# Best Practice Guidance for Suicide Prevention Services

**Working together for high-quality services**

*Co-produced by the HSE NOSP and NGO partners*

# Acknowledgements

The HSE National Office for Suicide Prevention gratefully acknowledges the time, energy and commitment given by everyone who participated in the development of the *Best Practice Guidance for Suicide Prevention Services.*

It must be acknowledged that this project could not have been achieved without a genuine desire by all involved to provide the highest quality services possible for people that may need them.

We would like to acknowledge all past and current staff of the HSE NOSP for their support to the project.

Appendix 1 reflects the many people and their organisations that have supported this process. We are deeply appreciative for the enthusiasm and commitment that they have demonstrated through their participation.

A sincere thank you to the Steering Committee and the Project Advisory Group for providing oversight and subject matter expertise to this project.

We are very grateful and appreciative to My Mind, Suicide or Survive, Childline, Pieta House and Samaritans Ireland for agreeing to become learning sites and test the draft guidance in 2018.

Special thanks to Linda Moore and Beverley Browne, Quality Service User Safety (QSUS), Mental Health Services for sharing the knowledge and materials gained from the Best Practice Guidance for Mental Health Services with this project.

And finally to Dr. Jane Pillinger, independent researcher and policy advisor, her expertise and commitment to this project has been unfailing and is deeply appreciated.

What we have achieved together is a framework that we believe will play an important role in ensuring high-quality services for people vulnerable to suicide. Our hope is that it will provide a platform from which to foster a continuous quality improvement agenda in Ireland over the coming years.

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Project Manager

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Section 1

# Introduction and overview

## 1.1 Introduction and background

The ***Best Practice Guidance for Suicide Prevention Services*** has been co-produced by the HSE National Office for Suicide Prevention (NOSP), and non-governmental organisations (NGOs) working in the area of suicide prevention.

The guidance is underpinned by the best available evidence. It aims to support organisations to deliver high-quality, evidence-based suicide prevention services and is an important step in assuring quality in the provision of suicide prevention services. This gives an opportunity for organisations to demonstrate their commitment to best practice and to the delivery of quality services and the reduction of suicide.

### Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020

The development of this best practice guidance is set out under goal 5 (Action 5.1.1) of *Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020*. The HSE NOSP is the lead agency to deliver on this action, which is outlined in the box below.

The NOSP co-ordinates the implementation, monitoring and evaluation of *Connecting for Life (CfL).* As part of the *CfL* strategy there are 69 actions under seven strategic goals; 22 government departments/agencies have made commitments as lead and/or supporting partners to deliver on these actions. In addition, non-governmental organisations (NGOs) are funded (by the HSE) to deliver on work aligned with *CfL's strategic objectives*. The scope and scale of the different NGOs are highlighted by variations in for example, size, staff numbers and those having a national remit.

## Goal 5:
## To ensure safe and high-quality services for people vulnerable to suicide

Supporting people through a time of distress can be difficult work; therefore, agencies need to have good-practice guidelines, clear care protocols, appropriate training and supervision mechanisms. By ensuring the quality and standard of both statutory and funded non-statutory health and social care services and strong governance and accountability structures, service users and providers are protected and the professionalism and safety of the service response are enhanced. All services must promote an ambition for recovery, restoring the individual's independence built on self-worth and self-belief.

A key Action (5.1.1) under this goal is to 'Develop quality standards for suicide prevention services provided by statutory and non-statutory organisations, and implement the standards through an appropriate structure'. The development of the *Best Practice Guidance for Suicide Prevention Services* is key to achieving this goal.

## Alignment with national frameworks on mental health and quality and safety in healthcare

An important feature of the guidance is to help service providers understand and work towards meeting existing standards and guidelines in mental health and general health care, particularly in improving the governance and management of services. This includes:

— HSE Best Practice Guidance for Mental Health Services[1]

— Mental Health Commission Quality Framework for Mental Health Services in Ireland[2]

— HIQA standards Safer Better Healthcare[3]

— The Governance Code for Community, Voluntary and Charitable Organisations[4]

— Charities Regulator Governance Code[5]

Drawing on these national frameworks, the *Best Practice Guidance for Suicide Prevention Services* sets out the key principles and criteria for quality and safety improvements that should be applied to any suicide prevention service. This provides the basis for better governance in planning, managing and providing high-quality services, measuring improvement, identifying and addressing gaps, and identifying strengths, good practices and areas for improvement.

1. The Best Practice Guidance for Mental Health services is a practical tool and is based on legislation and best available evidence. This includes the Mental Health Act (2001) as amended, Statutory Instruments, Rules, Regulations and Codes of Practice; the Mental Health Commission Quality Framework (2007); the Mental Health Commission Judgement Support Framework (2017 Version 4); other national legislation and HSE policies and procedures; and national and international best practice. The guidance is informed and underpinned by the principles of recovery, which encompasses personal recovery as something worked towards and experienced by the person with mental illness and, clinical recovery, which is the contribution made by healthcare staff in supporting and facilitating the person in their journey towards recovery.
2. For further information see NALA: https://www.nala.ie/healthliteracy. See also explanation YouTube developed by NALA/HIQA: https://www.youtube.com/watch?v=PKq8hVoB4zs
3. Available at: https://www.hiqa.ie/standards/health/safer-better-healthcare
4. Available at: https://www.wheel.ie/sites/default/files/Guide%20to%20Governance%20Code%20FINAL.pdf
5. Available at: https://www.charitiesregulator.ie/media/1609/charities-governance-code.pdf

## 1.2 Overview of guidance

### What is the purpose of the guidance?

The guidance is designed to ensure that services to prevent suicide and support individuals, families and named supporters is:

- Based on evidence and best practice
- Person-centred, recovery oriented and responsive to the needs and expectations of people using the service
- Transparent and accessible to all people using the service
- Safe, with any potential risks identified and managed
- Reflective of current mental health, quality and safety policy and agenda
- In line with relevant standards, regulations and legislation
- Subject to high standards of management and governance
- Subject to structured monitoring and review, to promote continuous quality improvement

The *Best Practice Guidance for Suicide Prevention Services* puts people using the service at the centre of all service provision and gives a voice to the person using the service, their families and named supporters, in developing and assessing the quality of services.

### Who is the guidance for?

The guidance is designed to be used by organisations providing suicide prevention services, including services providing:

- Health promotion
- Early intervention and prevention
- Targeted suicide-prevention for high-risk individuals
- Crisis support and on-going intervention for people experiencing suicidal thoughts and behaviour
- Suicide prevention for communities or groups at risk of suicide
- Support for individuals or groups affected by suicide
- Suicide prevention interventions aimed at the whole of the population

These suicide prevention services may be delivered in a variety of ways, such as:

- Information and education – to individuals, groups and population-wide
- Support groups for people affected by suicide
- Helplines providing crisis support and information
- Online services aimed at raising awareness and information about services
- Acute services dealing with crisis situations
- Crisis and ongoing counselling and therapy

## Guiding principles

The *Best Practice Guidance for Suicide Prevention Services* starts from the basis that suicide prevention services are provided through evidence-based best practice and the principle of ***'first do no harm'*** to the people accessing them.

Five guiding principles form the basis for the delivery of services to support people at risk of suicide or self-harm:

— A clear suicide prevention objective is carried out in the organisation, as set out in *Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2020*

— Health and well-being of the whole population and the promotion of an ambition for recovery is at the core of work in suicide prevention

— Services are planned and provided using evidence-informed practice and in consultation with services users

— Access to services is timely, and individuals using the service are treated with dignity, equality and respect

— A collaborative approach to the delivery of service is adopted with people using the service, their families, and support networks, as well partnership working with relevant service providers

At the core of this is a person-centred and recovery-oriented approach to service delivery and the principle that people using the service have a right to services that are accessible, that treat people with dignity, respect and compassion, and that provide a safe and effective service. These principles are set out in the HSE's *National Healthcare Charter: You and Your Service* (2008).[6]



6. Available at: http://www.hse.ie/eng/services/yourhealthservice/hcharter/

## 1.3 Structure of the guidance

The ***Best Practice Guidance for Suicide Prevention Services*** offers:

— A set of quality improvement aims

— Practical guidance on how to achieve them

— A self-assessment framework to track progress

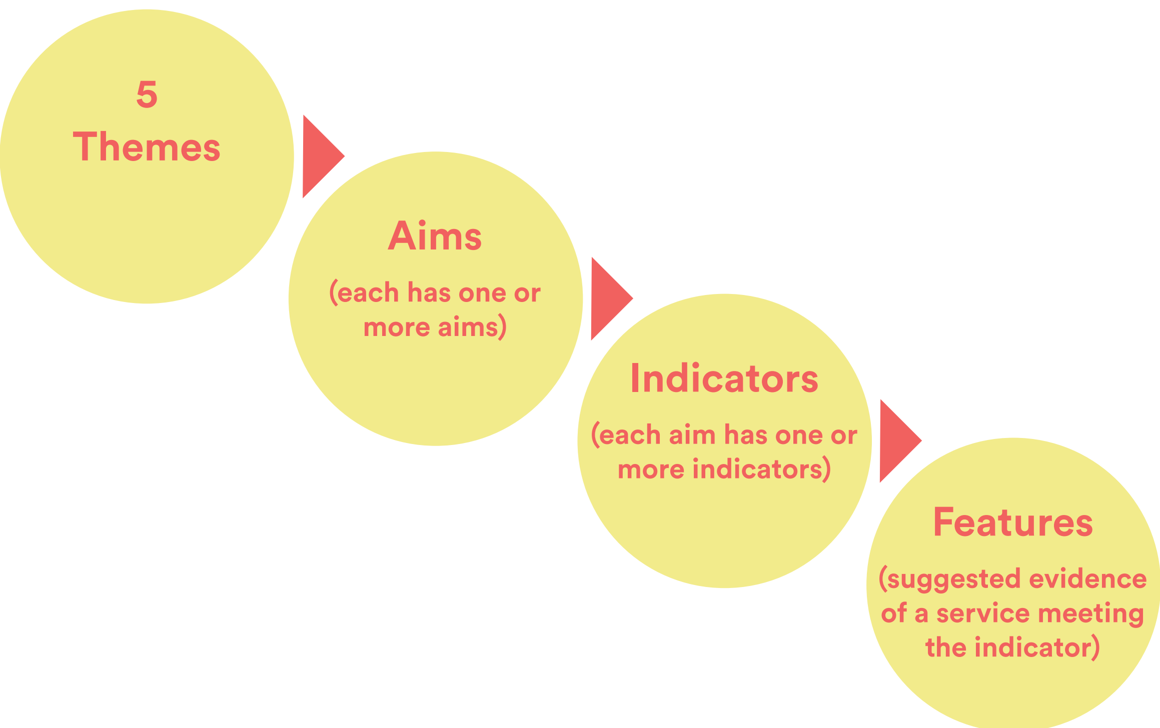
The document identifies five key themes for quality and safety in suicide prevention services (Chart 1):

1. Recovery oriented care and support
2. Effective care and support
3. Safe care and support
4. Leadership, governance and management
5. Workforce

### Chart 1: Structure of the *Best Practice Guidance*

Each **theme** has a one or more **aims** and related **indicators**, which describe what best practice in this area would look like in terms of quality and level of performance. To help organisations track progress, the guidance also lists **features** – examples of practical things the service can do to achieve the indicator.

### Chart 2: Organisation of the *Best Practice Guidance*




## 1.4 Quality improvement through self-assessment

The guidance asks suicide prevention services to self-assess their service against the guidance to track progress and identify:

— Examples of how they have implemented the guidance, including best practices

— Areas where improvements can or need to be made

— Future direction for the service

Self-assessment strengthens accountability and enhances responsibility by allowing people within the service to take ownership of the quality improvement process.

The self-assessment framework recognises that some suicide prevention organisations may be at an early stage in drawing up and implementing quality improvement measures, while others will be at a more advanced stage.

## 1.5 Self-assessment in practice

### Self-assessment teams

Depending on the size of the service, the self-assessment process will normally take place over a period of approximately 10 to 12 months (based on two months per each of the five themes).

The self-assessment framework should be used by designated self-assessment teams, which may include staff, members of the governance body, as well as people using the service.

This team should be led by a senior member of staff who acts as the designated lead for continuous quality improvement.

The self-assessment team will meet regularly during the self-assessment process.

A team approach can be useful in generating discussion about the quality of service and as an opportunity to discuss ways to improve and support service delivery through Quality Improvement Plans.

### Online self-assessment

An on-line self-assessment tool has been drawn up to facilitate the organisation in tracking their progress against the guidance framework. It is based on the Guidance Assessment Improvement Tool (GAIT), developed in HSE mental health services. This tool reflects the themes contained in the *Best Practice Guidance for Suicide Prevention Services*.

### Training and support

Self-assessment teams participating in the project will receive training and support from NOSP. Training will include how to use the guidance and the online tool, and how to gather information and data required for self-assessment.

### Documenting success

An important part of the self-assessment process is to provide evidence of action that has already been taken or progress made in implementing the guidance. This will help an organisation to acquire a shared understanding of the quality of the service being provided and the further improvements that need to occur in providing a quality, safe and effective service.

Evidence to support the self-assessment process should:

— Be clear and easy to understand

— Make reference to specific examples of how the different aims have been met

Many different forms of evidence can be used in the self-assessment process, for example:

— Policy documents

— Minutes from a staff or board meeting to show that action has been taken on a specific issue

— Documentation about training programmes provided to staff

— Evaluations of training

— Evidence collected from people using the service through anonymous questionnaires, or comment cards

— Evidence from participatory consultations such as focus group discussions with people using the service

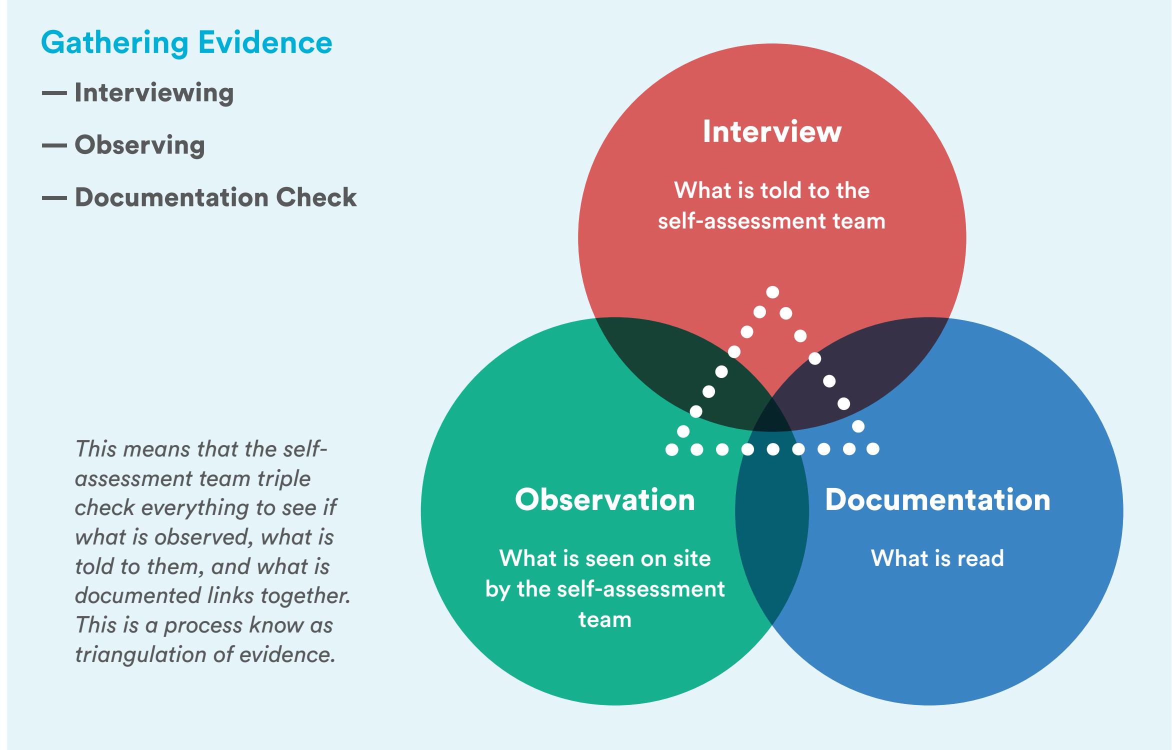
A **triangulation method** is used, allowing for multiple sources of information to be collected to inform the level of achievement in meeting the guidance framework.

### Gathering Evidence

— Interviewing

— Observing

— Documentation Check




*This means that the self-assessment team triple check everything to see if what is observed, what is told to them, and what is documented links together. This is a process know as triangulation of evidence.*

## 1.6 Assessing progress

A traffic light (red, amber, yellow and green) system aims to help organisations to assess and rate their progress in line with the guidance and with reference to each indicator. This system can also help to identify potential or actual areas of risk to people using the service and the organisation. A sample screen of the GAIT can also be found below.

**Red – Not achieved:** The organisation has not yet met the guidance and may need to carry out an urgent review if there are any risks arising from this. Some progress may have been made along the road to meeting the guidance. The emphasis is on continuous quality improvement.

**Amber – Partially achieved:** This indicates that some or few features of the relevant guidance have been met. Some good progress has been made and the emphasis is on sustained continuous quality improvement. However, the organisation still has some way to go before there is full implementation of this guidance.

**Yellow – Mostly achieved:** The organisation has partially achieved most features set out in the guidance.

**Green – Fully achieved:** The organisation has carried out actions to meet the guideline and has either achieved full implementation or is well on the way to full implementation of the guidance.

### Quality Improvement Plans

For service areas that have been identified as requiring improvement, an important task of the self-assessment team will be the development and monitoring of Quality Improvement Plans. The aim is to set out identified risks and quality improvement actions. The plans set out the timeframe for completion and monitoring and who is responsible for implementing the improvement actions.

## 1.7 Background to the development and testing of the guidance

A project was established by the NOSP with the main objective of developing an evidence-based set of guidance for non-governmental organisations (NGOs) providing suicide prevention services, and to support the implementation of the guidance through a training programme and self-assessment system.

To ensure the guidance is based on the best available evidence, the development process involved extensive and wide-ranging consultations and data-gathering. This included:

— Research evidence

— Consultations and engagement with organisations working in the area of suicide prevention

— Evaluation of existing programmes and guidelines

A key part of the development of the guidance was the engagement and partnership with NGOs providing suicide prevention services. This took place at different stages of the development, piloting and finalising of the guidance. The engagement was an opportunity for mutual learning and for agreeing terminology and definitions, while ensuring that the guidance could ensure quality improvements for NGOs providing suicide prevention services. The Glossary, for example, presented in this document, is the result of extensive discussion about and agreement of the appropriate terminology for use in the guidance, and was very important given the different backgrounds and definitions used amongst NGOs themselves and in the health sector.

The following sets out the timeline for the development, testing and finalising of the guidance:

**2014 –** In December 2014, NOSP established a multidisciplinary working group comprising representatives from community, statutory and voluntary organisations to progress the development of an evidence based set of guidance for organisations working in the area of suicide prevention.

**See Appendix 1 for membership of Multidisciplinary Working Group**

**2015 –** The multidisciplinary working group reviewed existing quality standards, guidelines and research in the area nationally and internationally and identified and prioritised the key themes and recommendations on the basis of research and consultations.[7] A draft document was produced. An engagement event was held in May 2015, with participation from 26 organisations working in the area of suicide prevention. However, progress on this project was delayed due to a number of issues identified relating to implementation, scope and timing. At the same time, HSE funded services were aligning with the Health Information and Quality Authority (HIQA) Safer Better Health Care (SBHC) Standards and the climate demanded robust provision pertaining to governance.

**2016 to 2017 –** A project to develop a Best Practice Guidance was also established by the Quality Service User Safety (QSUS) department within the Mental Health Services. It led to the guidance being based on the SBHC standards (based on five themes), and implementation was supported by a training programme and a system for monitoring and evaluation, which was launched in April 2017. The decision was taken to align with the project, in terms of the overall structure of the guidance framework. In order to progress this work, an independent researcher and policy advisor, Dr. Jane Pillinger, was contracted by the NOSP to align the draft document from the work carried out in 2015 and with this framework.

7. This includes a scoping exercise carried out by the Irish Association of Suicidology (IAS) "Researching Quality Systems and Developing Accreditation Standards for Voluntary Suicide Prevention Organisations in Ireland" (January 2013) and a public consultation process involving 272 written submissions and an engagement event attended by 32 statutory, community and voluntary organisations, held in June 2014. In August 2015, a further consultation was held and organisations were invited to input to the development of the 'indicators of achievement' for the national guidelines.

**2017 –** In December 2017, the first of two Engagement Events was held in which 23 NGOs began testing Theme 2 (Effective Care and Support) and Theme 4 (Leadership, Governance and Management) of the draft best practice guidance.

**2018 –** In February 2018, a second Engagement Event was held in which 23 NGOs began testing Themes 1 (Recovery Oriented Care and Support), 3 (Safe Care and Support) and 5 (Workforce).

The learning and input from the December 2017 and February 2018 Engagement Events was captured and collated in preparation for the testing of the draft guidance with five learning sites. The five learning sites were confirmed and agreed to test the 5 themes of the draft guidance – Samaritans Ireland, Pieta House, MyMind, Suicide or Survive and Childline.

April 2018 – A two day Self-Assessment Training programme was delivered to the five learning sites participating in the testing of the draft guidance. (Note: The training programme developed by the Mental Health Services was adapted for this training with NGOs).

Testing of the draft guidance by the learning sites took place over six weeks during May and early June. NOSP provided support and mentoring to the learning sites, including visits to each learning site.

May 2018 – An engagement event took place with HSE Resource Officers for Suicide Prevention. Fourteen Resource Offices from across the CHO areas attended. Again the learning was captured and collated and informed refinement of the draft guidance.

June 2018 – A 'capture the learning event' was held with the five learning sites following which a further review and analysis of the learning took place and the draft guidance was refined.

## Governance structure for project

Governance for the project was provided for by a Steering Committee and a Project Advisory Group:

— Steering Committee, its function to provide oversight and take responsibility for business issues in relation to the project.

— Project Advisory Group its function to provide subject matter expertise and to inform the development of the *Best Practice Guidance for Suicide Prevention Services*, the self-assessment framework and the associated training programme.

**See Appendix 1 for membership of these groups.**

## Implementation and embedding learning

The implementation of the *Best Practice Guidance for Suicide Prevention Services* will take a phased approach in 2019 with NGO partners. These partners are HSE funded NGOs who have service level agreements or grant aid agreements with the HSE. In the longer term it is intended that the guidance will be available to and have the capacity to be adapted for use by organisations operating in the area of suicide prevention beyond those that are currently funded by the HSE.

# Glossary of terms used in the guidance

The terminology used in the guidance draws on evidence-based definitions that were widely discussed and adapted in consultation with NGOs during the development, testing and finalisation of this guidance.

| | |
|---|---|
| Accountability | The obligation of a manager or organisation to account for its activities, accept responsibility for them, and to disclose the results in a transparent manner. |
| Advocate | An individual who has the role to empower and promote the interests of a person by supporting them to assert their views and claim their entitlements and, where necessary, to represent and negotiate on their behalf. An advocate can act on behalf of the **person using the service**, for example, in seeking information or making a **complaint**. |
| Articles of Association | In a company limited by guarantee, the articles of association set out the members' rights, directors' power and how the organisation makes decisions. This is one of the two formal governing documents which are used to set up a company limited by guarantee. The second is the Memorandum of Association. |
| Charities Regulatory Authority | The Charities Regulatory Authority (CRA) is Ireland's national statutory regulatory agency for charitable organisations. The CRA is an independent agency of the Department of Justice and Equality. |
| Charities Regulatory Governance Code | The Code, introduced in 2018, sets out minimum standards on governance for charities. Charities are required to be compliant with the minimum standards by 2020.[8] |
| Children First | National guidance for the protection and welfare of children. A checklist is available for implementation and compliance for HSE funded agencies.[9] |



8 For a copy of the Code see: https://www.charitiesregulator.ie/media/1609/charities-governance-code.pdf.

9 Available at: http://www.hse.ie/eng/services/list/2/PrimaryCare/childrenfirst/informationresponsibilities ChildrenFirstImplementationandComplianceChecklistforHSEFundedAgencies2016.pdf. See also Children's First website: http://www.hse.ie/childrenfirst

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| Collaboration | Collaboration involves change and dialogue between the person using the service and service providers. This may take place in the planning and design of services or at an individual level in the drawing up of **care/ recovery plans**. See also **co-production**. |
| Co-production | Co-production of services involves the **person using the service** working together as an equal partner with service providers in the development of services affecting them. People who use services are valued by organisations as equal partners, can share power and have influence over decisions made. |
| Company limited by guarantee | Company limited by guarantee is a legal entity normally chosen by voluntary organisations, charities and community groups. It is a distinct legal entity and in law is considered to be separate to its members or board members. It is a democratic structure – the company is controlled by the members who elect the Management Committee, usually known as the Board of Directors. Members cannot benefit from any profits made, and each board member's liability is limited to a nominal sum which they guarantee to pay if the company has debts on winding up. |
| Complaint | The **person using the service** has the right to make complaints if they believe a service falls short of standards of care and support of what is acceptable. Complaints can be made in writing or in person to a designated complaints officer or relevant person. Written complaints are different from feedback made through informal means such as an anonymous comment box. |
| Compliance | Meeting required rules or standards, for example, those of regulators or funders. |
| Conflict of interest | Applied to individuals when their different interests clash as a result of 'wearing more than one hat', in particular where a personal or professional interest may get in the way of making a decision in the best interest of the organisation. |
| Confidentiality | Treating a person's information - medical or other - as private and not for sharing. However, if the person who uses the services poses a significant risk of harm to themselves, another person or society, it will be important that the person using the service be told if this information needs to be shared with someone else and why. |
| Consent | The giving of permission, disclosure or agreement for an intervention, receipt or use of a service, where appropriate. Consent obtained should be in line with the latest HSE National Consent Policy,[10] as updated from time to time. |
| Contingency planning | Being prepared for a future circumstance that may occur, but of which there is uncertainty. |

10 Available at: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/

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| Incident Management Framework | The HSE Incident Management Framework (2018)[11] replaces the HSE Safety Incident Management Policy 2014. It is designed to provide services with a practical and proportionate approach to the management of incidents and seeks to place a particular emphasis on supporting the needs of the **person using the service**, families and staff in the aftermath of an incident. |
| Critical incident plan | This is the plan put in place for responding to critical incidents and implementing corrective action and recommended changes in practice and service delivery or relating to required organisational changes. |
| Data | Facts and statistics that are not **personal data** collected together for reference or analysis. |
| Personal data | Any information that relates to an identified person or identifiable natural person. An identifiable natural person is one who can be identified, directly or indirectly, by reference to an identifier such as a name, number, or by one or more factors that allow for that person to be identified. |
| Data protection | Management of **personal data** in accordance with **GDPR** (General Data Protection Regulation) and the Data Protection Acts 1988 to 2018, HSE Data Protection Policy 2018 and any other applicable law or regulation governing the processing of personal data. (See **GDPR** below). |
| Disability | Disability may be classified into a number of groupings, for example: physical disability; sensory disability – impaired sight, impaired hearing, or impaired speech; intellectual disability and mental health conditions. The legal definition of disability, as set out in the Disability Act 2005, used in relation to a person means "a substantial restriction in the capacity of that person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment".<br>For further information see National Disability Act 2015[12] and National Guidelines on Accessible Health and Social Care Services.[13] |
| Disability access | Disability access includes:<br>— Accessible buildings: Buildings that people with disabilities can readily enter, move around freely, use comfortably and exit safely<br>— Accessible communications: Communicating with people with disabilities in ways they can readily follow<br>— Accessible information: Information that people with disabilities can readily access and understand, including information available in different formats<br>— Accessible services: Services geared to serve people with disabilities alongside other people using the service<br>See: National Guidelines on Accessible Health and Social Care Services.[14] |

11 Available at: https://www.hse.ie/eng/about/qavd/incident-management/hse-2018-incident-management-framework-guidance-stories.pdf

12 Available at: http://www.irishstatutebook.ie/eli/2005/act/14/enacted/en/html

13 Available at: http://nda.ie/Publications/Health/Health-Publications/National-Guidelines-on-Accessible-Health-and-Social-Care-Services.pdf

14 Available at: http://nda.ie/Publications/Health/Health-Publications/National-Guidelines-on-Accessible-Health-and-Social-Care-Services.pdf

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| Emergency plan | An emergency plan is a high-level plan for events which, usually with little or no warning, cause or threaten death or injury, serious disruption of essential service or damage to property, the environment or infrastructure. Such events include fire, flooding, assault and medical emergencies. |
| Evidence-based | Practice and decisions informed and made on the basis of best available research and evidence, including the perspective of the **person using the service**. |
| Garda vetting | As of April 29th 2016, the National Vetting Bureau (Children and Vulnerable Persons) Act, 2012-2016 provides the legislative framework for Garda Vetting in Ireland. Under the Act, it is mandatory for people working or volunteering with children or vulnerable adults to be vetted by the National Vetting Bureau. Workers include staff, volunteers and those on student placements working for a relevant organisation through which they have unsupervised access to children and/or vulnerable adults. |
| Gender expression | Each person's manifestation of their **gender identity**, and/or the one that is perceived by others. |
| Gender identity | A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the person's sense of the whole body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender including dress, speech and mannerisms. |
| General Data Protection Regulation (GDPR). | A Europe-wide framework known as the General Data Protection Regulation (GDPR) has led to new rules on data protection. GDPR provides for a more uniform interpretation and application of data protection standards across the EEA. The GDPR came into force across the EEA on 25 May 2018. GDPR introduces new accountability requirements, including audits, breach incident reporting and risk impact assessments, and new mandatory consent conditions.[15] |
| Governance | The systems and processes concerned with ensuring the overall direction, supervision and accountability of an organisation. |
| Governing body | The grouping of people in an organisation which undertakes the **governance** role. This can be the Board of Governors or a Management Committee. The appointed representatives are responsible for making sure that the organisation is run in line with the governing document. |

15 For further information see: https://www.dataprotection.ie/docs/GDPR/1623.htm

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| Governance Code | The 'Code of Practice for Good Governance of Community, Voluntary and Charitable Organisations in Ireland' provides guidance to assist community, voluntary and charity (CVC) organisations develop their overall capacity in terms of how they run their organisation. It a voluntary code, provided free to all boards/committees/executives of not-for-profit groups to encourage them to check themselves against best practice in the management of their affairs. It is based on principles-based governance relating to how an organisation is run, directed and controlled to achieve its strategic objectives. It contains five principles:<br>— Principle 1: Leading the organisation<br>— Principle 2: Exercising control over the organisation<br>— Principle 3: Being transparent and accountable<br>— Principle 4: Working effectively<br>— Principle 5: Behaving with integrity<br>The Code caters for three organisational types: A, B and C.[16] |
| Individual Plan | An Individual Plan (which is sometimes called an Individual Care Plan, Recovery Plan or Care Plan) is a plan drawn up and agreed between the person using the service and the service provider. It sets out a summary of the needs, support and service options identified through **co-production** and/or **collaboration** with the **person using the service**, the processes for reviewing goals set and the resources necessary to meet the goals. Some people using the service draw up and agree Personal Recovery Plans, which set out tools to use in the recovery process. |
| Information and Communications Technology (ICT) | ICT refers to technologies that provide access to information through telecommunications. It is similar to Information Technology (IT) but focuses primarily on communication technologies. This includes the Internet, wireless networks, mobile phones, and other forms of communication such as instant messaging, video and social media. |
| Informed consent | Informed consent is a process involving communication and information to enable a person to understand the benefits of the proposed service or healthcare intervention, as the basis for getting permission before a person using the service engages in the service or healthcare intervention. It also relates to the disclosure of personal information and participation in research. If an individual is considered unable to give informed consent, another person is generally authorised to give consent on their behalf, e.g., parents or legal guardians of a child. |
| Irish Sign Language | Irish Sign Language (ISL) is the first and preferred language of many deaf people. It is a visual and spatial language with its own distinct grammar. The 'Recognition of Irish Sign Language for the Deaf Community Act 2016' ensures that public services are available through ISL. |

16 Further information about the organisational types and the guidance in the Code see: https://www.governancecode.ie/the-code.html

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| Intersex | A person born with gender features which are indeterminate or ambiguous or who was born with characteristics of more than one gender. |
| Involvement of the person using the service | This refers to the involvement of the person using the **suicide prevention service** and their role as an expert, based on their experience of accessing the service. There are different levels of involvement ranging from provision of information, consultation, participation and **co-production** of services. |
| Key worker | The worker assigned to work with the **person using the service**, for example, in supporting and **co-producing** and/or collaborating with the person using the service or in drawing up, agreeing and monitoring the individual's plan for care, support and/or recovery. |
| Lived experience | Experiences and choices made by a person and the learning that they gain from these experiences and choices. |
| LGBTI+ | Lesbian, gay, bisexual, transgender and intersex.[17] This relates to a person's **sexual orientation, gender identity, gender expression** and **sex characteristics** (each defined in the glossary). |
| Management | The process of organising, planning, leading and controlling resources within an organisation with the overall aim of achieving its objectives. |
| Mitigation | Reducing the severity or seriousness of something. |
| Monitoring | Routine and systematic collecting and recording of information that can be used for evaluation purposes. |
| Named supporter(s) | This is the support person or persons named by the **person using the service** to provide support. The named supporter can be a family member, carer, friend or advocate involved in the care, support and recovery of the person using the service. |
| Open disclosure | Open disclosure occurs when staff in a health and social care service communicate an open and honest manner when things go wrong with a person's care, i.e. when an adverse event occurs. An adverse event is when an incident occurs which results in harm to the person using the service. This may or may not be the result of an error. The HSE has drawn up a range of open disclosure resources, including policy and guidance.[18] |
| Person-centred | Person-centred means that the person using health and social services is an equal partner in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome. |

17 For further information see: http://yogyakartaprinciples.org/wp-content/uploads/2017/11/A5_yogyakartaWEB-2.pdf

18 Available at: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/opendisclosure/

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| Person using the service | This is the generic term used for the person using/accessing a **suicide prevention service**, and includes a 'service user', a person with lived experience of suicide, a person in crisis and/or a person bereaved by suicide. It can include callers to helplines and people accessing information via a website, visitors to an information service, as well as people accessing an individual or group face-to-face service. In some organisations, the person using the service is defined as a 'caller' to the service, a 'participant' in the service or a 'client' of a service. There may also be circumstances where the person using the service is a family member/support person accessing information or support for themselves. The term 'person using the service' is therefore used to capture all relevant ways in which people access suicide prevention services. |
| Policy | A clear statement of intent about how an organisation will behave in relation to certain issues. |
| Positive risk-taking | Positive risk-taking is part of a recovery-oriented approach and model of practice that promotes the taking of risks within the context of strengths and opportunities. Positive risk-taking provides the opportunity to discuss risk in relation to issues such as self-harm or suicidal behaviours, and plan ways to reduce or manage those risks. |
| PPPG | **Policy, procedure,** protocol and guidance. |
| Procedures | A written statement that describes the way in which a **policy** will be implemented. |
| Protocol | A protocol is a written plan that specifies procedures to be followed in defined situations; it describes an intervention or set of interventions. Protocols are more explicit and specific in their detail than guidelines, they specify who does what, when and how. |
| Recognised best practice | This means using the best available research, evidence and **data** throughout the process of making decisions, planning, implementing and monitoring suicide prevention activities. |
| Recovery-oriented service | There are different models of recovery, but all share a common goal that recovery is a journey of both 'recovery and discovery', which can be an ongoing and take place in different ways at different stages of a person's lifecycle.<br><br>A recovery-oriented service is built on a culture of hope and expectation that the person can recover from their mental health challenges and build a fulfilling life of their own choosing. Such a service is outward looking, to engage with all the aspects and supports that will constitute and sustain recovery in an individual's life. In this context, service providers empower and facilitate the process of an individual's self-determined recovery. See for example, the HSE's National Framework for Recovery in Mental Health (2018-2020),[19] and in the HSE's Advancing Recovery in Ireland Framework.[20] |

19 Available at https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/national-framework-for-recovery-in-mental-health/recovery-framework.pdf

20 Available at: https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/

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| Referral | Referral is the act of referring someone to another service and may include transfer of notes, passing over the care of the person using the service to another provider and working collaboratively. |
| Risk | Any situation involving exposure to danger. A list of potential organisational risks can be identified, together with their probability, impact, controls and systems for monitoring. |
| Risk analysis | The process of ranking and analysing identified **risks**. Risk analysis can include financial risks (such as inadequate reserves); human risks (such as departure of key staff); operational risks (such as theft of computers); technological risks (such as the computers dying without sufficient backup); physical risks (such as someone falling off a ladder); reputational risks (such as media exposure of bad practice); and **governance** and management risks (such as a lack of a plan to guide the organisation's work). |
| Risk management | The strategic process of managing an organisation's potential exposure to legal liabilities and other **risks**. Risk management can be viewed as a cyclical process that involves identifying risks, analysing them, controlling them and monitoring them. Risk management can be approached as part of the day-to-day management of the organisation. |
| Risk register | A listing of organisational **risks** identified, together with their probability, impact, controls and systems for monitoring. |
| Safety incident management | The process for managing and investigating safety incidents, in compliance with legislative and regulatory requirements and conducted in a manner in which managers, staff and the person using the service can be confident. |
| Safety statement | A safety statement is a written plan that specifically identifies and assesses safety risks in an organisation and ways to manage them. It identifies the controls to be put in place, the people responsible and resources necessary to ensure the safety of people at work. It is required by Section 20 of the Safety, Health and Welfare at Work Act 2005. |
| Service level agreement | A contract between a statutory agency (e.g. the HSE) and a voluntary/ community organisation to provide services on behalf of that agency. |
| Section 38 and Section 39 of the Health Act 2004 | Under the Health Act 2004, provision of funding is made to voluntary agencies under Section 38 (limited to 23 non- acute agencies and 16 voluntary acute hospitals currently within the HSE Employment Control Framework) and Section 39 (grant aid to other voluntary agencies).<br><br>Section 39 *Service Arrangements* cover all voluntary and community agencies in receipt of funding over €250,000 and Section 39 *Grant Aid Agreements* cover all agencies in receipt of funding under €250,000. |

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| Sex characteristics | The chromosomal, gonadal and anatomical features of a person. These include primary characteristics such as reproductive organs and genitalia, chromosomal structures and hormones and secondary characteristics such as muscle mass, hair distribution, breasts and/or physical structure. |
| Sexual orientation | Sexual orientation defines who a person is attracted to and wants to have a sexual relationship with. Common sexual orientations include gay, lesbian, straight/heterosexual and bisexual. |
| Social inclusion | The participation of individuals or groups in the social, cultural, economic, educational/learning and other activities of their local and wider community. |
| SORP | SORP is a Statement of Recommended Practice by charities, which sets out how charities should prepare their annual accounts and report on their finances. The SORP is an interpretation of the underlying financial reporting standards and generally accepted accounting practice. Although not mandatory, it is considered best practice. Under SORP, the following is provided online: details of a charity's activities during the reporting period; income and expenditure information about the charity; accounts and reports; a declaration that details are up to date and the annual return is complete. |
| Stakeholder | An individual, group, professional or organisation that actively participates in promoting suicide prevention, recovery, equality and inclusion at an individual or organisational level. |
| Statement of purpose | This is a description of the service that includes who the service is for, the type of service provided, the opening hours and the people (e.g. children or adults) that can be catered for by the service. It helps to ensure that people who use the service, families and all **stakeholders** have a common understanding of the nature of the service, and anyone reading it should be easily able to understand and identify the service provided. The statement of purpose is a short, succinct document. |
| Strategy | A strategy sets out the goals for the future of the organisation and the steps necessary to achieve these over a defined period of time. It represents a broad course of action with an identifiable outcome. |
| Suicide prevention service | A suicide prevention service aims to raise awareness and skills amongst the general population, in the community and amongst professionals and service providers, and with people who are at risk of suicide. |
| Terms of reference | This sets out the scope or limitation of a defined activity that is to be carried out, as well as roles of those involved. |

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| Third party | A person or organisation other than the **person using the service** or the service provider. Third parties can include other health care professionals, family members, NGOs, companies, governmental agencies, and employers. |
| Training Needs Analysis (TNA) | TNA is a process to identify training needs in an organisation in order to improve the skills and performance of employees. A TNA identifies who needs training and what kind of training is needed. |
| Transgender man | A person having a male **gender identity** who was assigned a female sex at birth. |
| Transgender women | A person having a female **gender identity** who was assigned a male sex at birth. |
| Vulnerable adults | A vulnerable adult means a person, other than a child, who has a condition or injury which is of such a nature or degree as to restrict the capacity of the person to guard himself or herself against harm by another person, or that results in the person requiring assistance with the activities of daily living.<br><br>This can include mental illness or dementia, an intellectual disability, a physical impairment, whether as a result of injury, illness or age, or a physical disability.<br><br>The 'Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures'[21] identify several forms of possible abuse: physical, sexual, psychological, financial or material, institutional, neglect and actions of omission, discriminatory. Additional guidance exists regarding abuse of Older Persons and Persons with Disabilities.[22] |



21 Available at: https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/

22 Available at: https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf

Section 2

# Best Practice Guidance

This section sets out the guidance across each of the five themes:

- Theme 1: Recovery oriented care and support
- Theme 2: Effective care and support
- Theme 3: Safe care and support
- Theme 4: Leadership, governance and management
- Theme 5: Workforce

# Theme 1:

# Recovery Oriented Care and Support

Recovery-oriented care and support has lived experience at its centre. Recovery-oriented suicide prevention services are person-centred and promote kindness, consideration and respect for people's rights, dignity, privacy and autonomy. They empower people to be involved in shaping the services they are using, to making informed choices and to promote their own wellbeing and recovery.

Best Practice Theme 1 *Recovery Oriented Care and Support* has eight aims. Each aim has one or more indicators. Best-practice guidance is provided for each indicator, with examples of features of a service that meet the indicator.

| **Theme 1: Recovery Oriented Care and Support – Summary** | |
|---|---|
| **Aim** | **Indicator** |
| **Collaborative and person-centred planning and delivery**<br>1. The planning, design and delivery of the suicide prevention service is informed by lived experience, identified needs and preferences. | 1.1 People using the service are supported to co-produce and/or collaborate in the governance of the suicide prevention service.<br>1.2 The suicide prevention service establishes mechanisms for engaging people who use the service, and/or relevant named supporters, in strategic and operational planning, design and implementation.<br>1.3 People who use the service and, where relevant, named supporters, co-produce in the planning of their care and support, including but not limited to, areas of consent, capacity, choice, rights and responsibilities. |

| Theme 1: Recovery Oriented Care and Support – Summary | |
|---|---|
| **Aim** | **Indicator** |
| **Accessible, timely, recovery-oriented services**<br>2. The suicide prevention service is recovery-oriented and person-centred, timely and appropriate, and based on the person's assessed needs. | 2.1 The suicide prevention service promotes a timely and appropriate recovery-oriented service, based on assessed needs.<br>2.2 Information is available from the service about how to access the suicide prevention service or alternative services.<br>2.3 The suicide prevention service provides accessible services. |
| **Equality and diversity**<br>3. People experience care and support that values them, respects their diversity and protects their rights. | 3.1 The suicide prevention service ensures that the person using the service is valued and that their rights and equality/diversity are respected.<br>3.2 The suicide prevention service supports and promotes opportunities for people who use the service to strengthen their social connections (e.g. through signposting). |
| **Co-produced care/support plans**<br>4. People who use the service are supported and enabled to co-produce their care and support plan. | 4.1 The suicide prevention service supports and enables co-production by the person using the service in their care and support plan. |
| **Informed consent**<br>5. People who use the service give informed consent to care and support, obtained in accordance with legislation and best-available evidence. | 5.1 All care and support delivered is evidence-based and is subject to the informed consent, where required, of the person who uses the service, in accordance with their will and preferences and in accordance with legislation. |
| **Dignity, privacy and autonomy**<br>6. The confidentiality, dignity, privacy and autonomy of people who use the service are respected and promoted at all times. | 6.1 Each person who uses the service receives care and support that respects their confidentiality, dignity, privacy and autonomy. |

| Theme 1: Recovery Oriented Care and Support – Summary | |
|---|---|
| **Aim** | **Indicator** |
| **Handling complaints (and compliments)**<br>7. Complaints (and compliments) by people who use the service are responded to promptly, openly and effectively, with clear communication and support provided throughout this process. | 7.1 Processes are in place to support the recognition, reporting and management of complaints and compliments. |
| **Promoting health and wellbeing**<br>8. People who use the service are encouraged and supported to maintain and improve their own health and wellbeing. | 8.1 The general health and wellbeing of each person is promoted, with an emphasis on self-help and signposting, where possible. |

# Theme 1: Recovery Oriented Care and Support

## Aim 1

**The planning, design and delivery of suicide prevention services is informed by lived experience, identified needs and preferences.**

## Indicator 1.1

People who use the service are supported to co-produce and/or collaborate in the governance of the suicide prevention service.

### Features of a service meeting this indicator include the following:

1. There are policies and procedures in place to engage and co-produce and/or collaborate with people using the service and, where relevant, named supporters, in the governance of the suicide prevention service (Governance Code (2016), Sub-principle 3.3).
2. The policies and procedures relating to engaging people who use the service and, where relevant, named supporters, in the governance of the suicide prevention service are implemented.
3. There are policies and procedures in place to actively involve people who use the service and, where relevant, named supporters, in the governance relating to planning, service delivery and evaluation at all levels (e.g. satisfaction surveys, interviews, focus groups, advocacy networks, co-production and/or collaboration with the person using the service in the evaluation of services). All responses from people who use the service and named supporters are kept confidential and appropriate consent is obtained.
4. The policies and procedures relating to actively involving people who use the service and, where relevant, named supporters in the governance relating to planning, service delivery and evaluation at all levels are implemented.
5. Terms of reference are in place, which describe the responsibilities for co-production and/or collaboration with people who use the service and, where relevant, named supporters, in governance bodies (e.g. Board of Governors or Management Committee.) (See Glossary for full definition of governance).
6. People who use the service and, where relevant, named supporters are offered training to support co-production and/or collaboration in governance, strategic and operational planning, design and delivery of services.
7. Relevant documentation from committees and meetings reflect co production in governance activities. All responses from people using the service and, where relevant, named supporters are kept confidential, are data protection compliant and the appropriate consent is obtained (see the HSE National Consent Policy in box below).
8. There are mechanisms to ensure that feedback from people using the service is analysed, discussed and incorporated into ongoing governance mechanisms and quality improvements.
9. The board and/or senior management engage effectively with people using the service, where relevant.

## Further information

HSE National Consent Policy.[23]

The Wheel. Your Guide to The Governance Code for Community, Voluntary and Charitable Organisations.[24]

Charities Regulator Governance Code.[25]

For further information in developing the governance functions of your organisation, including engaging the person using the service in governance, see *Theme 4: Leadership, Governance and Management.*

23 Available at: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/

24 Available at: https://www.wheel.ie/sites/default/files/Guide%20to%20Governance%20Code%20FINAL.pdf

25 Available at: https://www.charitiesregulator.ie/en/information-for-charities/charities-governance-code

## Indicator 1.2

The suicide prevention service establishes mechanisms for engaging people who use the service, and/or relevant named supporters, in strategic and operational planning, design and implementation.

### Features of a service meeting this indicator include the following:

1. There are policies and procedures in place that describe the role of people who use the service and/or named supporters in strategic and operational planning and design.
2. The policies and procedures that describe the role of people who use the service and/or named supporters in strategic and operational planning and design are implemented.
3. There are policies and procedures in place in relation to working with families and/or named supporters, incorporating confidentiality and consent.
4. These policies and procedures are implemented.
5. There is involvement of people who use the service in the co-production/ co-design of the service.
6. All documentation provided to people who use the service and, where relevant, named supporters, is clear and understandable.

## Indicator 1.3

People who use the service and, where relevant, named supporters, co-produce the planning of their care and support, including but not limited to, areas of consent, capacity, choice, rights and responsibilities.

### Features of a service meeting this indicator include the following:

1. The person who uses the service co-produces all relevant aspects of their assessment, care and support and recovery planning, including when someone leaves a service (discharge planning).
2. Personal information regarding the person using the service is not communicated to a third party without their consent, unless a duty of care requires this information to be shared. For example, if the person who uses the services poses a significant risk of harm to themselves, another person or society.
3. The person using the service has knowledge of and gives informed consent to the involvement of other people in their assessment, ongoing care, support and recovery planning, and information, as appropriate.
4. Up-to-date written information, including information on the organisation's website, is available regarding suicide prevention services and other support and advocacy services in the community to support the recovery process.
5. People who use the service are encouraged and supported to develop their own peer supports.
6. Completed consent forms or verbal consent given over the telephone by people who use the service demonstrate informed consent, where required.
7. Care and support is developed and evaluated co productively. This is documented in the individual's plan, where relevant.
8. Feedback from people who use the service and, where relevant, from named supporters is used to improve the experience for people who use the service.

# Theme 1:
# Recovery Oriented Care and Support

## Aim 2

**The suicide prevention service is recovery-oriented and person-centred, timely and appropriate, and based on the person's assessed needs.**

## Indicator 2.1

The suicide prevention service promotes a timely and appropriate recovery-oriented service, based on assessed needs.

### Features of a service meeting this indicator include the following:

1. Priority is given to ensuring that services are accessible to those most in need, as far as available resources allow, and ensuring that the needs of specific groups who are known to be at greatest risk of suicide are fully taken into account in the provision of services.
2. Policies and procedures are in place for when people first contact or access a service, in line with the organisation's Statement of Purpose, admission policy or other relevant documents.
3. The policies and procedures for access and admission to the service are implemented.
4. Staff/volunteers have read and understand the policy and procedures and can demonstrate their understanding. This is documented.
5. A contingency plan is in place for where timeframes cannot be met and people are on a waiting list. For example, for counselling or psychotherapy services.
6. Policies and procedures are in place for signposting to other services. For example, where a service cannot be provided or where the service does not meet the needs of the person using the service. A smooth transition to another service is negotiated between relevant services and the person who uses the service, where possible.
7. The policies and procedures for signposting to other services are implemented.
8. Policies and procedures are in place for when and how a person disengages with the service, including identifying and managing any risks posed.
9. Staff/volunteers have read and can demonstrate that they understand the policies and procedures.

## Indicator 2.2

Information is available from the service about how to access the suicide prevention service or alternative services.

### Features of a service meeting this indicator include the following:

1. Relevant information is provided to the public, people who use the service and named supporters on the services that are available, how they work and how to access them, particularly in a crisis.
2. The information provided by the suicide prevention service promotes equality in accessing a service, as provided for under the nine grounds in the Equal Status Acts (gender, civil status, family status, sexual orientation, religion, age, disability, race, ethnicity, membership of the Traveller community). Gender identity, gender expression, sex characteristics, culture or socio-economic status may also be relevant factors to take into account.
3. Information is accessible to all people who use the service and is provided in a range of accessible formats, taking into account people with mobility, literacy or sensory disabilities, e.g. on the website, by telephone or through other information sources, such as Irish Sign Language for people who have hearing difficulties.
4. Where possible, information resources are developed collectively and co-produced by staff/ volunteers and people who use the service and reflect recognised best practice (see below, how to ensure accessibility of information).
5. There are agreed protocols about working in partnership with and across all HSE mental health services regarding crisis interventions, how a person accesses a service, signposting and self-directed referrals, demonstrating collaborative working and are drawn up in agreement with the person who uses the service.

#### Further information

Citizens Information Board *Accessible Information for All: Guidelines on Developing Accessible Information in your Organisation.*[26]

The National Adult Literacy Authority (NALA) has a range of useful resources relating to literacy-friendly quality standards in health settings (linked to HIQA's National Standards for Safer Better Healthcare and the Mental Health Commission's *Quality Framework for Mental Health Services in Ireland*).[27]

26 Available at: http://www.citizensinformationboard.ie/downloads/accessibility/Accessible_Information_For_All.pdf

27 Available at: NALA https://www.nala.ie/healthliteracy. See also explanation YouTube developed by NALA/HIQA: https://www.youtube.com/watch?v=PKq8hVoB4zs

## Indicator 2.3

The suicide prevention service provides accessible services.

### Features of a service meeting this indicator include the following:

1. The suicide prevention service is located in accessible premises, where possible. If premises are not accessible to people who use the service, the organisation has a plan and procedure to ensure that they can access the service, for example, by being met in a mutually agreed, alternative accessible venue.

2. The suicide prevention service complies with relevant legislation and is in line with new legislation that is introduced over time, including but not limited to the following:

   — Part M Building Regulations 1997, as amended

   — Safety Health and Welfare at Work Act 1989/2005, as amended

   — Employment Equality Acts 1998/2004, as amended

   — Equal Status Acts 2000-2004, as amended

   — Disability Act 2005

   — Irish Human Rights and Equality Commission Act 2014 (Section 42)[28]

   — Irish Sign Language Act 2017

3. Four dimensions of access are reviewed and evaluated:

   — **Physical access** - For wheelchair users and people with mobility/walking difficulties requiring the use of wheelchairs and walking aids. For example, provision of handrails, ramps, lifts and low counters

   — **Sensory access** - For people with hearing and visual impairment. For example, Braille, tactile markings, signs and labels, hearing augmentation listening systems, audio cues for lifts and lights

   — **Communication access** - For people with difficulty with the written word, vision speech and language problems or for who English is not their first language. For example, translation services, pictorial or written materials that are easy-read and in plain English

   — **Cognitive access** - For people with impaired perception, reasoning and judgement. For example, through provision of information through alternate formats or strategies

28 Section 42 (1) states that: A public body shall, in the performance of its functions, have regard to the need to: a) eliminate discrimination, b) promote equality of opportunity and treatment of its staff and the persons to whom it provides services, and c) protect the human rights of its members, staff and the persons to whom it provides services. The Public Sector Duty applies to organisations in receipt of public funding, including organisations that are funded by the HSE.

4. The service works in partnership with a wide diversity of communities in Ireland, including people from ethnic minority groups, LGBTI+ people and other groups, reflecting an understanding of the accessibility needs of a diversity of cultures in the built environment, as appropriate.

5. The design of new premises should involve people with disabilities and take account of their accessibility requirements, where appropriate.

6. Available public transport options to access individual services and directions are detailed on the suicide prevention services' website and on notice boards in relevant places.

## Further information

NDA / HSE. National Guidelines on Accessible Health and Social Care Services.[29]

Citizens Information Board. Accessible Information for All: Guidelines on developing accessible information in your organisation.[39]

HSE Second National Intercultural Health Strategy 2018 – 2023.[31]

29 Available at: https://www.hse.ie/eng/services/yourhealthservice/access/NatGuideAccessibleServices/NatGuideAccessibleServices.pdf

30 Available at: http://www.citizensinformationboard.ie/downloads/accessibility/Accessible_Information_For_All.pdf

31 Available at: https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/second-national-intercultural-health-strategy.html

# Theme 1: Recovery Oriented Care and Support

## Aim 3

**People experience care and support that values them, respects their diversity and protects their rights.**

## Indicator 3.1

The suicide prevention service ensures that the person using the service is valued and that their rights and equality/diversity are respected.

### Features of a service meeting this indicator include the following:

1. The values of the suicide prevention service are clearly defined, communicated and implemented in practice.
2. Information is communicated to people who use the service and staff/volunteers about their rights and responsibilities relating to the service. This information is displayed in public areas and on the organisation's website.
3. There is a policy and procedure in place in relation to recognising the equality, diversity and rights of people when they access the service.
4. The policy and procedure on people who use the service' rights and equality/diversity relating to the service are implemented.
5. Staff/volunteers have read the policy and procedure on people who use the service's rights and equality/diversity relating to the service and can demonstrate that they understand the policy and procedure.
6. The organisation ensures that all staff/volunteers are aware of external agencies that provide specialist information and advice on the rights and equality of a person who uses the service.
7. People who use the service are supported to access their rights and are signposted to specialist information services and independent advocacy services to enable them to access relevant information.
8. Staff/volunteers receive training in cultural awareness and equality/diversity, including the impact of multiple forms of discrimination and stigma on people who use the service.
9. The suicide prevention service co-produces and/or collaborates with representatives of relevant groups who experience discrimination or barriers in accessing services in order to continuously improve the service and take account of and meet the needs of a wide diversity of people who use the service.

### Further information

For information about advocacy services in Ireland see:
https://www.hse.ie/eng/services/yourhealthservice/feedback/services/

## Indicator 3.2

The suicide prevention service supports and promotes opportunities for people who use the service to strengthen their social connections (e.g. through signposting).

### Features of a service meeting this indicator include the following:

1. Information and advice is made available to assist people who use the service to make decisions about forming positive social connections, taking into account their wishes about connections with family, children, friends and their community.
2. People who use the service are provided with information on how to access community and peer support groups and family and carer/support groups within their local community as an aid to recovery for those at risk of or affected by suicide.
3. Information about peer support groups, community and educational groups and services that can promote positive social connections is regularly updated and available in different formats and on the organisation's website.

# Theme 1: Recovery Oriented Care and Support

## Aim 4

**People who use the service are supported and enabled to co-produce their care and support plan.**

## Indicator 4.1

The suicide prevention service supports and enables co-production by the person using the service in their care and support plan.

### Features of a service meeting this indicator include the following:

1. Clear and accessible information is provided to people who use the service at all stages of service provision about options for care and support services available to them, supporting informed decision-making.
2. The policy and procedure on how information is provided to people who use the service includes:
   - The roles and responsibilities for the provision of information
   - The information provided to people when they first access the service
   - The information provided on an ongoing basis
   - The process for identifying their preferred ways of receiving and giving information
   - The methods for providing information to people with specific communication needs
   - Information about accessing interpreting and translation services and how to contract these services from external organisations
   - A process for managing the provision of information to the representatives, family and next-of-kin of the person using the service, as appropriate
   - Ways to learn from decisions that do not reflect best practice
3. The policies and procedures relating to how information is provided to people who use the service are implemented.
4. All staff/volunteers have read and understand the policy and procedures relating to how information is provided to people who use the service.
5. All staff/volunteers can articulate the processes for providing information for people who use the service, as set out in the policy.
6. The communication needs of the person who uses the service are catered for in the provision of services.
7. Information is provided in a manner that meets the assessed needs and wishes of each person who uses the service.

8. People who use the service are involved as much as possible in developing resources.

9. People who use the service are signposted to interpreting / translation and other advocacy and support services, as needed.

10. The person using the service is actively facilitated to exercise choice in the ongoing planning and delivery of their care and support.

11. There is ongoing monitoring to ensure the information given to people about the services they are accessing is appropriate, accurate and up-to-date.

12. Review and analysis are completed to identify opportunities to improve the processes for providing information to people who use the service. The findings and lessons from this process are shared and documented.

### Further information

Guidance on translation and interpreting services see: HSE (2009) On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services.[32]

The NOSP website lists relevant services when urgent help is needed, including how to contact HSE Resource Officers for Suicide Prevention.[33]

The HSE 'Your mental health' website gives information about local mental health services.[34]

See Appendix 2 for a list of relevant legislation.

32 Available at: http://www.hse.ie/eng/services/publications/

33 The list of Resource Officers for Suicide Prevention is available at: https://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP/resourceofficers/officers_suicide_prevention.html

34 Available at: http://www.yourmentalhealth.ie/supports-services/urgent-help.html

# Theme 1: Recovery Oriented Care and Support

## Aim 5

**People who use the service give informed consent to care and support, obtained in accordance with legislation and best available evidence.**

## Indicator 5.1

All care and support delivered is evidence-based and is subject to the informed consent, where required, of the person who uses the service, in accordance with their will and preferences and in accordance with legislation.

### Features of a service meeting this indicator include the following:

1. Consent of the person using the service is obtained, where appropriate.
2. There are policies and procedures for obtaining the ongoing informed consent of people who use the service, where required. This includes circumstances where a young person under the age of 18 years can access a service if parental consent is not forthcoming, taking into account the specific circumstances faced by some young people.
3. Policies and procedures on informed consent are implemented.
4. Staff/volunteers have read and understand the policy and procedures on informed consent. This is documented.
5. Staff/volunteers receive training on how to implement the policy and procedures on informed consent.
6. In the case of a child, policies and procedures are in place for obtaining informed consent from either a parent or the legal guardian or the courts, including in cases of emergencies where consent is required. The policies and procedures reflect the best interest of the child, and the views of the child are taken into consideration.
7. Policies and procedures on obtaining informed consent from a parental or guardian are implemented.
8. Staff/volunteers have read and understand the policy and procedures on obtaining informed consent from a parental or guardian. This is documented.
9. People who use the service confirm that they understand decisions about their consent to care and support. This is provided through discussion and in collaboration with them. This is in line with the General Data Protection Regulation (GDPR). (For definition of GDPR see the Glossary).

### Further information

The Wheel's GDPR Guide for Non-Profits.[35]

HSE National Consent Policy 2017.[36]

35 Available at: http://www.wheel.ie/content/download-wheels-gdpr-guide-for-nonprofits

36 Available at: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-august-2017.pdf

# Theme 1:
# Recovery Oriented Care and Support

## Aim 6

**The confidentiality, dignity, privacy and autonomy of people who use the service are respected and promoted at all times.**

## Indicator 6.1

Each person who uses the service receives care and support that respects their confidentiality, dignity, privacy and autonomy.

### Features of a service meeting this indicator include the following:

1. There are policies and procedures in place in relation to the confidentiality, dignity, privacy and autonomy of the person who uses the service. At a minimum, the policies and procedures should include:
    - An ethic of care about the confidentiality, dignity, privacy and autonomy of people who use the service
    - The roles and responsibilities to ensure the dignity of the person using the service is protected
    - The methods for identifying and ensuring, where possible, the expectations and preferences of the person who uses the service with respect to confidentiality, privacy and dignity
    - The process to be applied where the confidentiality, privacy and dignity of a person using the service is not respected by staff/volunteers or other people who use the service
2. The policies and procedures relating to the confidentiality, dignity, privacy and autonomy of the person using the service are implemented.
3. All staff/volunteers have read and understand the policies and procedures relating to confidentiality, dignity, privacy and autonomy, and this is documented.
4. All staff/volunteers can articulate the processes for ensuring that confidentiality, dignity, privacy and autonomy are respected.
5. An annual review is undertaken to check that the policies are being implemented, and that the premises and facilities in the service are conducive to people who use the service' privacy and dignity. This is documented.
6. People who use the service confirm that their privacy and dignity is respected at all times. This can be captured through regular feedback, reviews and evaluation of service quality involving people who use the service.
7. Personal information regarding the person using the service is not communicated to a third party without their consent, unless a duty of care requires this information to be shared, for example, if the person who uses the services poses a significant risk of harm to themselves, another person or society.
8. The creation and storage of records ensures confidentiality and respect. In situations where disclosure of information is required by law or is advisable from an ethical perspective, the rational for sharing such information is documented and the person who uses the service is informed and, where applicable, consent sought. This is in accordance with the data protection legislation.
9. Staff and volunteers create an inclusive environment where ageist, ableist, racist, sexist, homophobic, transphobic or other inappropriate comments, 'banter' or 'jokes' are not acceptable. If they occur, they are discussed and addressed appropriately.
10. Staff and volunteers uphold the right to the dignity and confidentiality of people who use the service when discussing the service provided with them.

# Theme 1:
# Recovery Oriented Care and Support

## Aim 7

**Complaints (and compliments) by people who use the service are responded to promptly, openly and effectively, with clear communication and support provided throughout this process.**

## Indicator 7.1

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

### Features of a service meeting this indicator include the following:

1. People who use the service are encouraged to provide feedback – both positive and negative – about their experience of the service.

2. Processes are in place to enable people who use the service to complain or give positive feedback/compliments. For example, through web-based feedback, feedback questionnaires or a comment box.

**The following features relate specifically to requirements on the making and handling of complaints as set out in Service Level Agreements:**

3. For a small organisation receiving between €1 and €49,999 in funding from the HSE annually (without paid employees or direct involvement with children or vulnerable adults). A statement regarding how to complain, recording and resolution of complaints is made, and this is displayed.

4. Organisations with paid employees and receiving over €50,000 annually, and/or where staff and volunteers have direct involvement with children or vulnerable adults, there is a complaints policy developed in line with the HSE policy 'Your service your say: The Management of Service User Feedback for Comments, Compliments and Complaints, HSE Policy 2017', which is submitted to HSE Consumer Affairs for approval.

### Further information

HSE Guidance document: Complaints Management Procedure for Providers who have entered into a Service Agreement under Section 38 or 39 of the Health Act, 2004.[37]

37 Available at: https://www.hse.ie/eng/about/qavd/complaints/ncglt/toolkit/volstoolkit/guideline-document-for-providers-who-have-entered-into-a-service-agreement.pdf

5. The complaints policy should include:

   — Definition of a complaint

   — Purpose of the policy

   — How complaints are made

   — The roles and responsibilities associated with the management of complaints within the organisation, including a nominated person responsible to deal with all complaints

   — The complaint management process (acknowledgement of complaints, point of contact resolution, formal investigation process, review, independent review)

   — The communication of the complaints policy and procedure with people who use the service, their representatives, their family, next of kin and named supporters, where relevant

   — That the complaints policy is available in a user-friendly format in plain English and, where possible, in other accessible formats, including a child-friendly format

   — That the complaints policy is easy to access, for example, on the organisation's website

   — The methods available to all persons to make complaints about service, care or support services provided

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

   — The timeframes for complaint management, including the timeframe for the service to respond to the complaint, and for the complaint to be resolved

   — Communication with the complainant during the complaint process

   — The process to escalate complaints that cannot be addressed by the nominated person

   — The appeals process available if the complainant is dissatisfied with the outcome of the complaint investigation

6. The complaints policy is fully implemented.

7. The details of the complaints policy and the nominated person for dealing with complaints are on display in a prominent position.

8. Relevant staff and volunteers are trained in the complaints-management processes. Relevant people include the nominated person for dealing with complaints and other staff and volunteers involved in screening, investigating and managing complaints.

9. Staff and relevant volunteers have read and understand the policy relating to complaints. This is documented.

10. Staff and relevant volunteers are able to articulate the process for making, handling and investigating complaints, as set out in the policy.

11. People who use the service are made aware of the complaints procedure and all methods by which a complaint can be made.

12. A consistent and standardised approach is implemented for the management of all complaints.

13. All matters relating to the complaint are fully and properly recorded. This includes complaints made, the results of any investigations into them, any action taken on foot of a complaint, and whether the person who uses the service is satisfied. Such records are in addition to and distinct from the individual care plan of the person using the service, if relevant.

14. The nominated person for dealing with complaints maintains an up-to-date complaints log.

15. All records relating to complaints are stored confidentially, in accordance with legislation.

16. All complaints are investigated and managed promptly, in accordance with the time-frame for the management of complaints set out in the HSE national policy.

17. Complaints are audited and assessed on a regular basis. Learning from complaints, including trends, is fed into quality-improvement plans.

18. Complaints are analysed regularly and reported to and discussed by the senior management of the service.

19. All processes for complaints are compliant with data protection.

## Further information

HSE. Your Service Your Say: The Management of Service User Feedback for Comments, Compliments.[38]

38 Available at: https://www.hse.ie/eng/about/QAVD/Complaints/ysysguidance/ysys2017.pdf

# Theme 1:
# Recovery Oriented Care and Support

## Aim 8

**People who use the service are encouraged and supported to maintain and improve their own health and wellbeing.**

## Indicator 8.1

The general health and wellbeing of each person is promoted, with an emphasis on self-help and signposting where at all possible.

### Features of a service meeting this indicator include the following:

1. The suicide prevention service provides information and signposting for people who use the service about general health and wellbeing as part of a person's overall recovery.

2. If relevant, information and signposting about health and wellbeing are included in the individual plan of the person using the service.

#### Further information

Healthy Ireland: A Framework for Improved Health and Wellbeing (2013-2025).[39]

39 Available at: http://www.healthyireland.ie/wp-content/uploads/2015/10/Healthy-Ireland-Framework1.pdf

Theme 2

# Effective Care and Support

Delivering an effective suicide prevention service means that the person using the service receive the best achievable outcome within the context of the service provided and the resources available to it. Effective care and support in suicide prevention – including therapeutic support – is informed by national and international evidence and ongoing evaluation of outcomes of the person using the service to determine the effectiveness of the design and delivery of care and support.

Effective care and support provide the best outcome for the person using the service. It is informed by assessed needs, with effective planning and delivery, accurate information, coordination and integration of services.

Best Practice Theme 2 *Effective Care and Support* has six aims and six corresponding indicators to promote effective care and support. Best-practice guidance is provided for each indicator, with examples of features of a service that meet the indicator.

| **Theme 2: Effective Care and Support – Summary** | |
|---|---|
| **Aim** | **Indicator** |
| **Evidence-based policies and practice**<br>1. The suicide prevention service reflects national and international evidence of what is known to achieve the best outcomes for the person using the service. | 1.1 The suicide prevention service is based on current best practice and supported by evidence-based policies, procedures and guidelines and the knowledge and experiences of staff, volunteers and the person using the service. |
| **Individualised care**<br>2. The suicide prevention service is planned and delivered to meet the initial and ongoing needs of the person using the service. | 2.1 Where relevant, the person using the service has an individual plan that describes the level of care and support they need. This is coordinated by an identified key worker or team. |

| Theme 2: Effective Care and Support – Summary | |
|---|---|
| **Aim** | **Indicator** |
| **Coordinated care**<br>3. The person using the service receives integrated care and support, which is coordinated effectively within and between services. | 3.1 Suicide prevention services are coordinated and integrated to meet the full range of care and support needs of the person using the service. |
| **Record-keeping**<br>4. All relevant information is available to support the provision of effective care and support, including information provided by the person using the service. | 4.1 Accurate, integrated and readily accessible records of the person using the service are developed, in line with best practice. Such records are available to the workforce at the point of care/support. |
| **Safe and suitable premises**<br>5. The suicide prevention service is provided in a physical environment that supports the delivery of high-quality, safe and reliable services. | 5.1 The premises and facilities comply with relevant legislative requirements and current best practice. |
| **Monitoring and evaluation**<br>6. The effectiveness of suicide prevention initiatives and outcomes is systematically monitored, evaluated and continuously improved. | 6.1 There is a structured approach to quality improvement that involves co-production and/or collaboration between the person using the service, named supporters, staff and volunteers. |

# Theme 2: Effective Care and Support

## Aim 1

**The suicide prevention service reflects national and international evidence of what is known to achieve the best outcomes for the person using the service.**

## Indicator 1.1

The suicide prevention service is based on current best practice and supported by evidence-based policies, procedures and guidelines and the knowledge and experiences of staff, volunteers and the person using the service.

## Features of a service meeting this indicator include the following:

1. The policies, procedures and guidelines of the organisation comply with relevant legal and regulatory requirements, and evidence-based practice and guidelines (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.1). These may be developed in accordance with the HSE *National Framework for developing Policies, Procedures, Protocols and Guidelines*, 2016.[40]

2. The policies, procedures and guidelines include but not limited to the following:

   **Service provision policies/procedures**

   — Admission/discharge (when a person first accesses a service and when they leave the service)

   — Feedback, compliments and complaints

   — High-risk clients and the aftermath of suicide death

   — Responding to suicide and self-harm

   — Procedures for a client who disengages from a service

   — Signposting and referrals

   — Equality and diversity

   — Meaningful co-production, collaboration, involvement and participation with the person using the service

   — Confidentiality

   — Recovery planning

   — Risk-management framework and risk register

   **Policies / procedures for the protection of children and vulnerable adults**
   *(see Theme 3: Safe Care and Support)*

   — Child protection policy

   — Vulnerable adult protection policy

40 Available at: http://www.hse.ie/eng/about/Who/QID/Use-of-Improvement-Methods/nationalframeworkdevelopingpolicies/HSE-National-Framework-for-Developing-Policies-Procedures-Protocols-and-Guidelines-PPPGs-2016.pdf

### Data protection policies /procedures

- Data protection and information management
- Record-keeping policy and GDPR

### Policies on staffing and recruitment *(see Theme 5: Workforce)*

- HR policies and procedures
- Recruitment and selection policies
- Disciplinary policy and procedure
- Employment equality policy
- Volunteer policy
- Code of conduct for staff and volunteers
- Garda vetting policy for staff and volunteers
- Staff handbook
- Staff and volunteer code of conduct

### Finance policies / procedures *(see Theme 4: Leadership, governance and management)*

- Financial controls
- Purchases and payments
- Allocation of funds / petty cash
- Fundraising policy and charitable donations

### Other policies / procedures

- Health and safety policy
- Media policy

(Note: More detailed guidance on governance policies and procedures is found in Themes 4 and 5. Other policy areas are dealt with across several different themes in this guidance)

3. Agreed protocols and guidelines are in place for persons using the service assessed to be at high risk of suicide/suicidal behaviour, and for engaging with those who are particularly vulnerable in the aftermath of a suicide/loss of a client.

4. The protocols and guidelines are implemented.

5. Staff and relevant volunteers have read and understand all the policies and procedures. This is documented.

6. Services implement national and international best practices relating to self-harm, for example, as identified in the Self-Harm Intervention Programme (SHIP), which provides non-crisis time-limited specialist counselling support to people who are self-harming or at risk of suicide across the south east of Ireland.[41]

7. Where relevant, there is timely evidence of referrals / signposting to other relevant services relating to self-harm.

41 See for example the 2013 NOSP evaluation report of the SHIP programme: https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/self-harm-intervention-programme-ship-report.html

# Theme 2: Effective Care and Support

## Aim 2

**The suicide prevention service is planned and delivered to meet the initial and ongoing needs of the person using the service.**

## Indicator 2.1

Where relevant, the person using the service has an individual plan that describes the level of care and support they need. This is coordinated by an identified key worker or team.

### Features of a service meeting this indicator include the following:

1. Where relevant, evidence-based policies and procedures are in place on the development, use and review of the individual's plan (sometimes referred to as care plan, recovery plan, person centred plan or individual care plan).

2. The policies and procedures include:

    — The roles and responsibilities of staff relating to the individual's plan

    — Guidance on preliminary screening prior to comprehensive assessment, e.g. by phone

    — A procedure for staff on how to carry out a comprehensive assessment, including risk assessment when the person first accesses the service and on an ongoing basis

    — Signposting if the service is not suitable to meet the assessed needs of the person using the service

    — Alternatives, discussed in collaboration with the person using the service, if they do not want an individual plan

    — The required content in the set of documentation making up the individual's plan

    — The implementation of individual plan reviews and updates

    — Co-production and/or collaboration with the person using the service in individual planning, where practicable

    — The timeframes for assessment, planning, implementation and evaluation of the individual plan are co-produced and/or in collaboration with the person using the service

    — The person using the service has access and ownership of their individual plan

    — Process to externally review the case file in the event of the loss of a client

    — Communication to staff members post review, as relevant, taking account of data protection

3. Procedures are in place to confirm the identity of the person using the service, e.g. passport, college ID, birth certificate. Procedures should be in accordance with data protection requirements.

4. Relevant staff and volunteers have read and understand the policies and procedures on identification of the person using the service. This is documented.

5. A pre-admission/ screening assessment is carried out where appropriate to assess the needs of the person using the service and to ensure their assessed needs can be met by the service.

6. An initial assessment of need is carried out, which sets out the immediate care and support needs of the person using the service. Plans are put in place for ongoing assessment of need and these are documented in the plan.

7. A key worker is identified for each person using the service to ensure continuity in the implementation of their plan.

8. Evidence-based assessments, including risk assessments, are completed on first contact, at agreed regular intervals and on an ongoing basis by appropriately trained staff.

9. Relevant evidence-based policies, protocols and procedures for the assessment of risk in relation to self-harm are implemented for the development and reviewing of care plans.

10. The person using the service co-produces their plan.

11. Where the person using the service declines to engage with an individual care plan or a service, this is documented.

12. Appropriate outcome goals are clearly defined in planning the service and are provided for the person using the service. These goals are:

    — Based on their assessed needs.

    — Agreed between the person using the service and the key worker/therapist.

    — Regularly reviewed and revised to ensure effectiveness.

    — Regularly reviewed and revised to ensure they reflect the changing needs and preferences of the person using the service.

13. The individual plan identifies the care and support/service provision required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.

14. The individual care plan identifies the resources required to provide the care and support identified.

15. The individual care plan includes a separate risk and safety management plan.

16. The individual plan includes the next steps, as agreed with the person using the service, e.g. return to service /signpost to other services.

17. The individual plan is implemented and monitored by the key worker and other relevant staff and volunteers.

18. Audits of individual care plans are carried out on a quarterly basis. Improvements required are documented and implemented.

# Theme 2: Effective Care and Support

## Aim 3

**The person using the service receives integrated care and support, which is coordinated effectively within and between services.**

## Indicator 3.1

The suicide prevention service is coordinated and integrated to meet the full range of care and support needs of the person using the service.

### Features of a service meeting this indicator include the following:

1. Documented policies and procedures are in place to support the co-ordination of care and support within and between teams, services, and settings.

2. The policies and procedures are implemented.

3. Staff and relevant volunteers have read and understand the policies and procedures, and this is documented.

4. Staff and relevant volunteers can articulate the processes.

5. There is effective signposting to other services and, where relevant, referral pathways, resulting in collaboration between the service and relevant external service providers/ individuals. (e.g. Primary care services, acute hospitals, advocacy, voluntary and statutory agencies, Gardaí, external agencies, homeless agencies, etc.).

# Theme 2: Effective Care and Support

## Aim 4

**All relevant information is available to support the provision of effective care and support, including information provided by the person using the service.**

## Indicator 4.1

Accurate, integrated and readily accessible records of the person using the service are developed, in line with best available practice. Such records are available to the workforce at the point of care/support.

### Features of a service meeting this indicator include the following:

1. Policies and procedures are in place for the creation, access, retention and destruction of records. Policies and procedures should be in line with legislation on Data Protection and Freedom of Information Act, and record-retention periods, as set out in the Health Service Policy Record Retention Periods. (See also Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.1)

2. The policies and procedures on records are implemented.

3. All relevant staff and volunteers have read and understand the policies and procedures. This is documented.

4. All relevant staff and volunteers can articulate the policies and procedures.

5. Staff and relevant volunteers are trained in best-practice record-keeping.

6. All relevant records are available at the point of decision making (i.e. assessment, delivery of service and signposting).

7. All staff and relevant volunteers working with the person using the service have read the records to ensure they are familiar with the needs and wishes of the person using the service. This is documented.

8. Where the person using the service requires support in providing information for records, this is facilitated. (e.g. by an advocate, named supporter or staff member).

9. Records are developed in accordance with legislation and best- practice guidelines.

10. Records and reports are maintained in a manner to ensure completeness, accuracy and ease of retrieval.

11. The following requirements are in place regarding records of the person using the service:

    - Records are kept up-to date
    - Records are maintained in good order, in logical sequence and are accessible to authorised staff only
    - Only authorised staff make entries in records or specific sections therein
    - Records are maintained in a safe and secure place
    - Records are completed electronically or by hand. If they are completed by hand, they are written legibly in black ink and are readable when photocopied

- Records are factual, consistent, accurate and do not contain jargon, unapproved abbreviations or meaningless phrases or observations.
- Each entry includes the date and the time, using the 24-hour clock.
- Each entry is followed by a signature of the member of the staff and their role.
- The service also maintains a record (signature bank) of all signatures used in each record.
- Where an error is made, this is scored out with a single line and the correction written alongside, with date, time and initials.
- Correction fluid is not used on records.
- The name and date of birth of the person using the service is detailed on all documentation and is transcribed correctly.
- Where a member of staff makes a referral to or consults with another staff member, this person is clearly identified by their full name and title.

12. Where information, advice or signposting is provided over the telephone, this is documented by the member of staff who took the call, and the person giving the information or advice is clearly identified.
13. A record is initiated for every person assessed or provided with care and/or services by the service.
14. The records of the person using the service are reflective of the current status and the care and support being provided to the person using the service.
15. Documentation on inspections of health and safety and fire safety is maintained in the service.
16. Records are retained and destroyed in accordance with legislative requirements, the policy and procedure of the service, and the HSE Policy on Record Retention Periods (2013).
17. Audits are conducted into compliance with legislation to ensure completeness, accuracy and ease of retrieval (e.g. GDPR, Data Protection Act, Freedom of Information Act 2014). This is documented. The records of people using the service who have transferred/discharged are included in the audit, as far as is practicable.

## Further information

HSE (2011) Standards and Recommended Practices for Healthcare Records Management, 2011.[42]

HSE (2013) Policy on Record Retention Periods.[43]

Data Protection Commission (2011) Data Protection in the Charity and Voluntary Sector.[44]

Data Protection Commission (2018) GDPR and You.[45]

42 Available at: https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/v3.pdf

43 Available at: https://www.hse.ie/eng/services/yourhealthservice/info/dp/recordretpolicy.pdf

44 Available at: https://www.dataprotection.ie/docs/Data-Protection-in-the-Charity-Voluntary-Sector/f/1128.htm

45 Available at: http://gdprandyou.ie/organisations/

# Theme 2: Effective Care and Support

## Aim 5

**The suicide prevention service is provided in a physical environment that supports the delivery of high-quality, safe and reliable services.**

## Indicator 5.1

The premises and facilities comply with relevant legislative requirements and current best practice.

### Features of a service meeting this indicator include the following:

1. There are policies and procedures in place relating to the specific requirements of premises.
2. The policies and procedures include:
   - The roles and responsibilities for the maintenance of the premises and related processes
   - The legislative requirements to which the premises must conform
   - The premises' cleaning and maintenance programme
   - The premises' utility controls and requirements
   - Identifying hazards in the premises
   - The provision of adequate and suitable furnishings in the premises
3. The policies and procedures relating to premises are implemented.
4. Relevant staff and volunteers have read and understand the premises policies and procedures, and this is documented.
5. Relevant staff and volunteers can articulate the policies and procedures relating to the maintenance of the premises.
6. Premises are clean and maintained in good structural and decorative condition.
7. Premises are adequately lit, heated and ventilated.
8. There is a child-friendly waiting area, and children are appropriately safeguarded.
9. Hazards are minimized. For example large open spaces, steps and stairs, slippery floors, hard and sharp edges and hard or rough surfaces.
10. The condition of the physical structure of the building and the overall environment is developed and maintained with due regard to the safety, wellbeing, privacy and dignity of the person using the service, staff and visitors.
11. The design of the physical environment offers maximum opportunity to maintain and improve mental and general health, in so far as is practicable.
12. Remote or isolated areas of the service are monitored.
13. Appropriate security measures are in place to avoid unauthorized access.
14. If children are cared for in an adult service, there are appropriate safeguards in place.
15. There is a system to audit the premises and action is taken to address any improvements required.

# Theme 2: Effective Care and Support

## Aim 6

**The effectiveness of suicide prevention initiatives and outcomes is systematically monitored, evaluated and continuously improved.**

## Indicator 6.1

There is a structured approach to quality improvement that involves co-production and/or collaboration between the person using the service, named supporters, staff and volunteers.

### Features of a service meeting this indicator include the following:

1. A systematic approach is in place for reviewing and monitoring services to ensure that they meet the needs and preferences of the person using the service, and involves collaboration with service users. This includes the model of counselling/psychotherapy and other support services, such as one-to-one support services, suicide prevention helplines and support groups.

2. The service has an audit schedule which includes but is not limited to:

    — Individual plan/care plan/recovery plan

    — Records of people using the service

    — Operating policies and procedures

    — Complaints log

    — Risk register

    — Therapist accreditation and registration

    — DNAs (did not attend)

    — Cancellation of appointments

    — Waiting lists

    — How many people using the service are at high risk

3. The audit schedule includes self-assessment against this *Best Practice Guidance for Suicide Prevention Services*.

4. The records of audits and self-assessments include quality-improvement plans, any action taken, trends identified and learning gained.

5. Governance arrangements are in place to ensure that findings from audits / self-assessments, incident reports and complaints are effectively managed, monitored and disseminated to staff and the person using the service. Findings should be anonymized where appropriate.

6. Organisations keep up to date with research and evidence-based practices in suicide prevention, including self-harm.

7. The organisation communicates regularly with the HSE and other external agencies to identify emerging needs, based on current research and evidence.

Theme 3

# Safe Care and Support

Safe care and support means that people using a suicide prevention service are protected from potential harm, both in their personal circumstances and whilst seeking support from the service. A high-quality, safe service learns from all relevant information, including when things go wrong.

Best Practice Theme 3 *Safe Care and Support* has five aims and five corresponding indicators to promote safe care and support. Best practice guidance is provided for each indicator, with examples of features of a service in meeting each indicator.

| **Theme 3: Safe Care and Support** | |
|---|---|
| **Aim** | **Indicator** |
| **Protection from harm**<br>1. The suicide prevention service takes all reasonable measures to protect the person using the service, staff, volunteers and visitors from the risk of harm associated with the design and delivery of the service. | 1.1 There are mechanisms in place to identify and assess any risks for people using the service and stakeholders throughout the suicide prevention service. Measures needed to control the risks, including safety planning, are identified and implemented. |
| **Safety monitoring and improvement**<br>2. The suicide prevention service gathers, monitors and learns from information relevant to the provision of safe services and actively promotes learning, both internally and externally. | 2.1 The suicide prevention service has a system in place to monitor and report on the quality and safety of care and support provided, which supports improvement and learning. |

| Theme 3: Safe Care and Support | |
|---|---|
| **Aim** | **Indicator** |
| **Managing safety incidents**<br>3. The suicide prevention service effectively identifies, manages, responds to and reports on safety incidents. | 3.1 There are systems in place to identify, record, review report and learn from adverse incidents. |
| **Protection from abuse**<br>4. The suicide prevention service ensures all reasonable measures are taken to protect the person using the service from abuse. | 4.1 The person using the service is protected from all forms of abuse. |
| **Fire safety**<br>5. Effective fire safety systems are in place, in accordance with legislative requirements. | 5.1 There are adequate precautions in place against the risk of fire, and actions to take if there is a fire. |

# Theme 3: Safe Care and Support

## Aim 1

**The suicide prevention service takes all reasonable measures to protect the person using the service, staff, volunteers and visitors from the risk of harm associated with the design and delivery of the service.**

## Indicator 1.1

There are mechanisms in place to identify and asses any risks for people using the service and stakeholders throughout the suicide prevention service. Measures needed to control the risks, including safety planning, are identified and implemented.

### Features of a service meeting this indicator include the following:

1. There is a comprehensive written risk-management policy and procedure in place, which identify and manage all risks (Governance Code for Community, Voluntary and Charitable Organisations (2016) Sub-Principle 2.3).

2. The risk-management policy includes the following:

- Safety Statement, pursuant to Children's First Act 2015
- An annual risk assessment
- A plan for each risk identified
- The roles and responsibilities for risk assessment and management and the implementation of the risk management policy within the service
- The person with overall responsibility for risk management
- The responsibilities of staff and volunteers
- A defined quality and safety oversight and review structure, as part of the governance process for managing risk
- The processes for identifying, assessing, treating, reporting, reviewing and monitoring risks throughout the service, including:
    - Organisational risks
    - Capacity risks - relating to the number of people using the service
    - Health and safety risks to the person using the service, staff and volunteers and others
    - Risks to the people using the service during the provision of general care and support services
    - Risks to the person using the service during the delivery of individualised care and support
- The process for rating identified risks
- The precautions and systems in place to control risks

- The process for documenting, reporting, recording, investigating and learning from adverse incidents involving the person using the service and others
- The process for escalating risks within the organisation
- Arrangements for responding to emergencies
- Arrangements for the protection of children and vulnerable adults
- The process for maintaining and reviewing the risk register
- The record-keeping requirements on risk management
- The precautions in place to control the following specified risks:
    - Risks to vulnerable adults and children
    - Suicide and self-harm
    - Assault
    - Accidental injury to the person using the service or to staff/volunteers
    - The process for responding to specific emergencies, including responsibilities of key staff and volunteers, the sequence of required actions, the process for communication, and escalating crucial incidents/emergencies to management

3. Policies and procedures on risk management are implemented throughout the service.

4. All staff and relevant volunteers have read and understand the policies and procedures on risk management. This is documented.

5. All staff and relevant volunteers can articulate the process.

6. Relevant staff, including counsellors and support staff, and volunteers have received training in risk management and its implementation throughout the service. The training includes:
    - The identification, assessment and management of risk.
    - Health and safety risk management, including occupational health.
    - Organisational risk management for management staff.
    - Implementing the risk management strategy, assessing and managing risk in relation to suicide prevention and in working with vulnerable people using the service.
    - Incident reporting, documentation and review.

7. A health and safety committee is set up. Minutes of its meetings demonstrate that the safety of the service is being monitored, evaluated and improved.
8. Clinical risks are identified, assessed, treated, reported and monitored. Clinical risks are documented in the risk register, as appropriate.
9. Health and safety risks are identified, assessed, addressed, reported and monitored and escalated, where appropriate, by the service. Health and safety risks are documented in the risk register.
10. Responsibilities are allocated at management level and throughout the service to ensure that the risk-management policy is implemented.
11. A nominated person with responsibility for risk-management reviews incidents to identify any trends or patterns occurring in the services. He or she reports regularly to the governance body, e.g. board or management committee.
12. Strategic and operational (corporate) risks are identified, assessed, addressed, reported and monitored by the service. These are documented in the risk register.

## Further information

The Wheel. Reducing the Risk: Good Practice Guide.[46]

HSE Integrated Risk Management Policy – Incorporating an Overview of the Risk Management process.[47]

46 Available at: https://www.wheel.ie/advice-guidance/managing-your-organisation/risk-management

47 Available at: https://www.hse.ie/eng/about/qavd/riskmanagement/risk-management-documentation/hse%20integrated%20risk%20management%20policy%202017.pdf

## Health and safety

13. There are policies and procedures pertaining to the health and safety of the person using the service, staff, volunteers and visitors.

14. A safety statement is drawn up. This specifies who is responsible for health and safety in the organisation (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.1).

15. The policies and procedures/safety statement pertaining to the health and safety of the person using the service, staff, volunteers and visitors includes:

    — The roles and responsibilities for ensuring the health and safety of staff, volunteers, the person using the service and others

    — Specific roles are allocated to the senior manager and board in relation to the achievement of health and safety legislative requirements

    — The allocation of safety representative roles

    — The service's compliance with health and safety legislation, including the reporting requirements and process for escalating risks

    — The health and safety risk-management process

    — The fire management plan

    — First aid response requirements

    — The staff and volunteers' training requirements in relation to health and safety

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

    — Hand washing

16. All staff and relevant volunteers have read and understand the policies and procedures/safety statement and associated risk assessments, and this is documented.

17. The policies and procedures/safety statement clearly outline the measures in place to manage safety issues, in accordance with Section 20 of the Safety Health and Welfare at Work Act 2005 (as amended).

18. All staff and relevant volunteers can articulate the processes relating to health and safety as set out in the policies/safety statement.

19. Roles and responsibilities with regard to ensuring the health and safety of staff, volunteers, the person using the service and visitors are clearly defined.

20. Safety representative roles are allocated and documented. Staff and volunteers are aware of these.

21. The service complies with health and safety legislation.

22. Relevant staff and volunteers have received training in risk management and safe-work practices to which they are likely to be exposed.

## Individual risk and safety planning:

23. Risk and safety planning is delivered in line with evidenced-based practice and is carried out through co-production and/or in collaboration with the person using the service and, where relevant, named supporters.

24. A comprehensive risk-assessment and safety plan process is in place, and where relevant as outlined in the individual's plan, which is co-produced and/or carried out collaboratively, where relevant. This includes:

    — Connection between the person using the service and staff member and/or volunteer

    — Fostering a non-judgemental and positive attitude towards the person using the service

    — Possible options and solutions for positive risk-taking/ risk enablement (see Glossary for definition of positive risk-taking)

    — A focus on the strengths of the person using the service

    — Identification of protective factors

    — Empirically validated assessment tools

    — Risk categories, i.e. risk to self, risk to others, risk by others or risks caused by the service

25. Risk assessment and safety planning is carried out by trained personnel on an ongoing basis and, where relevant, with multi-disciplinary collaboration (rather than as a static or once-off event).

26. Risk assessment should be considered for all areas, including identifying individual risk factors (e.g. high risk and post-suicide, general health risks, risks of self-harm, vulnerable adult etc.), when a person has first contact with service and accesses a service (admission), and when they leave the service (discharge).

27. When a risk incident has been resolved, a proactive safety plan for the future is developed, through co-production and/or collaboration with the person using the service, when required.

28. The proactive safety plan contains a summary of the risks identified. This includes warning signs, factors that may escalate the risks and strategies to be taken collaboratively by staff, relevant volunteers and the person using the service in response to the risks identified.

29. The safety plan contains a clear statement of who is responsible for carrying out specific tasks and the timeframe for completion.

30. The person using the service has a copy of the safety plan and is asked to indicate their agreement with the plan, as far as is practicable. The person using the service is advised of the safety plan which is documented in their file.

## Assessing and reducing risks pertaining to the person using the service and the organisation:

31. There are systems in place to assess and reduce the following risks pertaining to the person using the service and the organisation, including[48]:

### i) Risk to self

- Harm to self (including unintentional harm), suicide, self-harm (including repetitive self-injury), self-neglect and substance abuse
- Loss of social and financial status arising from mental health difficulties (loss of employment, loss of accommodation, loss of support from family and friends, loss of custody of children, loss of reputation)
- Risk to physical, psychological and sexual health as a result of engaging in risk behaviours, such as substance misuse, sexual risk behaviour

### ii) Risk from others

- Physical, sexual or emotional abuse by others, including domestic violence and abuse
- Financial abuse or neglect by others
- Victimisation and harassment, in own home and in public, including sexual harassment
- Being treated unfairly/bullying and harassment in the workplace
- Losing accommodation or having difficulty getting accommodation
- Copycat behaviour/local suicide clusters
- Social media

### iii) Risk to others

- Violence, aggression, verbal or physical assault
- Sexual assault or abuse, sexual harassment, stalking or predatory intent
- Domestic violence and abuse
- Property damage, including arson
- Neglect or abuse of children or adults for whom care and support is being provided

48 This list has been adapted from Higgins A, Morrissey J, Doyle L, Bailey J, Gill A (2015). Best Practice Principles for Risk Assessment and Safety Planning: A guide for mental health nursing. Dublin: Health Service Executive.

— Behaviour that could be considered a risk to others, such as drink driving

— Murder suicide

— Death of a child/adult

— Wider impact on the community, including community response plan

#### iv) Risk from the suicide prevention organisation

— Stigma and discrimination

— Negative attitudes and controlling behaviours of staff and volunteers

— Violation of human rights

— Experiencing harassment within the service

## This is not an exhaustive list. Risks should be assessed on an individual basis.

32. There is a risk register in place, which is reviewed at least on a quarterly basis by the management team.

33. The terms of reference are documented along with the minutes of the meetings of management and the board. These demonstrate effective mechanisms to identify and manage risk.

34. There is a critical incident plan (emergency plan) in place. This includes a process for responding to specific risks and emergencies, including the role and responsibilities of key staff and volunteers and the sequence of required actions for communicating and escalating risks/emergencies to senior management.

35. Protocols are in place to ensure that organisations can work collaboratively on the management of critical incidents. (See: Connecting for Life, Strategic Goal 3 (3.1.2.) and HSE Incident Management Framework 2018[49]).

36. Staff and volunteers are aware of the critical incident plan. This includes planning for risks/ emergencies such as fire, flood, and medical emergencies.

49 Available at: https://www.hse.ie/eng/about/qavd/incident-management/hse-2018-incident-management-framework-guidance-stories.pdf

# Theme 3: Safe Care and Support

## Aim 2

**The suicide prevention service gathers, monitors and learns from information relevant to the provision of safe services and actively promotes learning both internally and externally.**

## Indicator 2.1

The suicide prevention service has a system in place to monitor and report on the quality and safety of care and support provided, which supports improvement and learning.

### Features of a service meeting this indicator include the following:

1. There is an agreed system in place to collect, monitor and evaluate data and/or personal data relevant to the provision of safe services.

2. Data and/or personal data collected is used to measure performance and improve the efficiency of suicide prevention services (e.g. from six-monthly audits, complaints, feedback from staff, volunteers and the person using the service, incident reports, risk register, etc.).

3. Quality Improvement Plans are in place and are informed by analysis of the information collected.

4. Minutes from team, management and board of governors' meetings demonstrate that reports on quality and safety are discussed at all appropriate levels of the organisation and actively inform change.

5. There is a system in place for implementing and monitoring Quality Improvement Plans.

6. Forums and approaches to share learning are in place (e.g. notice boards, discussion groups, focus groups, sharing-learning days, newsletters, teamwork initiatives). Learning notices and memos are circulated to share learning.

7. There is co-production and/or collaboration with the person using the service (and, if relevant, named supporters) in the analysis of information used to improve of services, in accordance with data protection rules.

# Theme 3: Safe Care and Support

## Aim 3

**The suicide prevention service effectively identifies, manages, responds to and reports on safety incidents.**

## Indicator 3.1

There are systems in place to identify, record, review report and learn from adverse incidents.

### Features of a service meeting this indicator include the following:

1. All incidents are recorded and their impact is rated, in accordance with policy.

2. Incident report forms are completed, signed and dated.

3. Senior managers and the board are aware of safety incidents. Records are maintained to demonstrate this.

4. The person using the service and, if relevant, named supporters co-produce and/or collaborate on safety incident management, in accordance with policy and procedures.

#### Further information

HSE (2013) Open Disclosure Policy and Guidance.[50]

50 Health Service Executive/State Claims Agency (2013) Open Disclosure: National Guidelines: Communicating with service users and their families following adverse events in healthcare. HSE, Dublin. Available at: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/Open_Disclosure/opendiscFiles/opdisc nationalguidelines2013.pdf

# Theme 3: Safe Care and Support

## Aim 4

**The suicide prevention service ensures all reasonable measures are taken to protect the person using the service from abuse.**

## Indicator 4.1

The person using the service is protected from all forms of abuse.

### Features of a service meeting this indicator include the following:

1. A policy and procedure is in place to protect children and vulnerable adults from abuse.

2. A Child Safeguarding Statement is drawn up, setting out the policies and procedures in place to manage the risks that have been identified.

3. A risk assessment is carried out to identify if a child or young person could be harmed while availing of a service – to identify potential risks, develop policies and procedures to minimise risk by responding in a timely manner to potential risks, and review whether adequate precautions have been taken to eliminate or reduce these risks.

4. Staff and relevant volunteers are fully aware of legislation and policy for the protection of children and persons at risk of abuse, including but not restricted to the following:

   - HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures, 2014[51]
   - Children First Act, 2015 as amended
   - HSE Child Protection and Welfare policy, 2016
   - Assisted Decision Making Capacity Act, 2015 as amended
   - HSE National Consent Policy, 2017[52]

5. The policies and procedures for the protection of children and vulnerable adults include the following:

   - The processes for safeguarding children and vulnerable adults
   - Dealing with child protection concerns
   - Staff and volunteer training
   - Working safely with children
   - Appointment of designated officers
   - Appointment of designated liaison persons

51 Available at: https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf

52 Available at: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-august-2017.pdf

- Responsibilities of all staff, volunteers and management, including designated officers and designated liaison persons
- Reporting concerns, suspicions and allegations
- The management of reported concerns, suspicions and allegations, including notifications, preliminary screening, safeguarding plans, investigations
- The process for interagency communication
- Implementing and reviewing safeguarding strategies

6. The policy and procedures on the protection of children and vulnerable adults are implemented.

7. Staff and relevant volunteers receive training on the protection of children and vulnerable adults, including training on child protection and safeguarding vulnerable adults from abuse.

8. Staff and relevant volunteers demonstrate an understanding of the different types of potential abuse. They have been trained to keep the person using the service safe in the event of an allegation, suspicion or disclosure of abuse, including training in processes for reporting and handling an incident.

9. Staff and relevant volunteers demonstrate an understanding of legal obligations relating to mandatory reporting of child abuse.

10. An audit is carried out of compliance with the Children First Act, 2015, covering the child protection and welfare policy, record keeping, selection/recruitment, training/supervision and other relevant policies and procedures.

11. The person using the service is aware of the person to whom they can raise concerns/ allegations.

12. The person using the service confirms that they feel safe within the service, as relevant. Their views are captured through ongoing reviews.

### Further information

Guidance on drawing up a Child Safeguarding Statement, policies and procedures, a guide for reporting child protection concerns and training, as well as a self-assessment checklist for an audit, can be found at: HSE (version 2, February 2018) Children First Implementation and Compliance HSE Funded and Contracted services, Self-Assessment Checklist: http://www.tusla.ie/children-first/organisations

# Theme 3: Safe Care and Support

## Aim 5

**Effective fire safety management systems and precautions against the risk of fire are in place, in accordance with legislative requirements.**

## Indicator 5.1

There are adequate precautions in place against the risk of fire, and actions to take if there is a fire.

## Features of a service meeting this indicator include the following:

### A. For new and proposed facilities

- A copy of the relevant Fire Safety Certificate (if applicable) received with respect to each premises identified for its intended usage. All documents submitted to the local Fire Safety Authority as part of the process should also be made available
- A copy of the Certificate of Compliance issued by either an architect or suitably qualified chartered engineer (i.e. who has specific fire safety qualifications), evidence that the plans for which the Fire Safety Certificate was issued for have been adhered to and that the building is fire safe
- Copies of the relevant Certificates of Design, Installation, Commissioning of the Fire Detection and Alarm System. This certificate confirms alarm type and compliance with the relevant IS 3218 Standard
- Copies of the relevant Certificates of Design, Installation, Commissioning of the Emergency Lighting System. These certificates confirm compliance with the relevant IS 3217 Standard
- A copy of the certificate for the electrical condition of the building, confirming it complies with ETCI Rules
- The facility is smoke free, in line with national policy
- There is accessible and appropriate fire safety equipment and devices in place, e.g. fire blankets, fire aprons, fire extinguishers, smoke alarms

### B. For existing facilities:

- Copies of current Fire Safety Management Policy and Safety Statement, complete with relevant records:
  - Relevant fire safety notices
  - Fire safety risk assessments
  - Maintenance contracts for:
    - i. Hand-held fire-fighting equipment
    - ii. Fire detection and alarm systems
    - iii. Emergency lighting systems
    - iv. Automatic suppression systems, if relevant

- Site-specific evacuation plans, including PEEPs, where necessary.
- Records of all associated fire safety training:
    i. Fire extinguisher training
    ii. General fire safety lecture
    iii. Site-specific evacuation training
- Fire door schedule and maintenance programme

2. Adequate arrangements in place for:
    - Detecting, containing and extinguishing a fire
    - Giving warning of a fire
    - Means for notifying the fire services
    - Means of containing a fire
    - Limiting the development and spread of fire
    - Means of escape
    - Signage
    - Fire services to access the facilities
    - Use of oxygen and medical gases, if relevant

3. The Fire Safety Register is up to date and maintained.

4. All relevant people are aware of their individual responsibilities in
    - The prevention of fires
    - The event of an outbreak of fire in their area of responsibility

5. The Fire Safety Management Plan and Fire Safety Register are updated to reflect any changes to the facility.

6. There is accessible and appropriate fire safety equipment and devices in place, e.g. fire blankets, fire aprons, fire extinguishers, smoke alarms.

Theme 4

# Leadership, Governance and Management

Leaders have a key role to play in strengthening and encouraging a culture of quality and safety within their service.

A well-managed and well-governed suicide prevention service ensures that the service effectively plans, organises and delivers safe, person-centred and recovery-oriented care, in compliance with legislation, standards, guidance and recommendations from relevant statutory bodies.

Best Practice Theme 4 *Leadership, Governance and Management* has five aims, to ensure that services have the appropriate leadership, governance and management structures to assure, promote and support the continuous improvement in the quality of services. Each aim has one or more indicators. Best practice guidance is provided for each indicator, with examples of features of a service in meeting each indicator.

| Theme 4: Leadership, Governance and Management | |
|---|---|
| **Aim** | **Indicator** |
| **Accountability**<br>1. The suicide prevention service has clear accountability arrangements in place to achieve the delivery of high-quality, safe and reliable services. | 1.1 The suicide prevention service identifies clear lines of accountability, responsibility and authority to oversee the management of quality and safety.<br>1.2 The suicide prevention service complies with all relevant legal and regulatory requirements, including the HSE's requirements under a Grant Aid Agreement or a Service Agreement (S.39 of the Health Act, 2004). |
| **Governance and policies**<br>2. The suicide prevention service has formalised governance arrangements for assuring the planning and delivery of high-quality, recovery-oriented, safe and reliable services. | 2.1 There are governance and management arrangements for assuring quality, risk-management and safety.<br>2.2 An integrated system is in place to govern the development, dissemination, approval, implementation, monitoring and review of policies, protocols, procedures and guidelines in accordance with regulations and best-practice requirements. |

| Theme 4: Leadership, Governance and Management | |
|---|---|
| **Aim** | **Indicator** |
| **Statement of Purpose**<br>3. The suicide prevention service maintains a publicly available Statement of Purpose that accurately describes the organisation, its ethos and the services provided, including how and where they are provided. | 3.1 A Statement of Purpose is in place for the suicide prevention service. |
| **Monitoring arrangements**<br>4. The suicide prevention service has systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of its services. | 4.1 The suicide prevention service has introduced systematic monitoring arrangements for identifying internal and external opportunities to improve quality and safety. |
| **Management and insurance arrangements**<br>5. Effective management arrangements are in place to support and promote the delivery of high-quality, safe, and reliable suicide prevention services. | 5.1 Management arrangements are in place to effectively and efficiently achieve planned objectives.<br>5.2 The suicide prevention service is adequately insured against accidents and injury to the person using the service, staff, relevant others and to the service itself. |

# Theme 4:
# Leadership, Governance and Management

## Aim 1

**The suicide prevention service has clear accountability arrangements in place to achieve the delivery of high-quality, safe and reliable services.**

## Indicator 1.1

The suicide prevention service identifies clear lines of accountability, responsibility and authority to oversee the management of quality and safety.

### Features of a service meeting this indicator include the following:

1. There is an organisational chart in place, which demonstrates management and staff roles and responsibilities at all levels of the service.

2. The organisation identifies clear lines of accountability, responsibility and authority to oversee quality and safety within the service.

3. The governing body[53] and its members are accountable and meet with the requirements set out in the Governance Code for Community, Voluntary and Charitable Organisations (2016).

4. Staff at all levels of the organisation have a clear understanding of their accountability, responsibility and authority for quality and safety. (This is in line with Governance Code Sub-Principle 1.3: The organisation manages, supports and holds to account staff, volunteers and all who act on behalf of the organisation.)

5. Staff job descriptions clearly identify responsibilities, authority and accountability for quality and safety.

6. The people who have responsibility, authority and accountability for quality and safety demonstrate their awareness of their responsibilities for quality and safety.

7. There are clear processes to bring concerns of the person using the service and staff-related concerns to the governing body, e.g. the Board or Management Committee.

8. Reviews of governance, management and accountability arrangements are carried out at least every three years, in line with the Governance Code for Community, Voluntary and Charitable Organisations (2016) (Principle 1 and Sub-principle 1.1).

53 The governing body is the grouping of people in an organisation which undertakes the governance role (e.g. Board of Governors or a Management Committee).

## Indicator 1.2

The suicide prevention service complies with all relevant legal and regulatory requirements, including the HSE's requirements under a Grant Aid Agreement or a Service Agreement (S.39 of the Health Act, 2004).

## Features of a service meeting this indicator include the following:

1. The organisation complies with the relevant legal and regulatory requirements on governance (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.1).

2. For charities as defined by the Charities Act, 2009, registration has been made with the Charities Regulatory Authority, and the organisation complies with all associated regulations (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.1 and the minimum standards contained in the 2018 Charities Regulator Governance Code, see box below).

### Charities Regulator Governance Code

The 2018 Charities Regulator Governance Code builds on the voluntary Governance Code for Community, Voluntary and Charitable Organisations. It is issued by the Charities Regulator under section 14(1)(i) of the Charities Act 2009. The Code aims to support charities in meeting their legal duties relating to systems and processes on advancing the charitable purpose and providing a public benefit, and ensuring charities are managed in an effective, efficient, accountable and transparent way. The Code sets minimum standards that all charities are required to be compliant with by 2020. Any organisation that is compliant with or working towards compliance with the existing voluntary code will meet most of the obligations set out in the new Charities Regulator Governance Code, but there are some new and additional demands on charities regarding documentation and procedural matters.

The Code covers minimum standards under six principles:

1. Advancing its charitable purpose
2. Behaving with integrity
3. Leading people
4. Exercising control
5. Working effectively
6. Being accountable and transparent

Each charity is required to report on compliance and to give evidence (of compliance or reasons for not complying) for each of the relevant standards in the Compliance Record Form, which can be downloaded from: www.charitiesregulator.ie. The Compliance Record Form has to be reported on an annual basis.

For a copy of the Code see:
https://www.charitiesregulator.ie/media/1609/charities-governance-code.pdf

For further information about what a charity is see:
https://www.charitiesregulator.ie/media/1544/what-is-a-charity-rev-001.pdf

1. If the organisation is a company limited by guarantee, a board member is appointed to act as Company Secretary. A non-board member, including a member of staff, but ideally not the CEO, may be considered for the Company Secretary role (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.1).

2. The organisation has appropriate internal financial and management controls in place (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.2).

3. An audit committee is appointed as a sub-committee of the governing body. It has written terms of reference for monitoring and review, approval and recommendations, and reports regularly to the governing body (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.1, for Type-C organisations only).

4. The organisation complies with the requirements set out in the Service Level Agreement (SLA) on governance relating to voluntary organisations, and is in line with requirements established by the HSE Compliance Unit for:

   — Service Arrangements (SA) (funding greater than €250,000)

   — Grant Aid Agreements (GA) (funding less than €250,000)

5. A formalised, signed Service Level Agreement is in place, setting out:

   — Scope of service(s) provided, required standards and resources required

   — Quality assurance, monitoring and governance arrangements for the quality and safety of services delivered

   — Requirements for written evidence of monitoring of the agreement and for non-compliance with the Service Level Agreement to be acted upon. Appropriate action is taken to address areas of non-compliance

6. All organisations funded by the HSE have written financial policies and procedures. The management arrangements for these and other policies are set out in 5.1 below.

7. An Annual Financial Statement (AFS) (as required under Service Level Agreements) is prepared, in accordance with generally accepted accounting principles (GAAP) and best-practice regulation under Financial Reporting Standard 102 under the Company's Act 2014.

8. An Annual Financial Monitoring Return (AFMR) is submitted to the HSE (and as required as an addendum to the audited financial statements and signed by the Chief Financial Officer and the Chief Executive Officer, or equivalents, and returned to the HSE with the AFS).

9. For organisations in receipt of funding of up to **€150,000** under a **Grant Aid Agreement** there is compliance with the following requirements over and above those in the Governance Code for Community, Voluntary and Charitable Organisations (2016):

   — A written Constitution/Memorandum and Articles of Association document for the organisation

   — A Chairperson's Statement that the funding received complies with the Grant Aid Agreement

   — Separate bank account in the name of the organisation

   — Financial procedures regarding cash handling/payments

   — Meeting of tax clearance requirements

   — Adherence to public and EU procurement policies

   — Complaints policy in line with Part 9 of the Health Act 2004 (if services to Children and/or vulnerable adults is provided). (Covered in Theme 3)

   — Freedom from abuse policy (if services to children and/or vulnerable adults are provided). (Covered in Theme 3)

   — Safeguarding of children and vulnerable adults policy, including Garda Vetting (if services to children and/or vulnerable adults are provided). (Covered in Theme 3)

10. For organisations where the **Grant Aid is from €150,000 to €249,999**, in addition to the above, the Annual Financial Statement is audited and submitted to the HSE.

11. For **Service Arrangements (funding over €250,000)** more extensive governance requirements are in place that go beyond those in the Governance Code for Community, Voluntary and Charitable Organisations (2016). At a minimum, the organisation's financial governance provides evidence that:

   — Funding records are administered in accordance with good financial governance

   — Effective internal financial controls and transparency are in place, including use of credit cards and handling of cash

   — There is a transparent audit trail for all financial transactions, allowing for a separation of the funding under the HSE's Service Arrangement from other financial activities

   — The funding is spent for the purposes intended and the related expenditure is capable of being vouched to original invoices, receipts and / or other relevant supporting documentation, as appropriate

   — The public accountability requirements are fulfilled, e.g. with regard to tendering, tax clearance certificates and prompt-payments legislation

- There is adherence to the principles as outlined in the Statement of Principles in Department of Public Expenditure and Reform (DPER) circular 13/2014, covering clarity, governance, value for money and fairness, and as set out in the Service Level Agreement
- The Annual Financial Statement is made available on the organisation's website

12. Where organisations are in receipt of **funding over €3 million** under a S.39 Service Arrangement, policies and procedures equivalent to the HSE's National Financial Regulations (NFR) are in place, where relevant to the organisation.

13. The statement of recommended practice (SORP) for charities is implemented, where relevant. Depending on the gross annual income of the charity, the following are the minimum requirements:

- For a charity with a **gross annual income of less than €10,000,** the financial information section is completed (optional to submit an income and expenditure account and statement of assets and liabilities for the reporting period)
- For a charity with a **gross annual income of €10,001 - €100,000,** the financial information section is completed with, information about income and expenditure account and statement of assets and liabilities for the reporting period
- For charity with a **gross annual income of more than €100,001,** the financial information section is completed and a full set of audited accounts is provided for the reporting period – including directors' and auditors' reports
- Organisations not legally required to provide annual accounts include charities with a gross income of less than €10,000, education bodies, and companies registered with the Companies Registration Office

## Further information

Guide for Small Voluntary Organisations wishing to comply with the requirements of the HSE's Governance Framework for the funding of Non-Statutory Organisations (HSE Compliance Unit, Non-Statutory Management Framework).[54]

SORP and recommended practice guidelines.[55]

54 Available at: https://www.lenus.ie/handle/10147/109187

55 Available at: https://www.wheel.ie/content/financial-reporting-charities

# Theme 4:
# Leadership, Governance and Management

## Aim 2

**The suicide prevention service has formalised governance arrangements for assuring the planning and delivery of high-quality, recovery-oriented, safe and reliable services.**

## Indicator 2.1

There are governance and management arrangements for assuring quality, risk-management and safety.

### Features of a service meeting this indicator include the following:

1. There is a clear governance and management structure. There is understanding by the governing body of delegated decision-making to the management (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 4.1).
2. There is a Quality and Safety Committee (sub-committee of the governance body), which reports to the management and the Board.
3. Minutes of meetings show that discussions on quality, risk and safety have taken place.
4. Minutes of all Quality and Safety Committee meetings demonstrate effective working of the committee and implementation of agreed actions from meeting to meeting.
5. There is a policy in place to escalate a quality and safety issue to the appropriate level.
6. The interests of the person using the service and the results of audits are taken into consideration when decisions are made about the planning, design and delivery of services.
7. The impact on the safety and quality of care of the person using the service is a high priority in business decision-making. This is demonstrated in the minutes of governance body and management meetings.
8. A mechanism exists to support the constitution of committees, including terms of reference, agendas and minutes for all meetings in the organisation. These are reviewed annually.

## Indicator 2.2

An integrated system is in place to govern the development, dissemination, approval, implementation, monitoring and review of policies, protocols, procedures and guidelines in accordance with regulations and best-practice requirements.

### Features of a service meeting this indicator include the following:

1. Policies are in place to meet statutory and best available practice requirements, including the HSE national framework for developing policies, protocols, procedures and guidelines (2016).[56]

2. All staff, the person using the service, named supporters and other stakeholders are involved, as appropriate, in the development of policies, protocols, procedures and guidelines (PPPGs).

3. All operational policies and procedures are reviewed by the governing body every three years, or as required under HSE or other contracting requirements.

4. There are policies and procedures which set out the development, dissemination, approval, implementation, monitoring and review of policies, procedures and guidelines, in accordance with the HSE national framework for developing policies, procedures and guidelines, 2016. At a minimum, this policy on PPPGs includes:

    — The roles and responsibilities for the development, management and review of operating policies and procedures

    — The processes for developing the operating policies and procedures

    — The processes for approving operating policies and procedures and the process for disseminating operating policies and procedures, either in an electronic or hard copy format

    — The process for reviewing and updating policies and procedures at least every three years

    — The processes for making obsolete and retaining previous versions of policies and procedures

    — The processes for training staff, including training following the release of a new or updated policy and procedure

    — The processes for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures

    — The standard operating policy and procedure template and layout used by the service

56 HSE (2016) National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPG). Available at: https://www.hse.ie/eng/about/who/qid/use-of-improvement-methods/nationalframeworkdevelopingpolicies/

5. Each policy, procedure, protocol and guidance (PPPG) has a signature sheet, which indicates that all staff and relevant volunteers have read and understand it.

6. Staff and relevant volunteers can articulate the processes for the development and review of operating policies and procedures. This is documented.

7. All policies and procedures are communicated and implemented.

8. An annual audit is carried out and analysed to determine compliance with policy and procedures and opportunities to improve the process of developing and reviewing the policies.

# Theme 4: Leadership, Governance and Management

## Aim 3

**The suicide prevention service maintains a publicly available Statement of Purpose that accurately describes the organisation, its ethos and the services provided, including how and where they are provided.**

## Indicator 3.1

A Statement of Purpose is in place for the suicide prevention service.

### Features of a service meeting this indicator include the following:

1. There is an up-to-date Statement of Purpose in place, which includes the:
   - Aims and objectives of the organisation, including how resources are aligned to deliver these objectives
   - Description of the services provided
   - Intended population group(s) of people using the service
   - Inclusion/exclusion criteria
   - Models of service delivery
   - Location/s of service delivery
2. The Statement of Purpose is signed off by governing body and the management team.
3. The service delivered reflects the approved Statement of Purpose.
4. The Statement of Purpose is communicated in an accessible format and is available publicly, including in the annual report.
5. The Statement of Purpose is reviewed regularly and amended to reflect changes in services offered, for example, in the organisation's strategic plan.
6. The Statement of Purpose is linked to the organisation's vision, mission and objectives (as set out in the Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 1.1). These are developed, resourced, monitored and evaluated in the organisation's strategic plan (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 1.2).

# Theme 4: Leadership, Governance and Management

## Aim 4

**The suicide prevention service has systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of its services.**

## Indicator 4.1

The suicide prevention service has introduced systematic monitoring arrangements for identifying internal and external opportunities to improve quality and safety.

### Features of a service meeting this indicator include the following:

1. Data and/or personal data of the person using the service is collected from quality, risk and safety systems and used to measure and improve the service (e.g. risk registers, audits, complaints, incidents and feedback from the person using the service, named supporters, and staff and volunteers).

2. Information is used and shared within and between services/agencies, as appropriate, to inform continuous improvement and the provision of safe services. For example, through quality and safety committees, notice boards, surveys, suggestion boxes, newsletters and conferences.

3. There are proactive measures and mechanisms in place to gather and respond to feedback from the person using the service, volunteers and named supporters.

4. The suicide prevention service monitors progress in implementing quality and safety improvement plans on a regular basis. The information gathered is used as a basis for service development, planning and strategic development.

5. Opportunities are sought for local and national benchmarking and sharing good-practice initiatives.

# Theme 4: Leadership, Governance and Management

## Aim 5

**Effective management arrangements are in place to support and promote the delivery of high-quality, safe, reliable and recovery-oriented suicide prevention services.**

## Indicator 5.1

Management arrangements are in place to effectively and efficiently achieve planned objectives.

### Features of a service meeting this indicator include the following:

1. The suicide prevention service reviews management arrangements, identifies gaps and acts to address these gaps.

2. Effective and efficient management arrangements include the use and review of the following structures, processes and systems, including, where relevant:

   **Workforce management**

   — A documented process for workforce planning, in line with the assessed needs of the person using the service, projected and actual service demand and the resources available, including volunteers

   — Attendance and absence records, policy and processes

   — Support for employees, e.g. an employee assistance system

   — Annual leave and records of planned annual leave

   — Records of allocations of staff and volunteers

   — Professional development planning and review

   — Exit interviews for staff and volunteers

   **See Theme 5: Workforce.**

### Communication management

— Terms of reference, agendas and minutes of all meetings

— Minutes available to all relevant stakeholders

— Clinical handover records, where applicable, for example, for counselling and psychotherapy

— Mechanisms to improve communication (e. g. staff discussion groups, information sharing)

— Information and communications technology (ICT) infrastructure to support communications

— Media management systems

— Terms of reference for project groups, to include how they are commissioned, established and terminated

### Information management

— Information governance policy

— ICT systems

— Data protection in line with GDPR and Freedom of Information legislation

— Safe storage of data and/or personal data in line with policy

— Consent policy

— Confidentiality agreements included in employment contracts

— Audit of records

— System to actively manage information pertaining to the person using the service (record retention policy, records management)

— Data protection breaches reported investigated and communicated in line with policy

### Environment and physical infrastructure management

- Records indicating management of estates/infrastructure and environment
- Maintenance records
- Health and Safety statement
- Minutes of health and safety committee
- Fire register/fire safety records
- Records of assessing, adapting and customising the environment to meet the needs of the person using the service (e.g. safety considerations, accessibility needs)
- Quality improvement and audit results being implemented

### Financial and resource management

- Financial and resource management system established in accordance with the requirements set out in the Governance Code for Community, Voluntary and Charitable Organisations (2016), Charity Regulator Governance Code (2018) and relevant SLA (as set out above under Aim 1 above)
- Committee meeting records (including audit and finance sub-committees, where in place)
- An agreed budget is appropriately managed to deliver the operational plan
- Records of monitoring and compliance with the Governance Code for Community, Voluntary and Charitable Organisations (2016), Charity Regulator Governance Code (2018) and SLA
- Internal and external financial audit records
- Evidence of implementation of actions from audits
- Records of measures taken to prevent theft and fraud
- Fundraising reports and management

## Indicator 5.2

The suicide prevention service is adequately insured against accidents and injury to the person using the service, staff, relevant others and to the service itself.

### Features of a service meeting this indicator include the following:

1. The organisation's insurance is comprehensive and covers accidents or injury to the person using the service, staff, volunteers, visitors and others, loss or damage to the assets of the person using the service, any services provided, and the building and its contents (Governance Code for Community, Voluntary and Charitable Organisations (2016), Sub-principle 2.3).

2. There are defined policies and procedures in place regarding insurance and they include:

    — The roles and responsibilities in relation to the sourcing, scope and payment of insurance

    — Process for ensuring insurance is in place and up to date

    — The process for required approval to renew the insurance annually, or as appropriate

    — The process for providing evidence of insurance to relevant individuals or bodies

    — The process to be applied in the event of a claim being submitted by the person using the service, visitor, volunteer or staff member

3. The policies and procedures cover the following:

    — Public liability

    — Employer's liability

    — Professional indemnity (e.g. for counsellors and psychotherapists)

    — Property and possessions

4. Relevant staff are aware of the processes relating to the organisation's insurance cover.
5. There is a process for an annual claims review with the insurance provider.
6. The insurance certificates are available and up to date.
7. There is a review of the scope of insurance cover in accordance with any increase in the risk of injury to the person using the service, staff, volunteers, visitors or others.
8. Confirmation of insurance is available in documentary form and dated.

# Theme 5

# Workforce

The workforce in a suicide prevention service is one of its most important resources. It is important that the workforce has the right mix of skills to deliver high-quality, safe and reliable care and support, and that the workforce is planned, structured and managed effectively.

Best Practice Guidance Theme 5: *Workforce*, contains four aims to ensure that suicide prevention services have the appropriate recruitment, staffing, supervision and workforce competencies. Each aim has one or more indicators. Best-practice guidance is provided for each indicator, with examples of features of a service in meeting each indicator.

| **Theme 5: Workforce** | |
|---|---|
| **Aim** | **Indicator** |
| **Workforce and skills management**<br>1. The suicide prevention service plans, organises and manages its workforce to achieve its objectives for high-quality, recovery-oriented, safe and reliable services. | 1.1 There is an appropriate number of staff and volunteers, with the required skill mix. |
| **Recruitment**<br>2. The suicide prevention service recruits staff and volunteers with the required competencies to provide high-quality, recovery-oriented, safe and reliable services. | 2.1 A recruitment process is in place in the service. |

| Theme 5: Workforce | |
|---|---|
| **Aim** | **Indicator** |
| **Skills development**<br>3. The suicide prevention service ensures that its workforce has the competencies and capabilities required to deliver a high-quality, recovery-oriented, safe and reliable service. | 3.1 Staff and volunteers are supported in maintaining and developing their competencies.<br>3.2 Regular formal and informal supervision is available to staff and volunteers to ensure they perform their job/role to the best of their ability. |
| **Supportive working environment**<br>4. The suicide prevention service supports its workforce in delivering a high-quality, recovery-oriented, safe and reliable service. | 4.1 The suicide prevention service has arrangements to support staff and volunteers in delivering high-quality care and support.<br>4.2 There is an effective and collaborative performance-management system in place.<br>4.3 The suicide prevention service has a culture of openness and accountability.<br>4.4 The service has formal processes to support and sustain team working. |

# Theme 5: Workforce

## Aim 1

**The suicide prevention service plans, organises and manages its workforce to achieve its objectives for high-quality, recovery-oriented, safe and reliable services.**

## Indicator 1.1

There are appropriate numbers of staff and volunteers, with required skill-mix.

### Features of a service meeting this indicator include the following:

1. There are written policies and procedures in place for services in relation to the recruitment, selection and vetting of staff (Governance Code for Community, Voluntary and Charitable Organisations (2016), Principle 1.3).

2. The policies and procedures on staffing include:

   - Roles and responsibilities for the recruitment, selection, vetting and appointment of all staff and volunteers, including re-vetting staff and volunteers every 3-5 years
   - Recruitment, selection and appointment processes, including Garda vetting requirements, as appropriate
   - Roles and responsibilities in relation to staff and volunteer training
   - Organisational structure of the suicide prevention service, including lines of responsibility
   - Contracts and job description requirements
   - Staff and volunteer planning requirements to address the number and skill mix of staff and volunteers appropriate to the assessed needs of the person using the service
   - Staff/volunteer rota details and how this is communicated to staff
   - Orientation and induction training for all new staff and volunteers
   - Type and frequency of staff and volunteer training needed on an ongoing basis to provide safe and effective care and support, in accordance with best practice
   - Required qualifications and accreditation of training personnel
   - Evaluation of training programmes
   - Staff and volunteer performance and evaluation requirements

3. Relevant staff and volunteers have read and understand the staffing policies and procedures. This is documented.

4. The policies and procedures are implemented.

5. Relevant staff and volunteers can articulate the policies and processes relating to staffing.

6. There are sufficient staff and volunteers with the appropriate qualifications to meet the number and assessed needs of people using the service.

7. There is a written staffing plan for the suicide prevention service, based on its Statement of Purpose, which takes into consideration the skill mix, competencies, number and qualifications of staff and volunteers required to fulfill the Statement of Purpose.

8. Specific services requiring enhanced qualifications and/or experience are outlined in individual contracts, for example, relating to counselling for bereavement, suicide or self-harm.

9. There is the required number of staff on duty to ensure the safety of the person using the service and staff in the event of a fire or other emergency.

10. There is a documented process in place for transferring responsibility of care and support from one staff member to another, e.g. change in staffing or a change of shift.

11. There is continuity of care and support provided to the person using the service, particularly where staff are employed on a less than full-time basis.

12. There is an appropriately qualified and experienced staff member on duty and in charge at all times. This is documented.

13. Strategies for the retention of staff are in place (e.g. provision of additional training, professional development and in-house career development and promotion opportunities).

14. There is ongoing workforce planning in the suicide prevention service to avoid gaps in service delivery.

15. The number and skill mix of staff and volunteers are reviewed against current and future staffing requirements.

16. Review and analysis are completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of the person using the service and needs of the service. The findings and lessons learned are shared and documented.

### Further information

The Wheel. Employer Resources. Best Practice for Irish Non-Profits.[57]

HSE Human Resources (2017) Induction Guidelines and Checklists.[58]

57 Available at: https://www.employerresources.ie/about.html

58 Available at: https://www.hse.ie/eng/staff/Resources/Employee_Resource_Pack/HSE-Induction-Guidelines-Checklists.pdf

# Theme 5: Workforce

## Aim 2

**The suicide prevention service recruits staff and volunteers with the required competencies to provide high-quality, recovery-oriented, safe and reliable services.**

## Indicator 2.1

A recruitment process is in place in the service.

### Features of a service meeting this indicator include the following:

1. There are written policies and procedures relating to the recruitment process, including selection, vetting and appointment of staff, based on Irish and European legislation and best practice.

2. The policies and procedures relating to the recruitment process are implemented.

3. Relevant staff and volunteers have read and understand the policies and procedures, and this is documented.

4. Relevant staff and volunteers can articulate the recruitment processes as set out in the policies.

5. The person using the service, and, where relevant, named supporters, co-produce and/or collaborate in the recruitment process, where appropriate.

6. Those co-producing and/or collaborating in recruitment and selection receive relevant training.

7. Staff, including temporary, permanent and contract staff, and volunteers are recruited in accordance with employment and equality legislation[59] and best practice.

8. The management and board identify the skills, competencies and personal attributes required of staff and volunteers, and recruit accordingly.

9. Garda vetting is carried out on all staff, contractors, volunteers, students on placements and on workplace experience, and all other relevant personnel working or volunteering with children or vulnerable adults. For further information and definitions see Garda vetting in the Glossary.

10. Contractors on site provide evidence of appropriate indemnity and insurance. Appropriate records of such indemnity and insurance are maintained by the suicide prevention service.

11. Depending on the level of seniority of the job and experience required, two or three satisfactory references are obtained and verified, before a person starts working in the service. These include one written reference from the most recent line manager/employer.

59 Employment Equality Acts 1998 to 2015 and Gender Recognition Act 2015.

12. Where employment records are maintained nationally (i.e. in head office), records are also maintained locally for verification, in accordance with data protection.

13. All staff have a written contract of employment signed by the staff member and on behalf of the employer, a job description and a copy of their employment terms and conditions prior to taking up their post.

14. Counsellors and psychotherapists have the relevant qualifications and the minimum hours of clinically supervised practice prior to providing a counselling or psychotherapy service.

15. Counsellors and psychotherapists are accredited with a relevant professional body to assure that individuals have achieved the required level of experience and training or have a time-framed action plan in place to work towards accreditation.

16. Counsellors and psychotherapists have documented experience of working in the field of suicide prevention, self-harm or bereavement counselling, as well as in-service training, if relevant.

# Theme 5: Workforce

## Aim 3

**The suicide prevention service ensures that its workforce has the competencies and capabilities required to deliver a high-quality, recovery-oriented, safe and reliable service.**

## Indicator 3.1

Staff and volunteers are supported in maintaining and developing their competencies.

### Features of a service meeting this indicator include the following:

1. Appropriate orientation, induction, probation and ongoing training programmes (including e-learning) are provided to staff and volunteers.
2. A training needs analysis (TNA) (see Glossary) is carried out annually on or on behalf of the service and is designed to reflect the needs of the organisation and any changes in the organisation. The TNA includes:
   - Circulation of TNA questionnaires
   - Feedback from staff, volunteers, managers, staff teams, the person using the service and, where relevant, named supporters
3. The TNA takes account of the following:
   - Workforce reviews
   - Systems audits
   - Review of incidents and other key indicators (e.g. suicide prevention training, suicide clusters, self-harm, complaints, safeguarding issues, safety issues, audit outcomes, changes to profiles and changing needs of people using the service)
   - Service needs and requirements
4. Annual training and development plans are completed and reviewed for all staff, to reflect the training needs analysis and the assessed needs of people using the service.
5. Where possible, staff have access to education and training resources, including local internet access HSE Land[60] and appropriate journal publications and library resources.
6. Staff are trained to implement therapeutic and recovery-based care and support for the person using the service at each stage of his or her care/support pathway, including signposting information.
7. Staff training records and logs are maintained by line managers. Training provided is in accordance with professional development planning and linked to the skills required in the organisation.
8. All education and training programmes delivered to staff are evaluated and periodically reviewed, and records are maintained of this.
9. Where appropriate and within available resources, staff are provided with leave and financial support to pursue education and training relating to their professional development.

60 HSE Land is an online learning forum developed and run by the Health Service Executive. It provides courses and learning resources for healthcare workers in both the hospital and community health settings and is available to NGOs. It is available over the internet, on a secure site. Further information about registration and resources is available at: www.hseland.ie

10. If possible and within available resources, facilities and equipment are available for staff in-service education and training, whether didactic or through e-learning, demonstration, work-based projects, etc.

11. In-service training is provided by appropriately trained and competent individuals. Training programmes are quality assured and training is evidence-based.

12. Records are maintained of management training, including supervision, which is provided to all managers who manage front-line staff, in line with data protection.

13. Staff are provided with training to meet the assessed needs of the person using the service, in accordance with their roles, responsibilities and areas of work.

14. All relevant staff are trained in the following, in accordance with legislation and best available practice, as pertinent to their role and any professional development requirements:

**Mandatory training**

- Fire safety / Health and Safety (see Health and Safety Authority): http://www.hsa.ie/eng/Topics/Work_Related_Vehicle_Safety/Legal_Requirements/
- Children First (see HSE e-learning module): https://www.hse.ie/eng/services/list/2/primarycare/childrenfirst/training.html

**Training relevant to suicide prevention provided by NOSP**

- esuicideTALK online course
- Understanding Self Harm Awareness Training Programme
- SafeTalk, 'suicide alertness for everyone'
- ASIST (Applied Suicide Intervention Skills Training)
- ASIST tune up
- STORM (Skills Training on Risk Management)
- Bereavement Training Programme for Professionals
- Community Bereavement Workshop

For further information on the full suite of training programmes please see the NOSP National Education and Training Plan: https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/national-education-and-training-plan.pdf

### Other relevant training

- Equality and diversity training
- Mental health promotion training
- Management of violence and aggression (e.g. Therapeutic Crisis Intervention (TCI) / Professional Management of Aggression and Violence (PMAV))
- Open disclosure training
- Recovery-centred approaches to mental healthcare and treatment, including individual rights
- Infection control and prevention (e.g. hand hygiene)
- Risk management – individual, organisational and care and support provision as appropriate to the staff role
- Incident reporting
- Documentation and record keeping
- Individual Care Planning
- Care/support of service users with an intellectual disability

### For information about training

Information about training from the HSE, contact Suicide Prevention Resource Officers: https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/resourceofficers/officers-suicide-prevention.html

Listings of training on Active Link:
https://www.activelink.ie/content/community-exchange/training

HSE Advancing Recovery in Ireland (ARI):
https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/

Mental health information and training events: HSE Your Mental Health:
http://www.yourmentalhealth.ie/get-involved/news-events/events/

HSE Land (Online learning, requires registration and is available to organisations receiving funding from the HSE):
https://www.hse.ie/eng/staff/leadership-education-development/onlinelearning/

15. Where relevant, training includes safeguarding vulnerable persons/adults at risk of abuse.

16. All staff and volunteers receive training to develop an understanding of suicide prevention, mental health and recovery, as appropriate to their role. (See list of NOSP/HSE training in box above.)

17. There is oversight of those professionals or organisations that are contracted to provide training to the service(s), to ensure a competent, coordinated and evidenced-based approach.

18. There is a collaborative approach to the development and delivery of all new suicide prevention and mental health training programmes that are in keeping with a recovery-oriented approach, including co-production, co-delivery and co-evaluation.

19. Wherever possible, staff education and training occur within a multidisciplinary and/or team context.

20. Relevant staff remain up to date with best practice and guidance in relation to self-harm and bereavement and are suitably trained.

21. Counselling staff undertake individual and organisational continuing professional development and remain up to date with best-practice guidance within their field.

22. Registration and professional ethics/education of counsellors and psychotherapists is in line with regulations for the establishment of the Counsellors and Psychotherapists Registration Board, with effect from 2018 (under the Health and Social Care Professionals Act 2005 (Section 4(2)(Designation of Professions: Counsellors and Psychotherapists and Establishment of Registration Board) Regulations 2018).

## Indicator 3.2

Regular formal and informal supervision is available to staff and volunteers to ensure they perform their job/role to the best of their ability.

### Features of a service meeting this indicator include the following:

1. There are guidelines to govern the implementation of supervision, including supervision provided by line managers, and peer-to-peer supervision.

2. There is a formalised written contract of supervision between the supervisor and the supervisee.

3. Counselling and psychotherapy personnel, social workers and other relevant professionals receive appropriate clinical supervision, in line with the requirements of the relevant professional body.

4. There is a system to track supervision.

5. A written record is kept of all supervision meetings and a copy is given to the member of staff.

# Theme 5: Workforce

## Aim 4

**The suicide prevention service supports its workforce in delivering a high-quality, recovery-oriented, safe and reliable service.**

## Indicator 4.1

The suicide prevention service has arrangements to support staff in delivering high-quality care and support.

### Features of a service meeting this indicator include the following:

1. There are policies and procedures on staff/professional development planning for staff and, where relevant, for volunteers.
2. The policies and procedures on staff/professional development planning are implemented.
3. A documented staff/professional development planning system is in place.
4. Individual staff/professional development plans and a log/record of staff and relevant volunteers' participation are in place.
5. A written record is kept of each staff/professional development planning meeting and a copy is given to the member of staff or volunteer. The record is signed by the line manager and staff member/volunteer at the end of each meeting. These records are maintained confidentially.
6. Mechanisms are in place to support staff/volunteer engagement, consultation and responding to staff/volunteer feedback.
7. Staff and relevant volunteers have access to health and safety programmes, employee assistance programmes and occupational health, as appropriate.
8. Staff and relevant volunteers receive debriefing in a timely manner after incidents or responding to people in crisis.
9. There are measures in place to protect the workforce by minimising the risk of violence, bullying and harassment by other members of the workforce or people using the service.
10. Measures are in place to provide safety and security for staff and volunteers working alone or in isolated locations.

## Indicator 4.2

There is an effective and collaborative performance management system in place.

### Features of a service meeting this indicator include the following:

1. There are policies and procedures in place on performance management, which aim to be effective and collaborative.

2. Performance management policies and procedures are implemented.

3. Where relevant, individual and team performance is monitored.

# Indicator 4.3

The suicide prevention service has a culture of openness and accountability.

## Features of a service meeting this indicator include the following:

1. Staff are supported to critically assess and reflect on their practice and to propose areas for improvement.

2. There is ongoing evaluation and response to feedback about the service from people using the service and staff.

3. Staff are aware of policies relating to openness and transparency and understand their responsibilities. Relevant policies include:

   — Complaints policy

   — Dignity at work

   — Children First

   — Safeguarding vulnerable persons at risk of abuse

   — Open disclosure policy

   — Whistleblowing policy

4. There is evidence that policies relating to openness and transparency are implemented.

5. Information and data and/or personal data on open disclosure is presented to the management and relevant committees, as appropriate.

6. Staff are appropriately supported if a complaint or concern has been expressed about them.

7. Staff who make a complaint or disclose breaches of openness or accountability are appropriately supported.

8. There are arrangements for the identification, recording, review, reporting and learning from adverse incidents and open disclosure.

### Further information

HSE/State Claims Agency. Open Disclosure: National Guidelines: Communicating with service users and their families following adverse events in healthcare, 2013.[61]

For further information and guidance about protected disclosure 'whistleblowing' see: https://www.hse.ie/eng/staff/resources/hrppg/protected-disclosures-of-information-in-the-workplace-.html

61 Available at: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/Open_Disclosure/opendiscFiles/opdisc nationalguidelines2013.pdf

## Indicator 4.4

The service has formal processes to support and sustain team working.

### Features of a service meeting this indicator include the following:

1. There are teams in place which include staff with the appropriate qualification, skills and experience to address the assessed needs of the person using the service in a recovery-oriented way.

2. Teams have clearly defined goals and governance structures.

3. There is a protocol about how communication will take place within teams, for example, during team and staff meetings or handover.

4. All team members are aware of their own team roles.

5. All team members understand the roles of other relevant teams in the organisation.

6. Minutes are maintained of team meetings.

# Appendix 1

# List of names and organisations involved in committees and engagement events

## 2015 – Membership Multidisciplinary Working Group

| Name | Organisation |
|---|---|
| Catherine Brogan (Chair) | Samaritans |
| Lisa O' Farrell | MHC |
| Elaine Geraghty | Reachout |
| Eithne Cusack | HSE |
| Joseph Duffy | Headstrong |
| John Saunders | Shine |
| Cindy O' Connor | Pieta House |
| Justin Brophy | IAS |
| Ciaran Austin | Console |
| Mary O' Sullivan | HSE, Resource Officer for Suicide Prevention |
| Margaret Brennan | HSE, Quality & Patient Safety |
| Brid Casey | NOSP |

## 2015 – May Engagement Event

| Name | Organisation |
|---|---|
| Caroline Mc Guigan | Suicide or Survive (SOS) |
| Cathal Kearney | Family Resource Centre |
| Michael Ryan | ARI |
| Jacinta Hastings | Bodywhys |
| Pearse Finnegan | ICGP |
| Karen Murphy | Turn2me |
| Ian Power | Spunout |
| Mary Kells | Endeavour DBT |
| Athol Henwick | SHIP |
| Michele Kerrigan | GROW |
| Odhran Allen | GLEN |
| Claire Hayes | AWARE |
| Sandra Walsh | DOH |
| Orla Barry | Mental Health Ireland |
| Lise Alford | 3 T's |
| Patricia O' Connell | TENI |
| Gerard O' Neill | NCS |
| Krystian Fikert | MyMind |
| Derek Mc Donnell | MOJO |
| Margie Roe | Childline |
| Mary Cunningham | NTCI |
| Stacey Cannon | GAA |
| Ella Arensman | NSRF |
| Nyle Lennon | Mental Health Reform |
| John Duffy | BeLonG To |
| Catherine Morley | Exchange House |
| Emer Smyth | HSE, Dept Health & Improvement |
| Gerry Raleigh | Former Director HSE NOSP |

## 2018-2019: Membership of Steering Committee

| Name | Title | Organisation |
|---|---|---|
| John Meehan (Chair) | Assistant National Director MH Strategy & Planning and Head of the NOSP | HSE Mental Health Strategy & Planning |
| Ciara Acton | MHD, Monitoring & Support for Non-Statutory Orgs | HSE Mental Health |
| Linda Moore | Quality Standards &Compliance Officer | HSE Mental Health |
| Catherine Brogan | NGO CfL representative | Mental Health Ireland |
| John Saunders | NGO CfL representative | Shine |
| Teresa Nilan | Office for Mental Health Engagement | ARI |
| Mary O' Sullivan | Resource Officer for Suicide Prevention | HSE |
| Justin Brophy (to Sept 2018) | Clinical Lead, NOSP | HSE NOSP |
| Colum Bracken (to Sept 2018) Annemarie Dooley | Project Manager MHD SPPMO | MHD Strategic Portfolio and Programme Management Office |
| Brid Casey | Project Manager | HSE NOSP |

## 2018-2019: Membership of Project Advisory Group

| Name | Title | Organisation |
|---|---|---|
| Brid Casey | Project Manager | HSE NOSP |
| Linda Moore | Quality Standards &Compliance Officer | HSE Mental Health |
| Carmen Bryce & Sue Carroll | Communications Officer HR | MyMind |
| Patricia Mc Keever & Susan Mc Feely | Team Leader – Day Resource Services National Training Support & Awareness Team Leader | Shine |
| Cindy O' Connor & Linda Murray | CCO – Clinical Co-ordinator Clinical Centre Manager | Pieta House |
| Sandra Taylor | Resource Officer for Suicide Prevention | HSE |
| Caroline Mc Guigan & Paula Lawlor | Founder & CEO National Programme Manager | Suicide or Survive |
| Kevin Burn & Allyson Coogan | CEO Head of Mental Health Service | Exchange House |
| Moninne Griffith & John Duffy | Executive Director National Network Manager | BeLonG To |
| Salina Haldane & Aileen Downer | Head of Quality & Service Improvement Quality Manager | Samaritans |
| Margie Roe & Emma Mc Cluskey | Childline Manager Childline Best Practice Officer | Childline |

## 2017 – December Engagement Event

| Name | Organisation |
|---|---|
| Dominic Layden | AWARE |
| John Duffy | BeLonG To |
| Margie Roe | Childline |
| Finian Murray | MHFI |
| Patricia Mc Keever | Shine |
| Clare O' Brien | 3 T's |
| Caroline O' Sullivan | ISPCC |
| Carmen Bryce | My Mind |
| Kevin Burn | Exchange House |
| Ciaran Moore | Samaritans |
| Cillian Russell | Shine |
| Mary O' Sullivan | HSE |
| John Saunders | Shine |
| Ailish O'Neill | NYCI |
| Cindy O' Connor | Pieta House |
| Hannah Byrne | Spunout |
| Rosemary Scott | NYCI |
| Gill Leo | Samaritans |
| Paula Lawlor | Suicide or Survive |
| Breffni Burke | 3 T's |
| Paula Fagan | LGBT Helpline |
| Marjo Mooan | SDCP |
| Joe Mac Avin | 3 T's |
| Catherine Brogan | ARI |
| Hugh Duane | HSE NOSP |
| Anita Munnelly | HSE NOSP |
| Derek Mc Donnell | MOJO |
| Martin Rogan | Mental Health Ireland |
| Susan Kenny | HSE NOSP |
| John Meehan | Head of HSE NOSP |
| Sarah Woods | HSE NOSP |

## 2018 – February Engagement Event

| Name | Organisation |
|---|---|
| Dominic Layden | AWARE |
| Caroline O' Sullivan | ISPCC |
| John Saunders | Shine |
| Moninne Griffith | BeLonG To |
| Sam Blackensee | TENI |
| Clare O' Brien | 3 T's |
| Carmen Bryce | My Mind |
| Susan Mc Feely | Shine |
| Collette O' Regan | LGBT Helpline |
| Kiki Martire | Spunout |
| Patricia Mc Keever | Shine |
| Haley Banahan | My Mind |
| Sarah Murray | Exchange House |
| John Duffy | BeLonG To |
| Stacey Cahill | GAA |
| Anne Corcoran | Samaritans |
| Marguerite Kiely | Pieta House |
| Paula Lawlor | Suicide or Survive |
| Aisling Doherty | Mental Health Ireland |
| Lise Alford | 3 T's |
| Catherine Brogan | ARI |
| Kevin Burn | Exchange House |
| Lorcan Brennan | MHFI & MDN |
| Karen Johnson | FRC |
| Mary O' Sullivan | HSE |
| Gillian O' Brien | BeLonG To |

# Appendix 2

# List of relevant legislation and policies

This is not an exhaustive list and other relevant legislation may be included pertinent to your service:

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|---|
| Assisted Decision Making Capacity Act, 2015 as amended |
| The Charities Act, 2009 / Charities Regulator |
| Charities Statement of Recommended Practice (SORP) |
| Child Care Acts, 1991 – 2013 |
| Children First – National Guidance for the Protection and Welfare of Children 2017 and Children's Act 2001, 2015 |
| Children First Act, 2015, as amended |
| Code of Practice for Good Governance of Community, Voluntary and Charitable Organisations in Ireland, 2015 |
| Companies Acts, 1963 - 2009 |
| Employment Equality Acts 1998-2011 and relevant employment legislation (see Theme 4) |
| Equal Status Acts, 2000-2008 |
| Freedom of Information Acts, 1997 & 2003 |
| The Good Samaritan Act (2011) ROI (part of the Civil Law (Miscellaneous Provisions) Act, 2011 |
| Guide for the Development of Child Protection Policy, Procedure & Practice (Tusla, March 2015) |
| The General Data Protection Regulation, 2018 |
| HSE Child Protection and Welfare policy, 2016 |
| HSE Complaints Policy |
| HSE National Consent Policy, 2017 |
| HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures, 2014 |
| National Strategy for Service User Involvement, 2008- 2013 |
| Safety, Health and Welfare at Work Act, 2005 |

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Stewarts Hospital, Palmerstown, Dublin 20. Tel: 01 620 1670 / E: info@nosp.ie