

# **Accreditation for Acute Inpatient Mental Health Services (AIMS)**

## **Standards for Acute Inpatient Wards – Older People**

Standards have been classified as follows:

Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;

Type 2: standards that an accredited ward would be expected to meet;

Type 3: standards that an excellent ward should meet or standards that are not the direct responsibility of the ward.

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1st Edition January 2009 Pub. No. CRTU068

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NUMBER	TYPE	STANDARD
<b>SECTION 1: GENERAL STANDARDS</b>		
<b>Policies and Protocols</b>		
1.1	1	All staff are informed how to access policies, procedures and guidelines and are able to do so when required.
1.2	1	MDT staff are consulted in the development of policies, procedures and guidelines that relate to their practice.
1.3	2	Managers audit the implementation of policies and procedures and provide feedback to MDT staff.
1.4	1	All policies and protocols are reviewed every two years with the support of the policy development/clinical governance teams.
1.5	2	There is a local clinical governance group that relates to a service-wide clinical governance committee.
<b>Staffing</b>		
2.1	1	The ward has an agreed minimum staffing level across all shifts, which is met.
2.2	1	A qualified mental health nurse is available to be in charge of the ward across all shifts, including night shifts, to a level of 100%.
2.3	2	A suitably qualified, experienced and competent nurse is on all wards where there is a possibility of section 5(4) being invoked.
2.4	1	There are systems in place that ensure that all factors that affect nursing staff numbers and skill mix are taken into consideration, and staffing levels are reviewed on a daily basis. The factors are: <ul style="list-style-type: none"> <li>• levels of observation;</li> <li>• sickness and absence;</li> <li>• training;</li> <li>• supervision;</li> <li>• escorts;</li> <li>• therapeutic engagement;</li> <li>• risk of falls.</li> </ul>
2.5	1	There is a dedicated nurse in charge of the shift who is the point of contact for consultation, negotiation and decision-making for all ward operational matters.
2.6	1	A member of staff is assigned to maintain general observation in patient day areas at all times, including during personal care, to observe for risk behaviour and intervene or call for assistance to maintain patient safety.

<b>2.7</b>	1	The ward has its own dedicated lead consultant psychiatrist who can provide expert input into key matters of inpatient service delivery, staff support and decision-making, and overall service co-ordination.
<b>2.8</b>	2	Ward managers have control over the ward budget.
<b>2.9</b>	2	The ward has access to sessional or part-sessional support from the following services: <ul style="list-style-type: none"> <li>• psychology;</li> <li>• psychological therapies;</li> <li>• occupational therapy;</li> <li>• social work;</li> <li>• pharmacy;</li> <li>• physiotherapy;</li> <li>• dietetics;</li> <li>• speech and language therapy.</li> </ul>
<b>2.10</b>	2	The ward has access to support from the following referral services: <ul style="list-style-type: none"> <li>• dental assessment and dental hygiene services;</li> <li>• visual reviews;</li> <li>• hearing reviews;</li> <li>• podiatry;</li> <li>• wound care services;</li> <li>• palliative care services;</li> <li>• phlebotomy services;</li> <li>• specialist infection control services;</li> <li>• a tissue viability nurse;</li> <li>• specialist continence services.</li> </ul>
<b>2.11</b>	2	There is access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.
<b>2.12</b>	2	There is access to adequate dedicated sessional or part-sessional administrative support on the ward.
<b>2.13</b>	1	Levels of sickness, absence and injuries are monitored.
<b>2.14</b>	1	At all times, a doctor is available to attend an alert by staff members within 30 minutes.
<b>2.15</b>	1	There is a policy ensuring that staff carrying out physical examinations/procedures are either the same sex as the patient or there is a same sex chaperone present.
<b>2.16</b>	1	There is a designated full-time named officer with lead responsibility for the protection of vulnerable adults.
<b>2.17</b>	1	There is a policy and procedure on the recruitment and use of volunteer staff on the ward.

<b>Recruitment and Retention of Staff</b>		
<b>3.1</b>	1	There is a system to routinely monitor and report on the use of bank and agency staff.
<b>3.2</b>	2	When any posts are vacant or in the event of long-term sickness, immediate arrangements are made for temporary staff cover.
<b>3.3</b>	2	Ward managers receive feedback from nursing staff exit interviews.
<b>3.4</b>	2	Patients are involved in the recruitment of ward-based staff.
<b>3.5</b>	2	Carers are involved in the recruitment of ward-based staff.
<b>Appraisal, Supervision and Staff Support</b>		
<b>4.1</b>	1	There is a strategy and policy for staff appraisal and supervision.
<b>4.2</b>	2	All staff receive an annual appraisal and personal development planning.
<b>4.3</b>	2	Clinical/managerial supervisors receive appropriate training as agreed in local policy, taking into consideration profession-specific guidelines.
<b>4.4</b>	2	All MDT staff receive regular individual management supervision from a person with appropriate experience and qualifications.
<b>4.5</b>	2	All non-clinical staff are able to access supervision as needed.
<b>4.6</b>	2	All staff are able to contact a senior colleague as necessary 24 hours a day.
<b>4.7</b>	1	All staff are aware of their level of authority and what decisions they can and cannot take.
<b>4.8</b>	2	All staff are able to take allocated breaks off the ward
<b>4.9</b>	2	Clinical staff receive training, support and supervision from experienced senior practitioners in providing one-to-one therapeutic contact and group work.
<b>Staff Education and Training</b>		
<b>5.1</b>	2	Training budgets enable all staff to meet requirements for their continuing professional development and the Knowledge and Skills Framework.
<b>5.2</b>	2	There are arrangements for staff cover to allow staff to attend training.

<b>5.3</b>	1	All new staff are allocated a person who oversees their induction, such as a mentor or preceptor.
<b>5.4</b>	1	Before being asked to carry out any clinical work, all staff receive mandatory training in line with Trust guidance, e.g. fire, manual handling and basic life support.
<b>5.5</b>	1	All qualified clinical staff are trained in adult protection, which includes local policies and procedures.
<b>5.6</b>	2	As part of their induction, all clinical staff receive basic training in how to assess capacity and an understanding of the Mental Capacity Act.
<b>5.7</b>	2	All qualified staff receive training in CPA or equivalent.
<b>5.8</b>	2	Staff who undertake assessment and care planning have received training in risk management and risk assessment.
<b>5.9</b>	2	Staff who undertake assessment and care planning have received training in suicide awareness and prevention techniques.
<b>5.10</b>	2	Staff who undertake assessment and care planning have received training in how to involve patients and carers.
<b>5.11</b>	2	Staff who undertake assessment and care planning have received training in the processes of referral to other agencies.
<b>5.12</b>	2	Staff who undertake assessment and care planning have received training in care planning as part of the care management programme, including discharge planning.
<b>5.13</b>	2	Staff who undertake assessment and care planning have received training in procedures for assessing carers' needs.
<b>5.14</b>	2	Staff who undertake assessment and care planning have received training in conflict resolution/de-escalation.
<b>5.15</b>	2	Staff who undertake assessment and care planning have received training in dementia awareness.
<b>5.16</b>	2	All staff have an awareness of how to support people with hearing/visual impairments.
<b>5.17</b>	3	Staff are able to access support/advice relating to patients who are registered deaf or blind.
<b>5.18</b>	2	There is clinical leadership training for registered mental health nurses (band 6 and above), psychiatrists and other members of the MDT.

<b>5.19</b>	2	There is an investment in the development of managerial and leadership competencies of ward managers and sister/charge nurses that emphasises clinical communication skills and negotiating skills.
<b>5.20</b>	1	All qualified nurses have been assessed as competent in the administration of medications.
<b>5.21</b>	1	All staff have received training in relation to confidentiality.
<b>5.22</b>	2	Clinical staff receive training and support from specialist psychological therapy practitioners in providing basic psychological and psychosocial interventions including, but not limited to: conflict resolution/de-escalation, engagement activity scheduling, group facilitation.
<b>Advocacy</b>		
<b>6.1</b>	1	The ward provides access to an advocacy service that includes IMCAs where appropriate.
<b>Compliments and Complaints</b>		
<b>7.1</b>	2	There are clear policies and procedures for managing complaints.
<b>7.2</b>	2	A range of supports is available for patients wishing to make a complaint.
<b>7.3</b>	2	Information is available for patients/carers about: <ul style="list-style-type: none"> <li>• how to make a verbal complaint;</li> <li>• how to make a written complaint;</li> <li>• how to suggest service improvements and enhancements;</li> <li>• how to make a written compliment;</li> <li>• how to make a donation.</li> </ul>
<b>7.4</b>	2	There is evidence of audit, action and feedback from complaints.
<b>Smoking</b>		
<b>8.1</b>	1	There is a smoke-free policy for the ward which follows HDA guidance and best practice.
<b>8.2</b>	2	There is support for staff and patients to assist with the smoking policy, including: <ul style="list-style-type: none"> <li>• consideration of the use of NRT while on hospital premises to help with withdrawal or as a coping strategy;</li> <li>• a comprehensive support programme, with information about the support on offer;</li> <li>• strategies to make sure staff know and understand the Trust's policy and monitor levels of comprehension.</li> </ul>

NUMBER	TYPE	STANDARD
<b>SECTION 2: TIMELY AND PURPOSEFUL ADMISSION</b>		
9.1	1	There is a policy in place to promote the sharing of information between identified personnel and agencies in accordance with public protection and the Data Protection Act.
9.2	2	Information on previous care planning and interventions is sourced by the ward within 24 hours of admission.
9.3	1	The ward ascertains from the referring agency information as to the security of the patient's home, the wellbeing of dependents, the whereabouts of animals etc.
9.4	1	All assessments are documented, signed/validated (i.e. in electronic records) and dated by the assessing practitioner.
<b>Control of bed occupancy</b>		
10.1	1	Bed occupancy is managed at a service level, and there is a clear process for exceeding this level.
10.2	1	There are effective systems that support the senior team to prioritise waiting lists and facilitate timely admission.
10.3	2	The ward manager or nominated deputy participates in discussions regarding admissions, and her/his views regarding patient mix and safety are actively considered by the senior team.
10.4	2	When a patient is sent on leave, they are able to return if problems arise, and it is explained to them and/or their carers beforehand that they may not be able to return to the same bed/ward.
10.5	2	Local information systems are capable of producing accurate and reliable data about delayed transfers of care of patients.
10.6	2	Delayed discharges are routinely reviewed and action is taken to review any identified problems.
<b>Admission Systems</b>		
11.1	2	When talking to patients and carers, health professionals avoid using clinical language and jargon.
11.2	2	Managers and practitioners have written standards for the admission process.
11.3	2	The admission policy describes how decisions regarding the appropriate place of admission for older people are primarily based on mental and physical need.

<b>11.4</b>	2	There is a shared care protocol between adult and older people's mental health services for the care of "graduate" patients.
<b>Admission Process</b>		
<b>12.1</b>	1	Patients and accompanying persons are met on arrival, shown to an appropriate area, and offered refreshments etc.
<b>12.2</b>	1	Patients are introduced to a member of staff who will be their point of contact for the first few hours after their admission.
<b>12.3</b>	1	Within an hour of their admission or as soon as they are well enough, patients are shown around the ward and orientated to their bedroom area.
<b>12.4</b>	1	On the day of their admission or as soon as they are well enough, patients and/or carers are given a "welcome pack" or introductory booklet that contains the following: <ul style="list-style-type: none"> <li>• a clear description of the aims of the ward;</li> <li>• the current programme and modes of treatment;</li> <li>• a clear description of what is expected and rights and responsibilities;</li> <li>• a simple description of the ward's philosophy, principles and rationale, and the ward team membership, including the name of the patient's consultant psychiatrist and key worker/named nurse;</li> <li>• visiting arrangements;</li> <li>• personal safety on the ward;</li> <li>• ward facilities;</li> <li>• ward programme of activities;</li> <li>• what practical items patients need in hospital and what should be brought in.</li> </ul>
<b>12.5</b>	1	On the day of their admission or as soon as they are well enough, detained patients are, in accordance with section 132 of the MHA, given written information on their rights, rights to advocacy and second opinion, right to move hospital, right of access to interpreting services, professional roles and responsibilities, and the complaints procedures.
<b>12.6</b>	2	On the day of their admission or as soon as they are well enough, informal patients are given written information on their rights, rights to advocacy and second opinion, right of access to interpreting services, and professional roles and responsibilities.
<b>12.7</b>	2	On the day of their admission or as soon as they are well enough, patients are told the name of their named nurse/care team and how to arrange to meet with them.
<b>12.8</b>	1	On the day of their admission or as soon as they are well enough, patients receive a basic structured standard medical assessment and this is documented.

<b>12.9</b>	1	Further targeted examinations and investigations are undertaken if the physical history or physical symptoms demand, and a named individual is responsible for follow-up.
<b>Initial Assessment and Care Planning</b>		
<b>13.1</b>	2	Patients are able to involve the people they rely on for support in their assessment (i.e. carers/relatives/neighbours/friends).
<b>13.2</b>	2	Patients are involved in the decisions (wherever possible) about when, where, and with whom information about them is going to be shared and used and a record is kept of this.
<b>13.3</b>	1	The immediate risk assessment of the patient includes: <ul style="list-style-type: none"> <li>• identification of whether they may have been subject to abuse or inappropriate care;</li> <li>• potential psychological and social risks to themselves and/or others;</li> <li>• potential physical risks, including falls risk, malnutrition/dehydration risk, pressure ulcer development risk, risk of self-harm or suicide;</li> <li>• absconding risk, as well as risk of harm if the patient absconds;</li> <li>• consent or refusal of consent to treatment.</li> </ul>
<b>13.4</b>	2	Patients meet with their named nurse to complete the initial ward assessment and negotiate their care plan within the first 72 hours following admission. This should include: <ul style="list-style-type: none"> <li>• continence;</li> <li>• pain;</li> <li>• level of substance use;</li> <li>• ethnicity;</li> <li>• employment status;</li> <li>• gender needs;</li> <li>• spiritual needs.</li> </ul>
<b>13.5</b>	1	Care plans are based on a subjective and objective assessment of the person's life history, social and family circumstances, and preferences, as well as their physical and mental health needs and current level of functioning and abilities, which includes a comprehensive risk and strengths assessment.
<b>13.6</b>	2	A copy and explanation of the care plan is given to patients, if appropriate, and to their carer if patients agree.
<b>13.7</b>	2	The ward team agrees an evidence-based care plan for risk/severely challenging/violent/abusive behaviour that the named nurse or delegated deputy negotiates with the patient and/or carer, outlining issues and appropriate interventions.

<b>13.8</b>	1	<p>If a patient is identified as presenting with a risk of absconding, then a crisis plan is completed, which includes:</p> <ul style="list-style-type: none"> <li>• instructions for alerting carers and any other person who may be at risk from the patient, or</li> <li>• instructions for alerting carers and the police if the patient is at risk of significant harm when outside a safe environment alone.</li> </ul>
<b>13.9</b>	1	<p>On admission, patients who require staff to carry out personal care of an intimate nature are asked their preference for the gender of staff providing such care, and this is recorded.</p>
<b>Carers</b>		
<b>14.1</b>	1	<p>The patient's main carers/nearest relatives are identified and contact details, including emergency contact numbers, are recorded.</p>
<b>14.2</b>	2	<p>A record is kept of whether the nearest relative/main carer can be contacted during the night in the event of a physical or mental health crisis.</p>
<b>14.3</b>	2	<p>On admission, carers are asked to share information on the patient's current strengths and needs.</p>
<b>14.4</b>	2	<p>Carers are asked to provide background information to staff about the patient, e.g. former occupation(s), the people they love/have loved, etc.</p>
<b>14.5</b>	2	<p>The ward ensures that a principal carer needs assessment, conducted by a named professional, is signposted within three working days of admission and a record is kept of this.</p>
<b>14.6</b>	2	<p>The principal carer is offered a meeting with a named professional, within three working days of admission. This should include:</p> <ul style="list-style-type: none"> <li>• their wishes in respect of involvement in decision-making and care planning on the ward, and these are recorded;</li> <li>• their willingness and ability to collaborate with practitioners in order to provide future care.</li> </ul>
<b>14.7</b>	2	<p>Carers witness staff caring for patients in a meaningful, person-centred way.</p>
<b>14.8</b>	2	<p>Carers witness that staff recognise when patients are in need of help, e.g. feeling hungry or thirsty, or being in discomfort or pain.</p>
<b>14.9</b>	3	<p>If the patient is having difficulty settling and would benefit from extra contact with their carer, staff make efforts to facilitate this by showing flexibility around visiting times and telephone contact.</p>

<b>Continuous Assessment</b>		
<b>15.1</b>	2	Patients are asked their permission before any physical intervention/healthcare investigation is carried out, and this is recorded.
<b>15.2</b>	2	Patients are weighed on admission and in accordance with their care plan thereafter, but no less than monthly.
<b>15.3</b>	2	There is a standardised assessment tool/document to record mental capacity assessments.
<b>15.4</b>	2	The following tools/protocols are available for use on the ward: <ul style="list-style-type: none"> <li>• continence assessment tool;</li> <li>• pressure ulcer development risk assessment;</li> <li>• a standardised system (images and descriptors) for grading pressure ulcers, in accordance with NICE guidelines;</li> <li>• pain assessment tools (for patients who are able to verbally communicate their pain, and for those who are unable to verbally communicate their pain);</li> <li>• nutritional risk assessment;</li> <li>• dental health assessment;</li> <li>• manual handling risk assessment.</li> </ul>
<b>15.5</b>	1	Patients have a comprehensive, ongoing assessment of risk to self and others with the full involvement of patients and their carers (if the patients give consent), and risk management plans are reviewed accordingly.
<b>15.6</b>	2	Action from care management/treatment reviews is fed back to patients and/or carers, and this is documented.
<b>15.7</b>	2	Patients and/or carers have the opportunity to meet their doctor on a weekly basis outside of the ward round/review, should they request this.
<b>15.8</b>	2	If needs are identified that cannot be met by the ward team, then a referral is made to a service that can. The referral is made within a specified time period after identifying the need, and the date of the referral is recorded in the patient's notes.
<b>15.9</b>	2	There is a clear mechanism for reporting unmet needs.
<b>Reviews</b>		
<b>16.1</b>	1	There is a daily handover between the nursing staff, doctors and other relevant members of the MDT.
<b>16.2</b>	1	There is a nursing handover at each shift.

<b>16.3</b>	1	Each handover contains a discussion of risk factors and patient needs resulting in an MDT action plan for the shift, with individual and group responsibilities.
<b>16.4</b>	2	Managers and practitioners have agreed standards for ward rounds/reviews and these are sensitive to patients' needs.
<b>16.5</b>	1	A full multi-disciplinary ward round/review occurs at least once a week or more frequently, if needed.
<b>16.6</b>	2	Patients and/or carers are made aware of the standards for ward rounds/reviews.
<b>16.7</b>	2	The community care co-coordinator attends the first ward round/review if the patient is previously known to the service.
<b>16.8</b>	2	By the first ward round/review, MDT members have introduced themselves to patients.
<b>16.9</b>	2	A CPA review is held within one month of admission.
<b>Discharge Planning</b>		
<b>17.1</b>	2	Discharge planning is initiated within 72 hours of admission.
<b>17.2</b>	2	Patients are given the opportunity to be involved in developing their discharge plans.
<b>17.3</b>	2	Subject to the patient's agreement, carers are given the opportunity to be involved in developing the patient's discharge plan.
<b>17.4</b>	3	There is a named person with expertise in older people's care responsible for discharge co-ordination.
<b>17.5</b>	1	Findings from risk assessments are communicated across relevant agencies and care settings, in accordance with the laws relating to patient confidentiality as part of leave, transfer or discharge planning.
<b>17.6</b>	1	There is a protocol for admission to general hospital that ensures that when a patient is transferred to a medical bed, they are actively followed up and advice on mental health care management and treatment is provided to the medical team at a minimum frequency of weekly.

17.7	1	<p>The ward has an agreed protocol for the transfer or discharge of vulnerable patients. This includes:</p> <ul style="list-style-type: none"> <li>• consideration of the need for nurse escort/handover of patient;</li> <li>• affirmation of medical assessment prior to transportation of the patient's medical stability for transfer/discharge;</li> <li>• information on treatment outcomes, ongoing care requirements and diagnoses and prognosis;</li> <li>• communication of risk assessment and risk management approaches;</li> <li>• 'do not resuscitate (DNR)' status;</li> <li>• body map of wounds or injuries, with an explanation for how they were acquired;</li> <li>• communication of infections;</li> <li>• communication of medication prescription.</li> </ul>
17.8	2	<p>Patients and or/carers are given a copy of the patient's written aftercare plan, agreed on discharge, which sets out:</p> <ul style="list-style-type: none"> <li>• the care and rehabilitation to be provided;</li> <li>• the name of the care co-ordinator (if they require further care);</li> <li>• the action to be taken should signs of relapse occur or if there is a crisis, or if the patient fails to attend treatment;</li> <li>• specific action to take in the first week.</li> </ul>
17.9	2	<p>Prior to discharge, the date of the next CPA review or other review date is recorded in the notes and communicated to patients and members of the MDT.</p>
17.10	1	<p>Transfer/discharge documentation is communicated to key personnel, including the care co-ordinator, receiving care setting, GP, etc. on the day of discharge.</p>
17.11	2	<p>Written copies of discharge plans are sent out within seven days of discharge to the patient, carer(s) where relevant, social workers, community mental health nurses, GPs, and other community, residential and day-care staff.</p>
17.12	1	<p>There is a procedure in place for informal patients who discharge themselves against medical advice.</p>
17.13	2	<p>All staff have access to information about local resources/services to support the patient/carer on discharge.</p>
17.14	2	<p>The patient's allocated CMHT care co-ordinator/CPN visits the patient on the ward during the two weeks prior to discharge.</p>
17.15	2	<p>If patients do not have an allocated care co-ordinator/CPN, the newly-appointed one visits at least once before discharge.</p>
17.16	2	<p>There is an end-of-life care pathway.</p>

NUMBER	TYPE	STANDARD
<b>SECTION 3: SAFETY</b>		
<b>18.1</b>	1	There is an annual comprehensive general risk assessment to ensure the safety of the clinical environment.
<b>18.2</b>	1	There is a multi-agency policy in place and a related service-specific procedure for the protection of vulnerable adults from abuse and inappropriate care.
<b>18.3</b>	1	There is a policy and procedure for staff and patients to confidentially report or 'whistle-blow' on abuse or inappropriate care.
<b>18.4</b>	3	There is a written policy/procedure in relation to deprivation of liberty safeguards and how to seek authorisations.
<b>18.5</b>	1	There is a policy and procedure for missing persons and absconsions.
<b>Management of Violence</b>		
<b>19.1</b>	2	There is a written mutual code of conduct for ward behaviour of which patients are advised.
<b>19.2</b>	1	There is a protocol in place for responding to severely challenging/violent behaviour in older adults which focuses, in the first instance, on de-escalation and support for angry and/or distressed patients.
<b>19.3</b>	1	There are written policies on the use of restraint of older people, of which all staff are aware.
<b>19.4</b>	2	Staff are trained to an appropriate level in the use of de-escalation techniques and the use of minimal hands-on restraint with older adults.
<b>19.5</b>	1	There is a policy on the use of rapid tranquillisation in older people.
<b>19.6</b>	3	Pharmacists audit adherence to the rapid tranquillisation policy on a monthly basis.
<b>19.7</b>	1	Any incident requiring rapid tranquillisation, physical intervention or seclusion is recorded contemporaneously, using a local template, which records the use of these interventions, the procedures taken during these interventions and any adverse outcomes.
<b>19.8</b>	2	There are systems in place to ensure that post-incident support and review are available and take place. The following groups are considered: <ul style="list-style-type: none"> <li>• staff involved in the incident;</li> <li>• patients;</li> <li>• carers and family, where appropriate;</li> </ul>

		<ul style="list-style-type: none"> <li>• other patients who witnessed the incident;</li> <li>• visitors who witnessed the incident.</li> </ul>
<b>19.9</b>	2	There is a policy and procedure in place for managing vexatious visitors which advocates a zero tolerance approach to the abuse of staff and implements a staged approach to responding to such situations, from verbal caution through to security supervised visiting.
<b>Falls</b>		
<b>20.1</b>	1	There is an agreed falls prevention and intervention procedural guideline in place for the service.
<b>20.2</b>	2	All slips, trips and falls are reported in accordance with the agreed adverse clinical incident reporting procedure.
<b>20.3</b>	2	Each fracture resulting from a fall in the service is investigated for: <ul style="list-style-type: none"> <li>• time and place of fall;</li> <li>• mechanism of fall;</li> <li>• up-to-date falls risk assessment;</li> <li>• up-to-date falls prevention and intervention plan;</li> <li>• timely medical assessment, including skeletal survey;</li> <li>• timely transfer for emergency medical treatment if fracture is suspected, i.e. by 999 ambulance;</li> <li>• outcomes in terms of patient mortality.</li> </ul>
<b>20.4</b>	2	There is a system in place to ensure that all falls are reviewed by the MDT.
<b>20.5</b>	2	Patients have in place an up-to-date falls risk assessment.
<b>20.6</b>	2	Patients assessed as being vulnerable to falls have a linked multi-faceted falls prevention and intervention care plan.
<b>20.7</b>	3	For patients assessed as being frequent fallers (i.e. two falls within one month), there is the ready availability of appropriate equipment and resources, e.g. ultra-lowering beds.
<b>Pressure Ulcer Care</b>		
<b>21.1</b>	1	There is a policy on the prevention and management of pressure sores.
<b>21.2</b>	2	All grade 2 or above pressure ulcers are reported in accordance with the agreed adverse clinical incident reporting procedure.
<b>21.3</b>	2	The ward has access to equipment to support the prevention of and care of the needs of people with pressure ulcers, e.g. pressure-relieving mattress systems.

<b>Infection Control</b>		
<b>22.1</b>	1	There is an infection control policy including the prevention of C. Diff. (Clostridium Difficile) and MRSA (Methicillin Resistant Staphylococcus Aureus).
<b>22.2</b>	1	All staff are trained in hand-washing techniques.
<b>22.3</b>	1	There are prominent signs showing hand-washing techniques near all clinical hand-washing sinks.
<b>22.4</b>	1	There are replenished soap and alcohol gel dispensers at all hand-washing sinks.
<b>22.5</b>	1	Staff carry alcohol gel dispensers or they are readily available.
<b>Management of Alcohol and Illegal Drugs</b>		
<b>23.1</b>	1	There are clear and comprehensive policies and procedures regarding positive risk-taking, including self harm and risk of harm to others and illicit drug use within the inpatient unit.
<b>23.2</b>	2	The ward has a strategy for the comprehensive care of patients with dual diagnosis.

NUMBER	TYPE	STANDARD
<b>SECTION 4: ENVIRONMENT AND FACILITIES</b>		
<b>Safety</b>		
24.1	1	Levels of security are adjusted so that the risk of absconsions is minimised without compromising the liberty of those who are not at risk/detained.
24.2	3	For the benefit of patients/carers, all staff are identified by name, designation and photograph in a ward identification board. This includes contact details for senior managers in the service.
24.3	1	Facilities ensure routes of safe entry and exit in the event of an emergency.
24.4	2	Patients can lock their bedroom door, with external staff override.
24.5	2	Visiting times are clearly displayed on the ward.
24.6	1	There is a system in place to ensure that ward cleaning products and patients' toiletries are safely stored, e.g. in locked domestic cupboards/bathrooms, in patient rooms or other areas.
24.7	2	There are clear and simple signs at a visible height that include symbols as well as words, where possible.
<b>Alarm Systems</b>		
25.1	2	Alarm systems/call buttons are available on the ward.
<b>Medical Equipment</b>		
26.1	1	A crash bag is available within three minutes. This equipment includes: <ul style="list-style-type: none"> <li>• an automatic external defibrillator;</li> <li>• a bag valve mask;</li> <li>• oxygen;</li> <li>• cannulae;</li> <li>• fluids;</li> <li>• suction;</li> <li>• first-line resuscitation medications.</li> </ul>
26.2	1	The crash bag is maintained and checked weekly or after use.
26.3	1	There is a resuscitation policy which includes specific guidelines relating to 'do not resuscitate' orders.

<b>Confidentiality</b>		
<b>27.1</b>	2	In spaces where personal and confidential discussions are held, such as interview rooms and consulting/examination/treatment spaces, conversations are not audible outside of the room.
<b>Seclusion</b>		
<b>28.1</b>	1	If seclusion is used, there is a clear written policy on its use, which complies with the MHA.
<b>28.2</b>	2	In services where seclusion is practiced, there is a designated room fit for the purpose. The seclusion room: <ul style="list-style-type: none"> <li>• allows clear observation;</li> <li>• is well insulated and ventilated;</li> <li>• has access to toilet/washing facilities;</li> <li>• is able to withstand attack/damage.</li> </ul>
<b>Use of Rooms and Space</b>		
<b>29.1</b>	2	There is sufficient space for the needs of the ward and overcrowding is avoided.
<b>29.2</b>	2	The ward is managed to allow optimum use of available space and rooms.
<b>29.3</b>	1	Male and female patients have separate sleeping accommodation in separate areas of the ward.
<b>29.4</b>	2	The ward has access to a specific room for physical examination and minor medical procedures.
<b>29.5</b>	2	There is a designated area or room (de-escalation space) that staff may consider using, with the patient's agreement, specifically for the purpose of reducing arousal and/or agitation. Note: this area is in addition to the seclusion room (where applicable) and may be the patient's own room.
<b>29.6</b>	2	The ward is able to access a room for patients to receive visits from children.
<b>29.7</b>	2	There is at least one room for interviewing and meeting with individual patients and carers/relatives, which is furnished with comfortable seating.
<b>29.8</b>	2	Areas which need to be quiet are located as far away as possible from any sources of unavoidable noise.
<b>29.9</b>	2	The ward offers a range of semi-private and public spaces in addition to private bedroom areas.



<b>31.5</b>	2	Patients have access to items associated with specific cultural or spiritual practices, e.g. the Bible, copies of the Koran.
<b>31.6</b>	2	The ward has access to an appropriate range of assistive equipment to meet individual needs.
<b>31.7</b>	2	There is a ready supply and an appropriate range of continence management aids available on the ward.
<b>31.8</b>	1	There is a system in place to ensure that, where required, all patients are able to use an appropriate and well-maintained wheelchair.
<b>31.9</b>	1	There is a system in place to ensure that, where required, all patients are able to use an appropriate and well-maintained hearing aid.
<b>31.10</b>	1	Patients can wash and use the toilet in private.
<b>31.11</b>	2	Patients can make and receive telephone calls in private.
<b>31.12</b>	2	Patients' personal preferences are respected, e.g. in relation to food and drink choices, time to go to bed, clothing.
<b>31.13</b>	2	All patients have access to lockable storage.
<b>31.14</b>	1	Patients wear their own clothing.
<b>31.15</b>	2	Patients have access to shoes and/or sturdy slippers, and are wearing them.
<b>31.16</b>	2	Laundry facilities are available to all patients.
<b>31.17</b>	1	There is a system in place to ensure that all patients have individualised toothbrushes, toothpaste, dentures and denture pots etc.
<b>31.18</b>	2	Staff ensure that hearing aids are working and patients are wearing their glasses if required.
<b>Patient Comfort</b>		
<b>32.1</b>	2	The ward is able to control light and there is access to natural daylight.
<b>32.2</b>	3	There is an alternative to bright fluorescent lighting in the bedrooms, such as nightlights, providing different levels of lighting which both the patients and staff can control.
<b>32.3</b>	2	The ward is able to control temperature and ventilation.
<b>32.4</b>	2	The ward effectively controls avoidable noise.



<b>36.2</b>	3	All staff have access to lockable storage.
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<b>Staffing</b>		
<b>39.1</b>	2	Patients have access to specialist practitioners of psychological therapies for one session (four hours) per week.
<b>39.2</b>	3	Patients have access to specialist practitioners of psychological interventions for more than one session per week, who are able to offer more than one type of intervention.
<b>39.3</b>	3	Patients have access to evidence-based local complementary therapies, delivered by trained practitioners, in accordance with local policy and procedures.
<b>39.4</b>	2	Staff are given planned and protected time to make sure activities and interventions are provided regularly and routinely.
<b>39.5</b>	2	Healthcare assistants, occupational therapy support workers, STaR workers, volunteers and activity workers are involved in facilitating a broad range of therapeutic and leisure activities.
<b>39.6</b>	2	During the delivery of the formal therapeutic programme, there is at least one qualified member of staff in each group and activity, and others available if needed.
<b>39.7</b>	2	There is at least one suitably qualified OT/experienced practitioner on duty during the main daily therapeutic programme.
<b>Provision of Activities and Therapies</b>		
<b>40.1</b>	2	Patients have the opportunity to be involved in negotiating activity and therapy programmes, relevant to their identified needs, which include evening and weekend activity. This is recorded in their care plans, and regularly monitored and reviewed.
<b>40.2</b>	3	Patients are offered at least three psychological interventions, where appropriate, more than one session per week.
<b>40.3</b>	2	Patients have access to activity materials/equipment when requested.
<b>40.4</b>	1	All patients are offered specific psychosocial interventions appropriate to their presenting needs and in accordance with national standards (i.e. NICE).
<b>Group Activities and Therapies</b>		
<b>41.1</b>	2	Activities are provided on a timetabled basis, Monday to Friday.
<b>41.2</b>	2	Activities are provided in the evenings and at weekends, as and when required.



## Glossary of Terms and Abbreviations

CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CMHT	Community Mental Health Team
Graduate Patient	A person over 65 years of age who has a pre-existing mental health problem and 'graduates' into Older People's Mental Health Services
HDA	Health Development Agency
IMCA	Independent Mental Capacity Advocate
MDT	Multi-Disciplinary Team - all health professionals involved in patient care
MHA	Mental Health Act
Named Nurse	Inpatient nurse responsible for the individual patient's care
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
OT	Occupational Therapist
SMS	Security Management Service
STaR	Support, Time and Recovery
Ward review	Regular MDT patient-focused meeting – used interchangeably with 'ward round' in these standards



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