resident or some other effective method.

4.6. Resident records are developed and maintained to a logical sequence.

4.7. Resident records are maintained in good order; for example, no loose pages.

4.8. Resident records are accessible to authorised staff only. Staff have access to the data and information needed to carry out their job responsibilities.

4.9. Residents’ access to their records is managed in accordance to the Data Protection Acts.

4.10. Only authorised staff make entries in residents’ records, or specific sections therein.

4.11. Resident records are maintained appropriately. Requirements include:

4.11.1. Records are written legibly in black indelible ink and are readable when photocopied.

4.11.2. Entries are factual, consistent, accurate and do not contain jargon, unapproved abbreviations or meaningless phrases (e.g. observations – “resident kept a low profile”).

4.11.3. Each entry includes the date.

4.11.4. Each entry includes the time using the 24-hour clock.

4.11.5. Each entry is followed by a signature.

4.11.6. The approved centre also maintains a record of all signatures used in the resident record.

4.11.7. All entries made by student nurses/clinical training staff shall be countersigned by a registered nurse/clinical supervisor.

4.11.8. Where an error is made, this shall be scored out with a single line and the correction written alongside with date, time and initials. Correction fluid is not used on approved centre records.

4.11.9. Two appropriate resident identifiers are recorded on all documentation.

4.11.10. Where a member of staff makes a referral to, or consults with another member of the healthcare team, this person is clearly identified by their full name and title. ‘Seen by doctor’ or ‘doctor informed’ is not acceptable.

4.11.11. Where information or advice is given over the telephone, this is documented as such by the member of staff who took the call and the person giving the information or advice shall be clearly identified.

4.12. Records are appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

4.13. Documentation of food safety, health and safety and fire inspections is maintained in the approved centre.

4.14. Records are retained/destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.
## Scoring

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Regulation 28
Register of Residents

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

Purpose
The register of residents provides complete and accurate information about the resident demographic, ethnic, cultural, legal status and length of stay patterns in in-patient admissions.

Guidance for Compliance:

1. PROCESSES:

Processes are in place to support the following in relation to the register of residents in the approved centre:

1.1. The roles and responsibilities for the maintenance and access to the register.
1.2. A standard and agreed practice to be applied in updating and maintenance of the register.
1.3. The method to maintain the register in the format determined by the Mental Health Commission.

2. TRAINING AND EDUCATION:

Relevant staff are informed of the processes relating to the updating and maintenance of the register.

3. MONITORING:

The registered proprietor is responsible for ensuring that the register of residents contains up-to-date and accurate information.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the processes for the register of residents being implemented throughout the approved centre, including, but not limited to:

4.1. A documented register (electronic or hard copy) of all residents admitted to the approved centre is available. The register of residents contains at a minimum the following information (as per Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006):

- Full name
- Address
- Gender
- Date of birth
- Country of birth
- Ethnic or cultural background
  - White
  - Irish
  - Irish traveller
  - Roma
  - Any other white background
  - Black or Black Irish
  - African
  - Any other Black background
  - Asian or Asian Irish
  - Chinese
  - Any other Asian background
  - Other, including mixed background
- Next of kin/Representative(s)
- Admission date
- Discharge date
- Diagnosis on admission (or provisional diagnosis, where diagnosis is not available)
- Diagnosis on discharge
- Resident status, i.e. voluntary or involuntary.

4.2. The register of residents is up to date.

4.3. The register of residents is made available to the Mental Health Commission, where requested.

Scoring

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Regulation 29
Operating Policies and Procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

Purpose

All operating policies and procedures required by the Regulations are developed, approved, disseminated and reviewed in a standardised and effective manner throughout the approved centre.

Guidance for Compliance:

1. PROCESSES:

A written policy is available in relation to the development and review of operating policies and procedures required by the Regulations, including:

1.1. The roles and responsibilities in relation to the development, management and review of operating policies and procedures.

1.2. The process for the development of the operating policies and procedures required by the Regulations, incorporating relevant legislation, evidence-based best practice and clinical guidelines.

1.3. The process for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.

1.4. The process for the approval of operating policies and procedures.

1.5. The process for disseminating operating policies and procedures, either in electronic or hard copy.

1.6. The process for reviewing and updating operating policies and procedures, at least every three years.

1.7. The process for training on operating policies and procedures including the requirements for training following the release of a new or updated operating policy and procedure.

1.8. The process for making obsolete, and retaining, previous versions of operating policies and procedures.

1.9. The standardised operating policy and procedure layout used by the approved centre.

2. TRAINING AND EDUCATION:

Relevant staff are trained on the processes relating to the updating and maintenance of the operational policies and procedures.

2.1. Relevant staff have read and understood the policy on developing and reviewing operational policies. This is documented.

2.2. Relevant staff are trained on approved operational policies and procedures.

2.3. Relevant staff can articulate the processes for developing and reviewing operational policies, as set out in the policy.

3. MONITORING:

The operating policies and procedures are reviewed and updated by appropriate clinical and managerial teams to ensure they reflect the current operational practices in the approved centre.

3.1. An annual audit is undertaken to determine compliance with review timeframes.

3.2. Analysis is completed to identify opportunities to improve the processes of developing and reviewing policies.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of implementation of the policy on the development and review of policies and procedures throughout the approved centre, including, but not limited to:

4.1. The operating policies and procedures of the approved centre are developed with input from clinical and managerial staff and in consultation with all relevant stakeholders (including services users), as appropriate.

4.2. The operating policies and procedures of the approved centre incorporate relevant legislation, evidence-based best practice and clinical guidelines.

4.3. The operating policies and procedures of the approved centre are appropriately approved.
4.4. The operating policies and procedures of the approved centre are communicated to all relevant staff.

4.5. The following operating policies and procedures are required to be reviewed within three years for compliance with this regulation:
- Regulation 8: Residents’ Personal Property and Possessions
- Regulation 11: Visits
- Regulation 12: Communication
- Regulation 13: Searches
- Regulation 14: Care of the Dying
- Regulation 18: Transfer of Residents
- Regulation 19: Responding to Medical Emergencies
- Regulation 20: Provision of Information to Residents
- Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
- Regulation 24: Health and Safety
- Regulation 25: CCTV (where applicable)
- Regulation 26: Staffing
- Regulation 27: Maintenance of Records
- Regulation 31: Complaints Procedures
- Regulation 32: Risk Management Procedures

4.6. Obsolete versions of operating policies and procedures are retained but removed from possible access by staff.

4.7. The format of policies and procedures is standardised and includes:
- Title of the policy and procedure
- Reference number and revision of the policy and procedure
- Document owner
- Approvers
- Reviewers, where applicable
- Scope of the policy and procedure
- Date from which the policy will be implemented (effective from)
- Scheduled review date - the document is re-dated after each review
- Total number of pages in the policy and procedure.

4.8. Where generic policies (e.g. complaints, staffing, etc.) are used, the approved centre has a written statement to this effect (adopting the generic policy), which is reviewed at least every three years.

4.9. Any generic policies used are appropriate to the approved centre and the resident group profile.

Note on policies:

The following operating policies and procedures are required by the Judgement Support Framework, for a quality assessment of ‘Excellent’ in the relevant regulations. They are not assessed for compliance with Regulation 29:

- Identification of residents (Regulation 4)
- Food and nutrition (Regulation 5)
- Food safety (Regulation 6)
- Residents’ clothing (Regulation 7)
- Recreational activities (Regulation 9)
- Religion (Regulation 10)
- Individual care planning (Regulation 15)
- Therapeutic services (Regulation 16)
- Children’s education (Regulation 17)
- General health provision (Regulation 19)
- Privacy (Regulation 21)
- Maintenance of premises (Regulation 22)
- Policy development (Regulation 29)
- Mental Health Tribunals (Regulation 30)

For the avoidance of doubt, a number of policies are required by the Rules and Codes of Practice made under the Mental Health Act 2001. The Rules and Codes should be referred to directly for guidance on the policy content and the frequency of their review.
## Scoring

<table>
<thead>
<tr>
<th>Compliant – Excellent achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The approved centre complies with all aspects of Regulation 29: Operating Policies and Procedures; and there is evidence of the following:</td>
</tr>
<tr>
<td>• An up-to-date written policy on the processes for developing and reviewing policies; and</td>
</tr>
<tr>
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</tbody>
</table>
Regulation 30
Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

Purpose

Under the Mental Health Act 2001, any person who is involuntarily admitted to the approved centre is reviewed by a Mental Health Tribunal.

This Regulation does not apply to child residents.

Guidance for Compliance:

1. PROCESSES

A written policy and procedures are available in relation to the facilitation of Mental Health Tribunals. The policy and procedures address the following:

1.1. The roles and responsibilities in relation to Mental Health Tribunals relevant to the approved centre.

1.2. The relevant legislative requirements in relation to Tribunals.

1.3. The provision of information to the patient regarding the Mental Health Tribunals.

1.4. The communication processes between the approved centre and external parties involved in the Mental Health Tribunals.

1.5. The resources and facilities provided by the approved centre to support patients attending a Mental Health Tribunal, including the availability of staff to attend a Tribunal, as necessary.

2. TRAINING AND EDUCATION

2.1. Relevant staff have read and understood the policy relating to Mental Health Tribunals. This is documented.

2.2. Relevant staff can articulate the processes for facilitating Mental Health Tribunals as set out in the policy.

3. MONITORING

The implementation of the policy and procedures in relation to facilitating Mental Health Tribunals is monitored to ensure that the rights and needs of the patient are appropriately supported, including:

3.1. Analysis is completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.

4. EVIDENCE OF IMPLEMENTATION

There is evidence that policy and procedures relating to Mental Health Tribunals are being implemented throughout the approved centre including, but not limited to:

4.1. The approved centre provides private facilities to support the Mental Health Tribunal process.

4.2. The approved centre provides adequate resources to support the Mental Health Tribunal process.

4.3. Staff attend Mental Health Tribunals and provide assistance, as necessary, when the patient requires assistance to attend or participate in the process.
## Scoring

<table>
<thead>
<tr>
<th>Compliant – Excellent achievement</th>
<th>The approved centre complies with all aspects of Regulation 30: Mental Health Tribunals; and there is evidence of the following:</th>
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Regulation 31  
Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident’s individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

Purpose

The approved centre is open to residents, their representatives and visitors voicing complaints regarding the service, care or treatment provided by the approved centre, or on behalf of the approved centre. Complaints are dealt with in an appropriate way and in accordance with the approved centre’s policy and procedure which will be readily available to the resident, their representatives and visitors.

Guidance for Compliance:

1. PROCESSES:

Written operational policies and procedures are available in relation to the management of complaints. The policies and procedures include requirements relating to:

1.1. The roles and responsibilities associated with the management of complaints within the approved centre, including a nominated person responsible to deal with all complaints.

1.2. The process for the management of complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in, or on behalf of, the approved centre.

1.3. The communication of the complaints policy and procedure with residents, their representatives, family and next-of-kin, as well as visitors.

1.4. The methods available to all persons to make complaints regarding the service, care or treatment by the approved centre, which may include:

1.4.1. Verbal
1.4.2. Written
1.4.3. Electronically by email
1.4.4. Telephone
1.4.5. Through complaint, feedback or suggestions forms.

1.5. The confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.

1.6. The timeframes for complaint management, including the timeframe for the approved centre to respond to the complaint, and for the complaint to be resolved.

1.7. The documentation of complaints including the maintenance of a complaints log by the nominated person.

1.8. Communication with the complainant during the complaint process.

1.9. The process to escalate complaints that cannot be addressed by the nominated person.
1.10. The appeal process available where the complainant is dissatisfied with the outcome of the complaint investigation.

2. TRAINING AND EDUCATION:

2.1. Relevant staff are trained on the complaints management processes.
2.2. All staff have read and understood the policy relating to complaints. This is documented.
2.3. All staff can articulate the processes for making, handling and investigating complaints as set out in the policy.

3. MONITORING:

The implementation of the complaints policy is monitored and continuously improved. This includes:

3.1. Audits of the complaints log and related records are completed. These audits are documented and findings acted upon.
3.2. Complaints data is analysed. Details of this analysis are considered by senior management. Required actions are identified and implemented to ensure continuous improvement of the complaints management process.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the complaints policy being implemented throughout the approved centre. This evidence includes, but is not limited to:

4.1. There is a nominated person responsible for dealing with all complaints who is available to the approved centre.
4.2. A consistent and standardised approach is implemented for the management of all complaints.
4.3. Residents and their representatives are facilitated to make a complaints using the methods detailed within the complaints policy and procedure, which may include:
   4.3.1. Verbal
   4.3.2. Written
   4.3.3. Electronically by email
   4.3.4. Telephone
   4.3.5. Through complaint, feedback or suggestions forms.
4.4. The registered proprietor ensures access, insofar as practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process.

4.5. The approved centre’s management of complaints processes is well publicised and accessible to residents and their representatives. This includes:

4.5.1. The provision of information about the complaints procedure to the resident and their representative at admission or soon thereafter. This information may be provided within the resident information booklet.
4.5.2. The complaints procedure, including how to contact the nominated person, is publicly displayed.
4.5.3. If the nominated person is not based in the approved centre, their contact details are publicly displayed.
4.5.4. Residents, their representatives, family and next-of-kin are informed of all methods by which a complaint can be made.

4.6. All complaints, whether oral or written, are investigated promptly and handled appropriately and sensitively.
4.7. The registered proprietor ensures that the quality of the service, care and treatment of a resident is not adversely affected by reason of the complaint being made.

4.8. A method for addressing minor complaints within the approved centre is provided.

4.9. Minor complaints must be documented.
4.10. Where minor complaints cannot be addressed locally the nominated person must deal with the complaint.
4.11. All complaints (that are not minor complaints) are dealt with by the nominated person and recorded in the complaints log.
4.12. Details of complaints, as well as subsequent investigations and outcomes, are fully recorded and kept distinct from the resident’s individual care plan.
4.13. Where complaints cannot be addressed by the nominated person they are escalated in accordance with the approved centre’s policy. This is documented in the complaints log.

4.14. Timeframes are provided for:

4.14.1. Responding to the complainant following the initial receipt of the complaint.
4.14.3. The required resolution of complaints.

4.15. Where timeframes are not achieved, or further investigation time is required in relation to the complaint, this is communicated to the complainant.

4.16. The complainant is informed promptly of the outcome of the complaint investigation and details of the appeals process are made available to them. This is documented.

4.17. The complainant’s satisfaction, or dissatisfaction, with the investigation findings is documented.

4.18. Where services, care or treatment is provided on behalf of the approved centre by an external party, the nominated person is responsible for the full implementation of the approved centre’s complaints management process, including the investigation process and communication requirements with the complainant.

4.19. All information obtained through the course of the management of the complaint, and the associated investigation process, is treated in a confidential manner and meets the requirements of national guidelines and legislative requirements.

Scoring

Compliant – Excellent achievement

The approved centre complies with all aspects of Regulation 31: Complaints Procedures; and there is evidence of the following:

- An up-to-date written policy on the processes for complaints; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

Compliant – Satisfactory

The approved centre complies with all aspects of Regulation 31: Complaints Procedures.

Note: A written policy on the making, handling and investigating of complaints is required to attain compliance with this Regulation.

Non-compliant – Needs Improvement

The approved centre does not comply with all aspects of Regulation 31: Complaints Procedures.

Non-compliant – Inadequate

The approved centre does not comply with all aspects of Regulation 31: Complaints Procedures; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for complaints; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 32
Risk Management Procedures

(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.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;
(b) The precautions in place to control the risks identified;
(c) The precautions in place to control the following specified risks:
   (i) resident absent without leave,
   (ii) suicide and self harm,
   (iii) assault,
   (iv) accidental injury to residents or staff;
(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
(e) Arrangements for responding to emergencies;
(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) 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.

Purpose

The aim of risk management is to provide safe, effective, high quality care services. The approved centre's risk management process will incorporate the identification, assessment, management and ongoing review of risks on an organisational and individual level.

Guidance for Compliance:

1. PROCESSES:

A comprehensive written policy is available in relation to risk management and incident management procedures. The policy and procedures include requirements relating to:

Risk management

1.1. The roles and responsibilities for risk management and the implementation of the risk management policy within the approved centre, including:

1.1.1. The person with overall responsibility for risk management.
1.1.2. The responsibilities of the registered proprietor.
1.1.3. The responsibilities of the multidisciplinary team.
1.1.4. The person responsible for the completion of six-monthly incident summary reports.
1.1.5. A defined quality and safety oversight and review structure as part of the governance process for managing risk.

1.2. The process of identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre, including:

1.2.1. Organisational risks.
1.2.2. Structural risks, including ligature points.
1.2.3. Capacity risks relating to the number of residents in the approved centre.
1.2.4. Health and safety risks to the residents, staff and visitors.
1.2.5. Risks to the resident group during the provision of general care and services.
1.2.6. Risks to individual residents during the delivery of individualised care.

1.3. The process for rating identified risks.

1.4. The methods for controlling the following specified risks:

1.4.1. Resident absence without leave.
1.4.2. Suicide and self-harm.
1.4.3. Assault.
1.4.4. Accidental injury to residents or staff.

1.5. The process for maintaining and reviewing the risk register.

1.6. The record keeping requirements for risk management.
Incidents and adverse events

1.7. The process for managing incidents involving residents of the approved centre, including:
   1.7.1. The roles and responsibilities regarding the incident reporting process.
   1.7.2. The process for risk rating incidents.
   1.7.3. The process for recording and reporting incidents.
   1.7.4. The process for investigating incidents.
   1.7.5. The process for reviewing and monitoring incidents.
   1.7.6. The process for learning from incidents.
   1.7.7. The process for notifying the Mental Health Commission about incidents involving residents of the approved centre.

1.8. The process for responding to specific emergencies, including:
   1.8.1. The roles and responsibilities of key staff.
   1.8.2. The sequence of required actions.
   1.8.3. The process for communication.
   1.8.4. Escalating emergencies to management.

1.9. The process for the protection of children and vulnerable adults within the care of the approved centre.

2. TRAINING AND EDUCATION:

Relevant staff are trained in the risk management policy and procedures and their implementation throughout the service. Training requirements include:

2.1. Training in the identification, assessment and management of risk.
2.2. Health and safety risk management.
2.3. Clinical staff are trained in individual risk management processes.
2.4. Management staff are trained in organisational risk management.
2.5. All staff are trained in incident reporting and documentation.
2.6. All staff have read and understood the risk management policy.
2.7. All staff can articulate the risk management processes as set out in the policy.
2.8. All training is documented.

3. MONITORING:

The implementation of the risk management policy and procedures is monitored and continuously improved. Monitoring requirements include:

3.1. The risk register is reviewed at least quarterly to determine compliance with the approved centre’s risk management policy; the audit measures actions taken to address risks against the timeframes identified on the register.
3.2. Analysis of incident reports is completed to identify opportunities for improvement of risk management processes.

4. EVIDENCE OF IMPLEMENTATION:

There is evidence of the risk management policy being implemented throughout the approved centre, including, but not limited to:

Risk management

4.1. Responsibilities are allocated at management level and throughout the approved centre to ensure their effective implementation.
4.2. The person with responsibility for risk is identified and known by all staff.
4.3. The risk management procedures actively reduce identified risks to the lowest practicable level of risk.
4.4. Clinical risks are identified, assessed, treated, reported and monitored. Clinical risks are documented in the risk register, as appropriate.
4.5. Health and safety risks are identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation. Health and safety risks are documented within the risk register, as appropriate.
4.6. Structural risks, including ligature points, are removed or effectively mitigated.
4.7. Corporate risks are identified, assessed, treated, reported and monitored by the approved centre. Corporate risks are documented in the risk register.
4.8. The approved centre implements a plan to reduce risks to residents while any works to the premises are ongoing.
4.9. Individual risk assessments are completed prior to and during:
   4.9.1. Resident seclusion.
   4.9.2. Physical restraint.
   4.9.3. Mechanical restraint.
4.9.4. Specialised treatments, e.g. ECT.
4.9.5. At admission to identify individual risk factors, including general health risks, risk of absconision, risk of self-harm, etc.
4.9.6. Resident transfer.
4.9.7. Resident discharge.
4.9.8. In conjunction with medication requirements or administration.

4.10. Multi-disciplinary teams are involved in the development, implementation and review of the individual risk management processes.

4.11. Residents and/or their representatives, are involved in the individual risk management processes.

4.12. The requirements for the protection of children and vulnerable adults within the approved centre are appropriate and implemented as required.

**Incidents and adverse events**

**Scoring**

**Compliant – Excellent achievement**

The approved centre complies with all aspects of Regulation 32: Risk Management Procedures; and there is evidence of the following:

- An up-to-date written policy on the processes for risk management; and
- Staff training as detailed under Section 2: Training and Education; and
- Ongoing monitoring as detailed under Section 3: Monitoring; and
- All points under Section 4: Evidence of implementation, as applicable.

**Compliant – Satisfactory**

The approved centre complies with all aspects of Regulation 32: Risk Management Procedures.

Note: A comprehensive risk management policy is required to attain compliance with this Regulation.

**Non-compliant – Needs improvement**

The approved centre does not comply with all aspects of Regulation 32: Risk Management Procedures.

**Non-compliant – Inadequate**

The approved centre does not comply with all aspects of Regulation 32: Risk Management Procedures; and there is evidence (or a lack thereof) of the following:

- No written up-to-date policy on the processes for risk management; and
- No staff training as detailed under Section 2: Training and education; and
- No monitoring as detailed under Section 3: Monitoring; and
- The approved centre has not met applicable requirements under Section 4: Evidence of implementation.
Regulation 33

Insurance

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

Purpose

The approved centre’s insurance must be comprehensive and cover accidents or injury to residents, staff and visitors, loss or damage to the assets of the residents, all services provided and the building and its contents.

Guidance for Compliance:

1. **PROCESSES:**

   Processes are available to support the following in relation to insurance cover in the approved centre:

   1.1. The roles and responsibilities in relation to the sourcing, scope and payment of insurance.
   1.2. The process for required approval to renew the insurance annually or as appropriate.
   1.3. The process for the provision of evidence of insurance to the Mental Health Commission, where it is requested.
   1.4. The process to be applied in the event of a claim being submitted by a resident, visitor or staff member.

2. **TRAINING AND EDUCATION:**

   Relevant staff are aware of the processes relating to the approved centre’s insurance cover.

3. **MONITORING:**

   The scope of the approved centre’s insurance cover is reviewed by the registered proprietor in accordance with any changes to the scope of the services provided, should that change increase the risk of injury to the residents, staff or visitors to ensure that it addresses all requirements.

4. **EVIDENCE OF IMPLEMENTATION:**

   There is evidence of the insurance processes being implemented throughout the approved centre, including, but not limited to:

   4.1. Confirmation of insurance is available in documentary form and in date, on inspection and on request by the Mental Health Commission.
   4.2. The approved centre’s insurance covers the following:
       4.2.1. Public liability;
       4.2.2. Employers’ liability;
       4.2.3. Clinical indemnity; and
       4.2.4. Property.
   4.3. There is an indemnity scheme statement available for inspection or on request by the Mental Health Commission.

**Scoring**

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Regulation 34
Certificate of Registration

The registered proprietor shall ensure that the approved centre’s current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

Purpose

The registration of the approved centre is in accordance with the Mental Health Act 2001. An up-to-date certificate of registration must be displayed, confirming that the approved centre has been registered.

Guidance for Compliance:

1. **PROCESSES:**

   Defined processes are available to support the following in relation to the certificate of registration.

   1.1. The roles and responsibilities in relation to the management and display of the certificate of registration.

   1.2. The process to review the certificate of registration and communicate with the Mental Health Commission should a change be required to the content (e.g. the number of registered beds).

2. **TRAINING AND EDUCATION:**

   Relevant staff are aware of the processes relating to the approved centre’s certificate of registration.

3. **MONITORING:**

   The registered proprietor monitors the approved centre’s certificate of registration.

4. **EVIDENCE OF IMPLEMENTATION:**

   There is evidence of the processes for displaying the certificate of registration being implemented. These include, but are not limited to:

   4.1. There is an up-to-date certificate of registration prominently displayed in the approved centre.

   4.2. Any conditions relating to the certificate of registration are documented and prominently displayed.

4.3. Where changes have arisen in relation to the information detailed within the certificate of registration, this is communicated to the Mental Health Commission.

**Scoring**

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Part 4 of the Mental Health Act 2001:
Consent to Treatment

Section 56:
In this Part “consent”, in relation to a patient, means consent obtained freely without threats or inducements, where—

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

Section 60:
Where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either—

a) the patient gives his or her consent in writing to the continued administration of that medicine, or

b) where the patient is unable to give such consent—
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist […]

Purpose

The Inspector must assess an approved centre’s compliance with Part 4 of the Mental Health Act 2001, as amended, (the 2001 Act) as part of each annual regulatory inspection.

There are specific requirements in Part 4 of the 2001 Act in relation to medication administered to involuntary patients for a continuous period of 3 months. For these patients there are two questions that must be assessed in order to continue to administer medication:

• Does the patient have the ability to understand the nature, purpose and likely effects of the proposed treatment?
• Is the patient willing to consent?

All documentation set out below must be made available to the Mental Health Commission on request, or to the Inspector on inspection.

These requirements relate to medications administered for the purposes of ameliorating the patient’s mental disorder and do not relate to medication administered for general health purposes.

Guidance for Compliance:

Ability to consent (assessment of capacity)

Following the administration of medication for a continuous period of 3 months, the patient’s responsible consultant psychiatrist must assess their patient’s ability to consent to the treatment; this includes an assessment of the patient’s ability to understand the nature, purpose and likely effects of the proposed treatment.

EVIDENCE:

There must be documented evidence that the responsible consultant psychiatrist has undertaken this assessment. This may be
evidenced by a capacity assessment, or equivalent.

**Unable to consent**

Where a patient is assessed as being unable to consent to the continued administration of medication, the treatment may be approved and authorised by two consultant psychiatrists pursuant to the procedure set out in *Form 17: Administration of Medicine for more than 3 Months Involuntary Patient (Adult) – Unable to Consent.*

**EVIDENCE:**

The Form 17 must contain the following:

- The name of the medication(s) prescribed;
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose and likely effects of the medication(s);
- Details of the discussion with the patient, including:
  - the nature and purpose of the medication(s);
  - the effects of the medication(s) including any risks and benefits; and
  - any views expressed by the patient;
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist.
- Authorisation by a second consultant psychiatrist.

**Written consent**

Where a patient is assessed as being able to understand the nature, purpose and likely effects and is willing to consent to continue taking the medication, this must be recorded in a written consent form.

**EVIDENCE:**

The consent form must contain the following:

- The name of the medication(s) prescribed;
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose and likely effects of the medication(s);
- Details of the discussion with the patient, including:
  - the nature and purpose of the medication(s);
- Any supports provided to the patient in relation to the discussion and their decision-making.

**Children admitted under Section 25 of the 2001 Act**

A child admitted under Section 25 of the 2001 Act may be administered medication with or without consent for the purposes of ameliorating his or her mental disorder for a period of three months.

On the expiration of the three month period the administration of medication may only be continued if it is approved and authorised by two consultant psychiatrists pursuant to the procedure set out in *Form 18: Treatment without Consent – Administration of Medicine for more than 3 Months (Child).*

**Scoring**

<table>
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<tr>
<th>Compliant</th>
<th>The approved centre complies with all aspects of Part 4 of the Mental Health Act 2001.</th>
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<tbody>
<tr>
<td>Non-compliant</td>
<td>The approved centre does not comply with all aspects of Part 4 of the Mental Health Act 2001.</td>
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