

Accreditation for Acute Inpatient Mental Health Services (AIMS)

Standards for Assessment/Triage Wards

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.

2nd Edition edited by Joanne Cresswell and Mark Beavon

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Foreword

We are pleased to introduce the second edition of the AIMS standards for assessment/triage wards and welcome the collaborative effort to improve the quality of these wards.

For the purpose of these standards the definition of an assessment or triage ward is: a ward to which all patients requiring admission will go for initial assessment and treatment. Length of stay is anticipated to be brief and patients will either be discharged or transferred to a treatment ward if requiring a longer period of admission.

These standards have been developed from a literature review and in consultation with stakeholder groups. Care has been taken to include information from a wide range of sources and to take into account the views of ward staff, service users and carers.

We hope the standards will provide staff with a clear and comprehensive description of best practice within acute inpatient wards. We hope they will be educative and expect they will promote healthy debate in the more contentious areas! They will be reviewed each year, so please give the project team any comments, using the form provided at the back of this booklet.

These standards will be applied each year in self- and external peer-review by AIMS member wards. If you work in an acute inpatient setting, we hope you will support this important new network and join in the review cycle.

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AIMS Programme Manager and Nurse Advisor
January 2009

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Introduction

The accreditation standards, drawn from key documents, will help wards demonstrate compliance with the Healthcare Commission's 'Standards for Better Health' and will support implementation of NICE guidelines and the National Service Framework. They have been subject to extensive consultation with all professional groups involved in the provision of acute inpatient mental health services and with service users and their representative organisations.

The standards are reviewed on an annual basis and are applied each year during the self- and peer-review processes by AIMS member wards.

The standards cover the following topics:

- General Standards
- Timely and Purposeful Admission
- Safety
- Environment and Facilities
- Therapies and Activities

The full set of standards is aspirational and it is unlikely that any ward would meet all of them. To support their use in the accreditation process, each standard has been categorised 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.

Standards prefixed 'A': standards specific to assessment/triage wards.

A copy of these standards will be sent to every assessment/triage ward that becomes a member of AIMS.

The standards are also available on our website at: www.rcpsych.ac.uk/AIMS.

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NUMBER	TYPE	STANDARD
SECTION 1: GENERAL STANDARDS		
Policies and Protocols		
1.1	1	All staff are informed how to access policies, procedures and guidelines and are able to do so when required.
1.2	2	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	2	All policies and protocols are reviewed every two years with the support of the policy development/clinical governance teams.
Staffing		
2.1	1	The ward has an agreed minimum staffing level across all shifts which is met.
2.2	1	The agreed minimum staffing level includes more than one qualified mental health nurse per shift.
2.3	1	There are systems in place that ensure that all factors that affect staffing numbers and skill mix are taken into consideration, and staffing levels are reviewed on a daily basis. These factors are: <ul style="list-style-type: none"> • levels of observation; • sickness and absence; • training; • supervision; • escorts; • therapeutic engagement; • acuity levels; • conformance with local human resources guidance; • staff capabilities.
2.4	1	The nurse in charge of the shift is the point of contact for consultation, negotiation, and decision-making for all ward operational matters.
2.5	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 acute care service co-ordination.
2.6	2	The Ward Manager has control over the ward budget.
2.7	2	There is visible and accessible leadership at ward level, e.g. Lead Consultant, Modern Matron, Nurse Consultant.

2.8	2	All wards have access to the following services: <ul style="list-style-type: none"> • psychology; • occupational therapy; • social work; • administration; • pharmacy.
2.9	2	There is access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.
2.10	2	The available administrative support meets the needs of the ward.
2.11	1	Levels of sickness, absence and injuries are monitored.
2.12	2	Positive actions are identified that can be taken to reduce sickness levels.
2.13	1	An experienced member of staff is assigned daily to the floor to monitor patient interaction, observe for risk behaviour, and provide first point of contact to deal with patient needs when the primary or Allocated Nurse is absent or unavailable.
2.14	1	At all times, a doctor is available to quickly attend an alert by staff members when interventions for the management of disturbed/violent behaviour are required, according to documented guidelines or within 30 minutes.
2.15	1	Staff carrying out physical examinations are either of the same sex, or there is a same-sex chaperone present.
Recruitment and Retention of Staff		
3.1	2	When posts are vacant or in the event of long-term sickness, immediate arrangements are made for temporary staff cover.
3.2	2	There is a clear and written policy on the recruitment and use of bank and agency staff including: <ul style="list-style-type: none"> • a system to ensure staff have the basic skills, attitudes and competencies required; • proper arrangements for the induction and management of bank and agency staff; • a system to routinely monitor and report on the use of bank and agency staff.
3.3	2	Managers receive feedback from staff exit interviews.
3.4	2	Patients are involved in interviewing potential members of the MDT during the recruitment process.
3.5	3	Carers are involved in interviewing potential members of the MDT during the recruitment process.

Appraisal, Supervision and Staff Support		
4.1	1	There is a strategy and policy for appraisal and supervision.
4.2	1	All staff receive an annual appraisal and personal development planning.
4.3	2	Supervision is included in the job description of every member of the MDT.
4.4	2	At the start of employment, the supervision process is made clear to all new members of the MDT.
4.5	1	Staff receive regular managerial supervision from a person with appropriate experience and qualifications.
4.6	2	Clinical supervision occurs at a minimum of every eight weeks, or more frequently, as per professional body guidance.
4.7	2	Non-clinical staff are able to access supervision as needed.
4.8	2	Supervisors receive appropriate training as agreed in local policy, taking into consideration profession-specific guidelines.
4.9	1	Emergency ad hoc supervision is available.
4.10	2	All staff are able to contact a senior colleague as necessary, 24 hours a day.
4.11	1	All staff are aware of their level of authority/accountability and what decisions they can and cannot take.
4.12	2	Staff are able to access professional and management advice as necessary.
4.13	2	Clinical staff receive training, support and supervision from experienced senior practitioners in providing one-to-one therapeutic contact.
4.14	3	Staff have access to a ward-based reflective practice/staff support group to discuss clinical work.
4.15	2	All staff are able to take allocated breaks.
Staff Education and Training		
5.1	2	All staff have access to the Trust's intranet, knowledge-based systems – such as Medline – and online journals.
5.2	3	All ward staff have allocated time and resources to engage in clinical governance activity relevant to their work.

5.3	2	Training budgets enable all staff to meet requirements for their continuing professional development and the Knowledge and Skills Framework.
5.4	1	There is a strategy in place to ensure that training is available.
5.5	1	Access to training is facilitated, and there are arrangements for staff cover to allow staff to attend training.
5.6	2	There is clinical leadership training for registered mental health nurses, psychiatrists and other members of the MDT.
5.7	1	All new staff are allocated a mentor/preceptor who oversees their induction.
5.8	1	Before being asked to carry out any clinical work, all staff receive mandatory training in fire, manual handling and basic life support.
A5.8.1	1	All staff based on the ward are trained in the management of disturbed behaviour.
A5.8.2	2	All staff not based on the ward are trained in breakaway techniques and the management of violence, in line with national guidance.
5.9	2	Staff participate in an annual MDT team-building event facilitated by a management consultant, occupational psychologist or qualified suitable other.
5.10	2	Staff who undertake assessment and care planning have received training in risk management and risk assessment.
5.11	2	Staff who undertake assessment and care planning have received training in how to assess capacity.
5.12	2	Staff who undertake assessment and care planning have received training in self-harm and suicide awareness and prevention techniques.
5.13	2	Staff who undertake assessment and care planning have received training in how to involve patients and carers.
5.14	2	Staff who undertake assessment and care planning have received training in care planning as part of the care management programme, including discharge planning.
5.15	2	Staff who undertake assessment and care planning have received training in the use of appropriate patient outcome measures such as HoNOS.
5.16	2	Staff who undertake assessment and care planning have received training in procedures for assessing carers' needs.

5.17	2	Staff who undertake assessment and care planning have received training in physical health needs and referrals.
A5.17.1	3	Staff who undertake assessment and care planning have received training in psychiatric formulation.
5.18	2	Staff who undertake assessment and care planning have received training in CPA (or equivalent).
5.19	1	All staff have received training in relation to confidentiality.
5.20	2	There is an investment in the development of managerial and leadership competencies of ward managers and sisters/charge nurses.
5.21	1	All education and training in the safe and therapeutic management of aggression and violence is based upon the recommendations contained in the interim Mental Health Policy Implementation Guide 2004 and the NICE Guideline 2005.
5.22	1	NMC standards for the administration of medicines are adhered to.
5.23	1	All qualified nurses have been assessed as competent in the administration of medications.
5.24	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).
5.25	2	The ward can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology are developing the necessary skills to provide a repertoire of problem-specific, low intensity psychological interventions in line with NICE guidance.
5.26	3	The ward can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology receive ongoing training and supervision to provide a repertoire of problem-specific, high intensity psychological interventions in line with NICE guidance.
Advocacy		
6.1	1	The ward provides access to an independent advocacy service that includes IMCAs.
Compliments and Complaints		
7.1	2	There are clear policies and procedures for managing complaints.

7.2	2	Information is available for patients/carers about: <ul style="list-style-type: none"> • how to make a verbal complaint; • how to make a written complaint; • how to suggest service improvements/enhancements; • how to make a written compliment; • how to make a donation.
7.3	2	All MDT staff are trained as part of their induction to respond effectively to patients who express a concern regarding their hospital experience.
7.4	2	There is evidence of audit, action and feedback from complaints.
Smoking		
8.1	1	There is a smoke-free policy for staff and patients, which follows HDA guidance and best practice.
8.2	1	There is support for staff and patients to assist with the smoking policy, including: <ul style="list-style-type: none"> • consideration of the use of NRT while on the hospital premises to help with withdrawal or as a coping strategy; • a comprehensive support programme, with information available about the support on offer; • strategies to make sure staff know and understand the Trust's policy, and monitor levels of comprehension.

NUMBER	TYPE	STANDARD
SECTION 2: TIMELY AND PURPOSEFUL ADMISSION		
9.1	1	There is an information sharing protocol confirmed at Trust board level of which all staff are aware, and this is publicised to visitors and patients.
9.2	2	Information on previous care planning and interventions are sourced by the ward staff/acute care team within 24 hours.
9.3	2	There is an identified and documented contact or link person for each agency involved with each patient.
9.4	1	The specific reasons for admission are agreed between the ward/acute care team and the assessing team.
9.5	2	All community assessment paperwork is available to the admitting team when the patient arrives on the ward, including mental health and current risk assessments.
9.6	1	The admitting nurse checks that the referring agency gives clear information as to the security of the patient's home, whereabouts of children/animals etc.
Control of Bed Occupancy		
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 systems in place to raise concerns about inpatient mix, and the Ward Manager's views are actively considered by the senior team.
10.3	2	When a patient is sent on leave they are able to return and/or contact the crisis team if problems arise, and are told how to do this.
A10.3.1	2	The CRHT acts as gatekeeper for inpatient beds.
A10.3.2	1	There is access to local psychiatric intensive care beds.
A10.3.3	1	There are arrangements in place with other wards concerning patient transfers, to ensure that beds are available for new admissions.
A10.3.4	3	The ward has a minimum of two beds free to enable admissions of either gender at short notice.
A10.3.5	2	There are no out-of-area transfers for non-specialist inpatient care.
A10.3.6	1	When a patient is sent on leave the bed remains available initially, unless the patient was recently under the care of or is well known to the treatment ward, and a bed is available on that ward.

A10.3.7	2	There is a monitoring group to ensure adequate availability of inpatient provision and to address systematic underlying issues delaying transfer/ discharge.
Admission Systems		
11.1	2	When talking to patients and carers, health professionals avoid using clinical language and jargon.
11.2	1	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.
11.4	1	Admission to an adult unit of people under the age of 18 only happens if: <ul style="list-style-type: none"> • the local authority is informed of the admission; • the MHAC is informed (if the patient is detained); • all ward staff who have contact with the patient have enhanced CRB checks; • there is access to child and adolescent psychiatric consultation and advice throughout admission.
11.5	2	Admission to an adult unit of people under the age of 18 only happens if: <ul style="list-style-type: none"> • the length of stay anticipated is less than three months; • a single room is available; • the patient is under constant observation, if needed following risk assessment, for the duration of their stay.
11.6	2	There are protocols for transfer or shared care between LD and generic mental health services which clearly specify: <ul style="list-style-type: none"> • consultant responsibility; • the roles and responsibilities of inpatient and community teams in both mental health and learning disability services; • the requirement for joint care planning at an individual level; • the requirement for a written care plan to specify what support each service can expect from the other; • roles and responsibilities in relation to CPA; • information sharing.
Admission Process		
12.1	1	The patient and accompanying person (where appropriate) are met on arrival, shown to an appropriate area, and offered refreshments etc.
12.2	1	The patient is introduced to a member of staff who will be their point of contact for the first few hours of admission.
12.3	1	Within an hour of their admission or as soon as they are well enough, the patient is shown around the ward.

12.4	1	<p>On the day of their admission or as soon as they are well enough, the patient is given a "welcome pack" or introductory booklet that contains the following:</p> <ul style="list-style-type: none"> • a clear description of the aims of the acute ward; • the current programme and modes of treatment; • a clear description of what is expected and rights and responsibilities; • a simple description of the ward's philosophy, principles and their rationale, and the ward team membership, including the name of the patient's Consultant Psychiatrist and Key Worker/Primary Nurse; • visiting arrangements; • personal safety on the ward; • ward facilities; • ward programme of activities; • what practical items patients need in hospital and what should be brought in.
A12.4.1	1	The patient is informed on admission to the assessment ward that if they require a longer spell in hospital, they may be moved onto another ward in order to continue their treatment.
12.5	1	On the day of their admission or as soon as they are well enough, detained patients are, in accordance with section 132 of 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.
12.6	1	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, professional roles and responsibilities and the complaints procedure.
12.7	2	On the day of their admission or as soon as they are well enough, the patient is told the name(s) of their Primary Nurse/care team and how to arrange to meet with them.
A12.7.1	2	A full physical examination is carried out as part of the admission process.
A12.7.2	1	Further targeted examinations are undertaken if the physical history or physical symptoms demand (including urinalysis, ECG, EEG, X-rays and scans). This is undertaken promptly and a named individual is responsible for follow-up.
12.10	1	<p>Where the patient is found to have a physical condition which may increase their risk of collapse or injury during restraint this is:</p> <ul style="list-style-type: none"> • clearly documented in their records; • regularly reviewed; • communicated to all MDT members; • evaluated with them and, where appropriate, their carer/advocate.

Initial Assessment and Care Planning		
13.1	2	The patient is involved in the decisions (wherever possible) about when, where and with whom information about them is going to be shared and used.
13.2	2	The patient is able to involve the people they rely on for support (carers/relatives/neighbours/friends) in their assessment.
13.3	1	The immediate risk assessment of the patient includes: <ul style="list-style-type: none"> • identification of whether they may be predatory or likely to abuse or offend; • potential physical, psychological and social risks to themselves and/or others; • risk of self-harm; • level of substance use; • absconding risk; • consent or refusal of consent to treatment.
13.4	1	The patient meets with their Primary Nurse to complete the initial ward assessment and initiate their care plan within the first 72 hours following admission. This includes: <ul style="list-style-type: none"> • ethnicity; • employment status; • gender needs; • assessment of mental capacity (if required); • spiritual needs; • continuing consent or refusal of consent to treatment.
A13.4.1	2	The patient has a documented assessment by senior medical staff on the first full working day following admission.
A13.4.2	2	The patient has access to an Occupational Therapist for assessment during the first 72 hours.
A13.4.3	2	The patient's care co-ordinator (CCO) is contacted by the end of the CCO's next working day.
A13.4.4	2	Assessment and support from the CRHT is available within six hours of a request being made to facilitate early discharge.
A13.4.5	2	There is rapid access to a specialist medical opinion within 72 hours of request if needed as part of the assessment.
13.5	1	The care plans are based on a comprehensive physical, psychological and social assessment, which includes a comprehensive risk and strengths assessment.
13.6	2	The patient is informed of the process of how and when they may access their current records if they wish to do so.
13.7	2	The patient is offered a copy of their care plan, and/or is able to access their care plan when requested.

13.8	2	A copy of the care plan is given to their carer if the patient agrees.
13.9	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.
13.10	2	The patient is given the opportunity to discuss and plan their preferences regarding the use of physical healthcare investigations, such as blood glucose monitoring, blood pressure and weight checks. This is recorded in their individualised care plans or advance directives.
13.11	2	The ward team agrees a team management plan for risk/violent/abusive behaviour that the Primary Nurse or delegated deputy negotiates with the patient, outlining issues and appropriate interventions.
13.12	1	If a detained patient is identified as presenting with a risk of absconding, then a crisis plan is completed, which includes instructions for alerting carers and any other person who may be at risk.
13.13	1	Findings from risk assessments are communicated across relevant agencies and care settings, in accordance with the laws relating to patient confidentiality.
A13.13.1	2	There is a written assessment summary after the patient has been on the ward for a maximum of 72 hours. This would cover key features in the patient's history, mental state, physical health, risk, diagnosis and differential and current management plan.
A13.13.2	2	The patient's written assessment is discussed with them.
A13.13.3	2	There is a written case summary, in a form which can be easily updated within five working days, which will form part of CPA.
A13.13.4	2	The patient is offered a copy of their case summary.
A13.13.5	2	The patient's carer is offered a copy of the case summary, with the patient's permission.
13.14	3	The use of clinical outcome measures and other clinical data is promoted and supported. These measures include outcome measures, e.g. HoNOS, and risk indicators.
Carers		
14.1	1	The patient's main carers are identified and contact details are recorded.
A14.1.1	2	The patient's carer is contacted within 24 hours (with the patient's consent if the patient is informal) to assist the assessment, ascertain the carer's views re: care planning, and to determine whether the carer wishes to have a carer's assessment.

14.2	2	The principal carer is advised how to obtain an assessment of their own needs.
14.3	2	The principal carer is offered a meeting with a named professional, within three working days of admission, during which: <ul style="list-style-type: none"> • the carer's views about ongoing and future involvement are recorded; • the carer is given an explanation and information sheet about ward procedures etc.; • the carer is offered information on carer advocacy, welfare rights and mental health services.
Continuous Assessment		
15.1	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 should be made within a specified time period after identifying the need, and the date of the referral recorded in the patient's notes.
15.2	2	Where an unmet need is identified there is a clear mechanism for reporting it.
15.3	2	There is evidence within the notes of regular assessment of mental capacity using a formal document/standardised assessment tool.
15.4	2	Risk management plans are reviewed at a minimum frequency of once a month and updated accordingly in collaboration with the patient (wherever possible) and their carer (where appropriate).
15.5	1	Patients have a comprehensive, ongoing assessment of risk to self and others with the full involvement of the patient and their carer (if the patient gives consent).
Reviews		
16.1	1	There is a daily handover between the nursing staff, doctors and other relevant members of the MDT.
16.2	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.
16.3	2	Actions from reviews/ward rounds are fed back to the patient and this is documented.
A16.3.1	2	There are opportunities for carers to meet with members of the MDT to contribute to the review process.
16.5	3	Patients have the opportunity to meet their consultant on a weekly basis outside of reviews/ward rounds.

16.6	2	Managers and practitioners have agreed standards for reviews/ward rounds.
A16.6.1	1	There is a daily MDT review meeting with a minimum of two disciplines present.
A16.6.2	1	There is prompt access to senior medical staff to allow rapid decisions to be made about patients and their management.
A16.6.3	2	The care co-ordinator attends a review meeting within three working days.
Liaison with other wards		
A41.1	1	A policy is in place relating to the transfer of patients from an assessment ward to another ward.
A41.2	1	Up-to-date information is given to the receiving ward in verbal and written form, including the care plan and updated risk assessment, before the patient is transferred.
A41.3	2	The patient is given information about the ward they are going to be transferred to.
A41.4	3	The patient is given the information and ability to influence the choice of ward they are transferred to.
A41.5	2	The patient is given a minimum of two hours warning of transfer to another ward.
A41.6	2	The carer is informed of the patient's transfer within one hour.
A41.7	2	A clear review process exists for acute inpatient care pathway.
Discharge Planning		
17.1	2	Discharge planning is initiated within 72 hours of admission.
17.2	2	Managers and practitioners have agreed standards for discharge planning.
17.3	2	The patient is actively involved in developing their discharge plan.
17.4	3	The patient and carer (if requested by the patient) are actively involved in who takes part in discharge planning.
A17.4.1	1	Patients are not sent on leave into the care of carers without contact with the carers beforehand.

17.5	2	The patient is given timely notification of transfer or discharge and this is documented in their notes.
17.6	1	The patient is given a copy of a written aftercare plan, agreed on discharge, which sets out: <ul style="list-style-type: none"> • the care and rehabilitation to be provided; • the name of their care co-ordinator (if they require further care); • the action to be taken should signs of relapse occur or if there is a crisis, or if the patient fails to attend treatment; • specific action to take in the first week.
17.7	2	Prior to discharge, the date of the next CPA review or other review date is recorded in the notes and communicated to the patient and members of the MDT.
17.8	2	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, other community, residential and day-care staff.
17.9	1	There is a procedure in place for informal patients who discharge themselves against medical advice.
17.10	2	All staff possess knowledge of local resources to support the patient/carer on discharge.
17.12	1	The ward has a referral process for outpatient psychology, CMHT-based or otherwise.
17.13	2	Delayed discharges are routinely reviewed and action is taken to review any identified problems.

NUMBER	TYPE	STANDARD
SECTION 3: SAFETY		
18.1	1	There is a regular and comprehensive general risk assessment to ensure the safety of the clinical environment.
18.2	1	There is a management plan to address any shortfalls in the safety of the clinical environment.
18.3	1	All staff adhere to Department of Health Guidance on confidentiality (HSC 2000/009: Data Protection Act 1998: protection and use of patient information. Department of Health, 2000).
Observation		
19.1	1	<p>There is a policy on patient safety, the use of therapeutic interventions and observation that includes:</p> <ul style="list-style-type: none"> • how activities, therapies and staff skill mix are used specifically to improve patient safety; • how patients are informed about maintaining their personal safety including the use of alarms; • who can instigate observation above the general level and who can change the level of observation; • who should review the level of observation and when reviews should take place (at least every shift); • how the patients' perspective will be taken into account; • the process through which a review by a full clinical team will take place if observation above the general level continues for more than one week.
19.2	1	Patients receive information about the level of observation that they are under, how it is instigated, the review process and how patient perspectives are taken onto account.
Management of Violence		
20.1	1	There is an operational policy on searching, based on legal advice, which complies with the NICE Guideline.
20.2	1	There is a written mutual code of conduct for ward behaviour of which patients are advised.
20.3	2	Adherence to the code of conduct for ward behaviour is monitored.
20.4	2	There are agreed protocols in place with the local police that ensure effective and sensitive liaison regarding incidents of criminal activity/harassment/violence.

20.5	2	There are local protocols to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies. The policies set out what constitutes an emergency requiring police intervention.
20.6	1	There are written policies on the use of restraint of which all staff are aware. The policies include provision for review of each incident of restraint, and its application is audited and reported to the hospital managers.
20.7	1	Any incident requiring rapid tranquillisation, physical intervention or seclusion is recorded contemporaneously, using a local template, which records the use of these interventions and the procedures taken during these interventions, and any adverse outcomes.
20.8	1	The ward has mechanisms to document and monitor all incidents of violence and aggression.
20.9	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"> • staff involved in the incident; • patients; • carers and family, where appropriate; • other patients who witnessed the incident; • visitors who witnessed the incident.
20.10	2	A collective response to alarm calls is agreed before incidents occur and consistently rehearsed and applied.
20.11	2	Where risk assessment indicates, there is an established, reliable and effective means of communication during escorted leave etc. such as two-way radios or mobile phones.
Management of Alcohol and Illegal Drugs		
21.1	1	The ward has a strategy for the comprehensive care of patients with dual diagnosis that includes: <ul style="list-style-type: none"> • liaison between mental health and substance misuse services; • regular drug/alcohol screening to support decisions about care/treatment options; • liaison between mental health and statutory and voluntary agencies; • staff training (which includes input from the police); • the appointment of key staff who will lead clinical developments; • clear protocols, agreed with the police; • consideration as to the impact on other patients of adverse behaviours due to alcohol/drug abuse.
21.2	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.

NUMBER	TYPE	STANDARD
SECTION 4: ENVIRONMENT AND FACILITIES		
Safety		
22.1	2	Whilst ensuring appropriate levels of security, patients are cared for in the least restrictive environment possible.
22.2	1	The internal design of the ward is arranged to promote a safe environment: <ul style="list-style-type: none"> • sight lines are unimpeded; • measures are taken to address blind spots within the facility.
22.3	1	Potential ligature points are managed as part of individual and ward risk assessments.
22.4	1	Facilities ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour.
22.5	2	There is secure, lockable access to a patient's room, with external staff override.
22.6	2	Furniture is arranged so that alarms can be reached and doors are not obstructed.
22.7	3	The ward has access to cameras and technology for safety.
Alarm Systems		
23.1	2	Security measures, for example alarm systems or call buttons to alert staff, are available.
A23.1.1	1	All staff based on the ward have access to PIN alarms at all times.
A23.1.2	1	All staff not based on the ward have access to PIN alarms when required.
23.3	2	Alarm systems/call buttons are available to patients and visitors and instructions are given for their use.
23.4	2	Alarm systems/call buttons are checked and serviced regularly.
23.5	2	Alarms are accessible in interview rooms, reception areas and other areas where one patient and one staff member work together.

Medical Equipment		
24.1	1	A crash bag is available within three minutes. This equipment must include: <ul style="list-style-type: none"> • an automatic external defibrillator; • a bag valve mask; • oxygen; • cannulas; • fluids; • suction; • first-line resuscitation medications.
24.2	1	The crash bag is maintained and checked weekly or after use.
24.3	2	The ward has access to a specific room for physical examination and minor medical procedures.
Confidentiality		
25.1	1	All patient information is kept in locked cabinets, locked offices or securely password protected on IT systems.
25.2	2	In spaces where personal and confidential discussions are held, such as interview rooms and consulting/examination/treatment spaces conversations should not be heard outside of the room.
Seclusion		
26.1	1	There is a clear written policy on the use of seclusion, which complies with the MHA.
26.2	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"> • allows clear observation; • is well insulated and ventilated; • has access to toilet/washing facilities; • is able to withstand attack/damage.
Use of Rooms and Space		
27.1	2	Areas which need to be quiet are located as far away as possible from any sources of unavoidable noise.
27.2	2	There is at least one room for interviewing and meeting with individual patients and relatives, which is furnished with comfortable seating.
27.3	2	The ward is managed to allow optimum use of available space and rooms.
27.4	2	There is a designated space for patients to receive visits from children.

27.5	2	A separate area can be made available to receive patients with police escorts (this may be a designated 136 suite off the ward if available).
27.6	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, and may be the patient's own room if they are the sole occupier.
27.7	2	The ward environment is sufficiently flexible to allow for specific individual needs in relation to gender.
27.8	2	The ward environment is sufficiently flexible to allow for specific individual needs in relation to ethnicity.
27.9	2	The ward environment is sufficiently flexible to allow for specific individual needs in relation to disability.
27.10	1	Male and female patients have separate sleeping accommodation in separate areas of the ward.
27.11	2	The ward offers a range of semi-private and public spaces outside the private bedroom, which allow people a different level of participation with the life of the unit.
27.12	3	There are lounge areas that may become single-sex areas as required
27.13	2	Social spaces are located to provide views into external areas.
27.14	2	There is a quiet room with a variety of comfortable chairs.
Catering		
28.1	2	The dining area is big enough to allow patients to eat in comfort and to encourage social interaction, and staff should be able to move freely to enable observation.
28.2	1	The dining area is reserved for dining only during allocated mealtimes.
28.3	1	There is water/soft drinks available to patients 24 hours a day.
28.4	2	Hot drinks are available to patients 24 hours a day upon request.
28.5	2	Patients' views on catering are audited as part of the Performance Assessment Framework.
28.6	3	Meals or snacks are available outside of mealtimes.

Dignity		
29.1	2	All patients have access to lockable storage, which may include their own individual rooms or access to a safe on the ward.
29.2	2	There is access to the day room at night for patients who cannot sleep.
29.3	1	Patients can access resources that enable them to meet their individual self-care needs, including ethnic- and gender-specific requirements.
29.4	1	Patients can wash and use the toilet in privacy.
29.5	2	Patients can make and receive telephone calls in private.
29.6	2	There is a policy on the use of mobile phones, including camera phones, which is communicated to staff, patients and visitors, e.g. by means of a poster.
29.7	2	Laundry facilities are available to all patients.
29.8	2	Patients have access to items associated with specific cultural, religious or spiritual practices, e.g. copies of the Qur'an.
29.9	2	Relevant assistive technology equipment, such as hoists and handrails are provided to meet individual needs and to maximise independence in self-care needs.
29.10	2	Patients have access to the following within or near to the ward/hospital site: <ul style="list-style-type: none"> • gym; • library facilities; • music room; • computer room; • multi-faith prayer/worship room; • bank facilities; • canteen; • basic shop.
Patient Comfort		
30.1	2	The ward is able to control light.
30.2	3	The ward is able to control temperature.
30.3	2	The ward is able to control ventilation.
30.4	2	The ward is able to control noise.
30.5	3	There is an alternative (such as night lights) to bright fluorescent lighting in bedrooms, providing different levels of lighting which both the patients and staff can control.

30.6	2	The design of windows considers safety and patient comfort.
Provision of Information		
31.1	2	Information on work-related counselling services is clearly displayed.
31.2	2	Information leaflets about relevant psychiatric conditions are readily available, which include: <ul style="list-style-type: none"> • medications and their side effects; • treatment alternatives and their relative effectiveness, including complementary therapies.
31.3	2	Information is available for staff and patients/carers about mental health and local public and voluntary sector services that are available which include: <ul style="list-style-type: none"> • services and expected waiting times; • facilities; • advocacy services; • local support/advice organisations for patients and carers; • health promotion.
31.4	2	Information is up-to-date and regularly supplied to all relevant service areas in sufficient quantity.
Activity Equipment		
32.1	2	All patients can access a range of current culturally-specific resources for entertainment that includes the following: <ul style="list-style-type: none"> • good quality magazines; • daily newspapers; • board games; • cards; • a TV and VCR/DVD with videos/DVDs. • computers and internet access.
Outside Space		
33.1	2	The ward has direct access to an outside space for exercise and access to fresh air, which is safe and has seating available for relaxation and an area where patients and visitors can converse in private.
Staff		
34.1	2	Ward-based staff have access to a dedicated staff room, either on or off the ward.
34.2	2	All staff have access to a locker or locked area to store personal belongings.

NUMBER	TYPE	STANDARD
SECTION 5: THERAPIES AND ACTIVITIES		
Medication		
35.1	2	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.
35.2	2	The choice of medication is made jointly by the patient and the responsible clinician based on an informed discussion of: <ul style="list-style-type: none"> • the relative benefits of the medication; • the side effects; • alternatives; • the patient's physical, emotional and social needs; involving the patient's advocate or carer where appropriate.
35.3	2	The patient's Allocated Nurse monitors the tolerability and side effects of medication on a daily basis.
35.4	2	The responsible clinician and the Primary Nurse monitor the therapeutic response to medication on a weekly basis.
35.5	2	Patients have access to a pharmacist to discuss medications.
35.6	2	In preparation for discharge, the ward helps all patients to understand the functions, limitations and side effects of their medications and to self-manage as far as possible.
Engagement		
36.1	2	Staff and patients treat one another with mutual respect.
36.2	2	Patients have a minimum of twice-weekly documented sessions with their Primary or Allocated Nurse to review their progress.
36.3	1	Each patient is invited to meet with a member of staff for one-to-one contact each waking shift and this is documented. Time should be set aside purposely for this.
36.4	2	Each patient has the opportunity to have supportive one-to-one sessions with staff every day.
36.5	2	Each patient is offered supportive counselling for one hour per week, e.g. active listening, problem solving.
Staffing		
37.1	2	Healthcare Assistants, Occupational Therapy Support Workers, volunteers and activity workers are involved in facilitating a broad range of therapeutic and leisure activities.

37.2	2	During the delivery of the formal therapeutic programme, there is at least one member of staff in each group and activity, and others available if needed.
37.3	2	There is at least one suitably experienced practitioner on duty during the main daily therapeutic programme.
A37.3.1	2	Patients who would benefit have access to an assessment for psychological interventions within two days of the request being made.
37.4	1	Inpatients have access to specialist practitioners of psychological interventions for one half-day (four hours) per week per ward.
37.5	2	Inpatients have access to specialist practitioners of psychological interventions more than one half-day (four hours) per week per ward.
37.6	3	All patients have access to evidence-based local complementary therapies, delivered by trained practitioners, in accordance with local policy and procedures.
37.7	2	Staff are given planned and protected time to make sure activities and interventions are provided regularly and routinely.
Provision of Activities and Therapies		
38.1	2	Each patient has the opportunity to be involved in negotiating an activity and therapy programme, relevant to their identified needs, that includes evening and weekend activity. This is recorded in their care plan, and regularly monitored and reviewed.
38.2	2	Systems are in place to regularly review with patients and staff the quality and provision of therapeutic activities.
38.3	2	Systems are in place to regularly review with patients and staff the quality and provision of social activities.
38.4	2	The frequency, regularity and diversity of activities are monitored.
38.5	2	All patients are offered specific psychosocial interventions appropriate to their presenting needs and in accordance with national standards (i.e. NICE).
38.6	1	At least one staff member linked to the ward is delivering one basic, low intensity psychological intervention.
38.7	2	At least one staff member linked to the ward is delivering one problem-specific, high intensity psychological intervention.
38.8	3	At least one staff member linked to the ward is delivering two or more problem-specific, high intensity psychological interventions (to correspond to two or more diagnostic criteria as per NICE guidance).

38.9	2	Activities are provided on a daily basis.
38.10	2	Activities are provided at weekends.
38.11	2	Activities are provided during evenings.
38.12	2	Gender-sensitive groups are provided.
38.13	2	From Monday-Friday, 9am – 5pm, patients have access to therapy materials/equipment when requested.
Group Activities and Therapies		
39.1	2	Group activities are protected and not interrupted.
39.2	2	In addition to one-to-one therapeutic contact, each patient is invited to attend therapeutic group contact with both staff and fellow patients for at least one half-hour each day.
39.3	3	Patients have access to a weekly relapse prevention/staying well group, following an evidence-based methodology.
39.4	2	There is a weekly minuted patient community meeting.
39.5	2	Patients are able to access regular group meetings that have a psycho-educational focus.
39.6	3	Carers are able to access regular group meetings that have a psycho-educational focus.
External Activities and Therapies		
40.1	2	Patients are able to leave the ward to attend activities elsewhere in the building and, with appropriate supports and escorts, to access usable outdoor space every day.
40.2	2	Patients are supported and encouraged to access local organisations, advocacy projects and religious and cultural groups from their own community.
40.3	3	Patients have access to weekly outreach visits to community centres promoting recovery and social inclusion.

Glossary of Terms and Abbreviations

Allocated Nurse	The nurse allocated responsibility for the patient's care for the duration of a shift
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment
CRB	Criminal Records Bureau
HDA	Health Development Agency
HoNOS	Health of the Nation Outcome Scales
IMCA	Independent Mental Capacity Advocate
LD	Learning disabilities
MDT	Multi-Disciplinary Team - all health professionals involved in patient care
MHA	Mental Health Act
MHAC	Mental Health Act Commission
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NRT	Nicotine Replacement Therapy
OT	Occupational Therapist
PALS	Patient Advice and Liaison Services
Primary Nurse	Inpatient nurse responsible for the individual patient's care
STR	Support, Time, Recovery

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