CAMHS QUALITY NETWORK FOR INPATIENT CAMHS

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Quality Network for Inpatient CAMHS Standards for Deaf Services

Third Edition

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Contents

Introduction

The third edition standards have been drawn from key documents and expert consensus and have been subject to extensive consultation with professional groups involved in the provision of inpatient mental health services for children and young people, and with people and carers who have used services in the past.

The standards have been developed for the purposes of review and accreditation of deaf services as part of the Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC), however, they can also be used as a guide for new or developing services.

The standards cover the follow topics:

- Environment and Facilities
- Staffing and Training
- Access, Admission & Discharge
- Care & Treatment
- Information, Consent & Confidentiality
- Young People's Rights and Safeguarding Children
- Clinical Governance

Who are these standards for?
These standards are designed to be applicable specifically for deaf inpatient child and adolescent mental health services and can be used by professionals to assess the quality of the team and the ward. The standards may also be of interest to commissioners, patients, carers, researchers and policy makers.

Categorisation of standards
To support in their use during the accreditation process, each standard has been categorised as follows:

- Type 1: Criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;
- Type 2: Criteria that a service would be expected to meet;
- Type 3: Criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

The full set of standards are aspirational, and it is unlikely that any service would meet them all. To achieve accreditation, a service must meet 100% of type 1 standards, at least 80% of type 2 standards and 60% of type 3 standards.

Terms used in this document
In this document, the inpatient mental health service is referred to as 'the team' or 'the ward/unit'. People who are cared for by inpatient child and adolescent mental health services are referred to as 'young people' and their loved ones are referred to as 'parents/carers'. The standards are also available to download on our website: www.rcpsych.ac.uk/qnic

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- Individuals who attended the standards consultation workshop;
- Individuals who contributed feedback via the e-consultation process.

Environment and Facilities			
#	**Type**	**Deaf Standard**	**CCQI Core**
1.1	**The ward/unit is well designed and has the necessary facilities and resources**		
1.1.1	**1**	The unit is clean and well-maintained.	
1.1.2	**2**	Staff members and young people can control heating, ventilation and light. *Guidance: For example, patients are able ventilate their rooms through the use of windows, they have access to light switches and they can request adjustments to control heating.*	17.15
1.1.3	**2**	There is indoor space for recreation which is large enough to accommodate all young people.	
1.1.4	**1**	There is a designated safe outdoor space which young people are able to access every day, where clinically appropriate.	6.1.11
1.1.5	**1**	The ward/unit has access to rooms for individual and group meetings.	
1.1.6	**1**	The ward/unit has a designated dining area, which is available during allocated mealtimes.	
1.1.7 [DEAF]	**1**	Meal areas allow young people to communicate with each other and staff (round tables, good lighting)	
1.1.8	**2**	There is designated teaching space for education which can accommodate all young people in the unit.	
1.1.9	**1**	In wards/units where seclusion is used, there is a designated room that meets the following requirements: · It allows clear observation; · It is well insulated and ventilated; · It has adequate lighting, including a window(s) that provides natural light; · It has direct access to toilet/washing facilities; · It has limited furnishings (which include a bed, pillow, mattress and blanket or covering); · It is safe and secure – it does not contain anything that could be potentially harmful;	17.18

		• It includes a means of two-way communication with the team; • It has a clock that patients can see.	
1.1.10	**2**	All young people can access a range of current, culturally-specific resources for entertainment, which reflect the ward/unit's population. *Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.*	17.7
1.1.11 [DEAF]	**2**	One computer is provided for every young person in and out of school	
1.1.12	**1**	Young people use mobile phones, computers (which provide access to the internet and social media), and other electronic equipment on the ward, subject to risk assessment and in line with local policy. *Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.*	17.11
1.1.13 [DEAF]	**1**	Young people have access to the internet for recreational purpose. This must include: • Access to videoconferencing • Robust safeguarding tech	
1.1.14	**3**	All young people can access a charge point for electronic devices such as mobile phones (where risk permits).	17.8
1.1.15	**1**	There are sufficient IT resources (e.g. computers) to provide all practitioners with easy access to key information, e.g. information about services/ conditions/ treatment, young people's records, clinical outcome and service performance measurements.	
1.1.16	**2**	There are facilities for young people to make their own hot and cold drinks and snacks which are available 24 hours a day (where risk permits).	17.21
1.1.17	**2**	Parents/carers have access to refreshments at the unit.	
1.1.18	**2**	Ward/unit-based staff members have access to a dedicated staff room.	17.23
1.1.19 [DEAF]	**1**	The environment and facilities are suitable for deaf people. This includes: • Signage in plain English, including pictures • Deaf appropriate access • Appropriate acoustics and lighting to allow communication	
1.1.20 [DEAF]	**2**	Televisions on the unit have subtitles available which are used and staff are aware of programmes with BSL interpretation and make these available.	

1.2	**Premises are designed and managed so that young people's rights, privacy and dignity are respected**		
1.2.1	**1**	All information about young people is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	16.4
1.2.2	**1**	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	17.9
1.2.3	**2**	All young people have single bedrooms.	17.2
1.2.4	**1**	Young people have separate toilets, washing facilities and bedrooms, split according to self-identified gender.	17.1
1.2.5	**2**	The unit has at least one bathroom/shower room for every three young people.	17.4
1.2.6	**3**	Every young person has an en-suite bathroom.	17.5
1.2.7	**2**	There is a separable gender-specific communal space which can be used as required.	17.20
1.2.8	**1**	The ward/ unit has a designated room for physical examination and minor medical procedures.	17.17
1.2.9	**2**	The ward/ unit has at least one quiet room or de-escalation space other than young people's bedrooms.	17.19
1.2.10	**2**	There is a designated space for young people to receive visitors who are children, with appropriate facilities such as toys and books.	
1.2.11	**2**	There is a safe place for young people to keep their property.	
1.2.12	**2**	There is a safe place for staff to keep their property.	
1.2.13	**1**	Young people are supported to access materials and facilities that are associated with specific cultural or spiritual practices e.g. covered copies of	17.6

		faith books, access to a multi-faith room, access to groups.	
1.2.14	**1**	Staff members respect the young people's personal space, where risk permits, e.g. by knocking and waiting before entering their bedroom.	17.10
1.2.15	**2**	Young people are consulted about changes to the ward/unit environment.	17.24
1.2.16	**2**	Young people can personalise their bedrooms. *Guidance: For example, by putting up photos and pictures.*	17.3
1.2.17 [DEAF]	**2**	There is a board on display with the names, photographs and sign names of staff	
1.2.18 [DEAF]	**1**	Measures are in place to allow confidential conversations in a signed language such as British Sign Language (BSL).	
1.3	**The unit provides a safe environment for staff and young people**		
1.3.1	**1**	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	
1.3.2	**1**	Entrances and exits are designed to enable staff to see who is entering or leaving and if required CCTV is used to achieve this.	
1.3.3	**1**	The ward is a safe environment with clear sightlines (e.g. with use of mirrors) and safe external spaces. *Guidance: An audit of environmental risk, including potential ligature points, is conducted annually and a risk management strategy is agreed.*	17.12
1.3.4	**1**	Young people and staff members feel safe on the ward.	21.2
1.4	**Equipment and procedures for dealing with emergencies on the ward/unit are in place**		
1.4.1	**1**	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency	7.3
1.4.2	**1**	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly and after each use.	17.16
1.4.3	**1**	A collective response to fire drills is agreed by the team and is rehearsed annually.	
1.4.4	**1**	Staff members, young people and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms and there is an agreed response when an alarm is used.	17.14

1.4.5 [DEAF]	**1**	The alarm system includes personal alarms for deaf staff that vibrates when activated and indicates the nature of and location of the alert	
1.4.6 [DEAF]	**1**	All areas within the unit contain visual alarms or other systems alerting deaf staff and young people to fire	

Staffing and Training			
#	**Type**	**Deaf Standard**	**CCQI Core**
2.1	**The number of nursing staff on the unit is sufficient to ensure safety and meet the needs of the young people at all times**		
2.1.1	**1**	There are sufficient levels of staffing which can be adapted to reflect the acuity levels of the ward. *Guidance:* • *High dependency/high acuity cases (e.g. high levels of observation, use of seclusion, increased risk of violence or self-harm), there is a minimum ward staff to young people ratio of 1:1 which can be increased to 3:1 for the most highly acute cases;* • *Medium dependency (e.g. 10-minute checks, intensive support at meal times), there is a minimum ward staff to young people ratio of 1:2;* • *Where young people are on low dependency observations there is a ward staff to young people ratio of 1:3.*	
2.1.2 [DEAF]	**1**	At night-time in a unit with general observations there is a minimum of four staff on duty, including one registered member of staff and access to additional support as appropriate	
2.1.3	**1**	A typical unit with 12 beds includes a minimum of two registered nurses, with relevant experience of working with children and young people, per day shift and one at night, at least one of whom should have completed preceptorship.	
2.1.4 [DEAF]	**2**	The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need. Bank staff who work regularly on the unit will have deaf awareness training and be supported in BSL 1	19.2

2.1.5 [DEAF]	**2**	There is a policy in place that seeks to minimise the use of agency staff that should include active recruitment policies and a plan to train and develop a bank of appropriately trained staff e.g. deaf awareness, BSL	
2.1.6	**1**	The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels. This should include: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	19.1
2.1.7	**1**	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	18.2
2.1.8	**1**	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.	18.3
2.1.9	**2**	Appropriately experienced young person or parent/carer representatives are involved in the interview process for recruiting potential staff members.	20.1
2.2	**The ward/unit comprises a core multi-disciplinary team**		
2.2.1	**1**	A typical unit with 12 beds includes 1 WTE ward manager (band 7+ or equivalent).	
2.2.2	**1**	A typical unit with 12 beds includes at least 1 WTE consultant child and adolescent psychiatrist input (which may be provided by two clinicians in a split post).	
2.2.3	**2**	A unit with 12 beds includes at least 1 WTE non-consultant child and adolescent psychiatrist.	
2.2.4	**1**	A typical unit with 12 beds includes at least 1 WTE clinical psychologist who contributes to the assessment and formulation of the young people's psychological needs and the safe and effective provision of evidence-based psychological interventions. *Guidance: This does not include assistant psychologists.*	6.1.2

2.2.5	**2**	A typical unit with 12 beds includes an additional 0.5 WTE of non-consultant psychology input. *Guidance: This may include support from assistant psychologists.*	
2.2.6 [DEAF]	**2**	The unit includes at least 1 WTE input from a senior social worker	
2.2.7 [DEAF]	**1**	A typical unit with 6 beds includes at least 1 WTE occupational therapist who works with young people requiring an occupational assessment and ensure the safe and effective provision of evidence-based occupational interventions	
2.2.8	**1**	The unit has formal arrangements to ensure easy access to therapists trained in psychological interventions. *Guidance: For example, CBT, child and adolescent psychotherapy, psychodynamic psychotherapy, MBT, DBT, IPT, EMDR (list is not exhaustive).*	
2.2.9	**2**	The unit has formal arrangements to ensure easy access to a dietician.	
2.2.10	**2**	The unit has formal arrangements to ensure easy access to a speech and language therapist.	
2.2.11 [DEAF]	**1**	The unit includes at least 0.5 WTE input from a language therapist	
2.2.12	**3**	There is dedicated sessional input from creative therapists.	6.1.4
2.2.13	**1**	A typical unit with 12 beds includes at least 0.5 WTE family therapist.	
2.2.14 [DEAF]	**2**	There is a minimum of one qualified teacher of the deaf for every three students per lesson Guidance: The teacher of the deaf can be in training.	
2.2.15 [DEAF]	**2**	Young people have access to specialist teachers for the deaf who teach alongside specialist teachers when needed	
2.2.16	**3**	Young people have access to teachers of specialist subjects e.g. language tutors.	
2.2.17	**2**	A typical unit with 12 beds includes 1 WTE administrator (band 3 or above or local equivalent).	

2.2.18	**2**	A specialist pharmacist is a member of the MDT.	6.2.5
2.2.19	**1**	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency.	19.3
2.2.20 [DEAF]	**1**	On call doctors who attend any unit emergency have some deaf awareness training and should be able to access communication support (e.g. interpreters or a staff member)	
2.2.21	**1**	There has been a review of the staff capacity and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the ward/unit.	
2.2.22 [DEAF]	**1**	The deaf unit recruits deaf staff. This includes specific advertising in the 'deaf media' Guidance: There is an aim to recruit at least 20% deaf staff at all levels for the deaf CAMHS inpatient unit, using a positive recruitment strategy.	
2.3	**Staff are provided with a thorough training programme**		
2.3.1	**1**	New staff members, including bank staff, receive an induction programme specific to the ward/unit. This includes: • *Arrangements for shadowing colleagues on the team;* • *Jointly working with a more experienced colleague;* • *Being observed and receiving enhanced supervision until core competencies have been assessed as met.*	20.2
2.3.2		Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:	22.1
2.3.2a	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	22.1a
2.3.2b	**1**	Physical health assessment. *Guidance: This could include training in understanding physical health problems, undertaking physical observations and when to refer the patient for specialist input.*	22.1b
2.3.2c	**1**	Safeguarding vulnerable adults and children. This includes recognising and responding to the signs of abuse, exploitation or neglect.	22.1c

2.3.2d	**1**	Risk assessment and risk management. *Guidance: This includes: assessing and managing suicide risk and self-harm; prevention and management of aggression and violence.*	22.1d
2.3.2e	**1**	Recognising and communicating with young people with cognitive impairment or learning disabilities.	22.1e
2.3.2f	**2**	Supporting and communicating with young people with autism spectrum disorders. *Guidance: This might include training on the use of non-verbal cards, social stories, and understanding a PBS plan.*	
2.3.2g	**1**	Statutory and mandatory training. *Guidance: Includes equality and diversity, information governance, basic life support.*	22.1f
2.3.2h	**2**	Parent/carer awareness, family inclusive practice and social systems, including parents/carers' rights in relation to confidentiality.	22.1g
2.3.2i	**2**	Human rights and the potential harm of restrictive practices such as seclusion and long-term segregation.	
2.3.2j	**3**	Quality improvement methodology and identifying priority QI projects.	
2.3.2k [DEAF]	**1**	Managing relationships and boundaries between young people and staff, including appropriate touch within the cultural norms of the deaf community	
2.3.2l	**1**	Therapeutic observation (including principles around positive engagement with young people, when to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this and actions to take if the young person absconds) when they are inducted into a Trust or changing wards.	22.1h
2.3.3	**1**	All qualified nursing and medical staff that administer rapid tranquillisation have completed Intermediate Life Support training.	
2.3.4	**1**	All staff members who administer medications have been assessed as competent to do so.	6.2.4

		Assessment is done using a competency-based tool and is repeated at least once every three years.	
2.3.5	**2**	Shared in-house multi-disciplinary team training, education and practice development activities occur on the ward/unit at least every three months.	
2.3.6	**3**	Non-clinical staff have received mental health awareness training.	
2.3.7	**1**	All staff members who deliver therapies and activities are appropriately trained and supervised.	6.1.13
2.3.8	**2**	Young people, parents/carers and staff members are involved in devising and delivering training.	22.2
2.3.9 [DEAF]	**1**	Training is provided for all staff that is accessible and tailored for deaf and hearing staff	
2.3.10 [DEAF]	**2**	The personal development plan of all staff in a deaf service includes the development of expertise in mental health and deafness, deaf awareness training and BSL Guidance: This should include deaf awareness, hearing awareness, working together, linguistic differences, range of different presentations seen in deaf children and young people.	
2.3.11 [DEAF]	**1**	All staff working on the ward with deaf patients, including bank and agency staff, undertake deaf awareness training as part of induction. In particular, reception staff have some basic BSL as a minimum	
2.3.1	**1**	New staff members, including bank staff, receive an induction programme specific to the ward/unit. This includes: • *Arrangements for shadowing colleagues on the team;* • *Jointly working with a more experienced colleague;* • *Being observed and receiving enhanced supervision until core competencies have been assessed as met.*	20.2
2.3.2		Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:	22.1
2.3.2a	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	22.1a
2.4			

2.4.1	**1**	All clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	20.3
2.4.2	**2**	All staff members receive line management supervision at least monthly.	20.4
2.4.3	**1**	All staff members receive an annual appraisal and personal development planning (or equivalent).	
2.4.4	**1**	There are written documents that specify professional, organisational and line management responsibilities.	
2.4.5	**1**	The ward/unit actively supports staff health and wellbeing. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	21.1
2.4.6	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	21.3
2.4.7	**3**	Staff members are able to access reflective practice groups at least once every six weeks where teams can meet together to think about team dynamics and develop their clinical practice.	18.1
2.4.8	**2**	The team has protected time for team building and discussing service development at least once a year.	

2.4.9 [DEAF]	**1**	All deaf staff are referred for an Access to Work (ATW) assessment to ensure appropriate support in terms of communication and equipment	
2.4.10 [DEAF]	**3**	The service offers the opportunity for placements to deaf trainees and students from various disciplines	
2.4.11 [DEAF]	**3**	Senior managers and ward managers of the unit should have an understanding and some knowledge of working with deaf young people, and should demonstrate a commitment to understanding the deaf experience and developing BSL skills. This should be reflected in the job specification	

Access, Admission & Discharge			
#	**Type**	**Deaf Standard**	**CCQI Core**
3.1	**Assessment and treatment are offered without unacceptable delay**		
3.1.1	**1**	The service provides information about how to make a referral.	1.1
3.1.2	**1**	If the unit admits young people in cases of emergencies, young people can be admitted within 24 hours (including out of hours).	
3.1.3	**1**	Young people have a comprehensive mental health assessment which is started within four hours and completed within one week. This involves the multi-disciplinary team and includes young people's: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development.	2.4
3.1.4	**1**	Young people have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. The assessment is completed within one week, or prior to discharge.	2.5
3.1.5 [DEAF]	**1**	Young people have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. The assessment is completed within one week, or prior to discharge	

		Guidance: Particular attention is given to ensure that any hearing aids or implants are monitored. There is a procedure in place for referral to audiology if required and replacing hearing aid batteries.	
3.1.6	**1**	Teaching staff complete an assessment of each young person's educational needs which is reviewed at each CPA review (or local equivalent).	
3.1.7	**1**	There is a documented Care Programme Approach (or equivalent) or ward round admission meeting within one week of the young person's admission. Young people are supported to attend this with advanced preparation and feedback.	4.2
3.1.8 [DEAF]	**1**	Access to health services (e.g. Dentist, GP) is supported by appropriate staff and qualified BSL interpreters to ensure effective communication	
3.2	**Young people and their parents/carers are supported throughout the admission process**		
3.2.1	**1**	On admission to the ward/unit, young people feel welcomed by staff members who explain why they are in hospital. *Guidance: Staff members show young people around and introduce themselves and other young people, offer young people refreshments, address young people using the name and pronouns they prefer.*	2.1
3.2.2	**1**	The young person's parent/carer is contacted by a staff member (with the young person's consent) to notify them of the admission and to give them the ward/unit contact details.	2.2
3.2.3	**2**	Parents and carers are offered individual time with staff members (with the young person's consent), within 48 hours of the young person's admission to discuss concerns, family history and their own needs.	13.3

3.2.4	**1**	On admission, if a Local Authority has parental responsibility as a result of a care order, the service identifies a named clinician who should be responsible for consultation around care planning.	
3.2.5	**2**	The service actively supports families to overcome barriers to access.	
3.2.6	**1**	Young people admitted to the ward outside the area in which they live have a review of their placement at least every three months.	2.8
3.3.	**Discharge plans are agreed with and communicated to all relevant parties**		
3.3.1	**1**	Mental health practitioners carry out a thorough assessment of the young person's personal, social, safety and practical needs to reduce the risk of suicide on discharge.	9.1
3.3.2	**1**	When staff members are concerned about an informal young person self-discharging against medical advice, the staff members undertake a thorough assessment of the young person, taking their wishes into account as far as possible.	9.6
3.3.3	**2**	Teams provide specific transition support to young people when their care is being transferred to another unit, to a community mental health team, adult services, or back to the care of their GP. *Guidance: The team provides transition mentors; transition support packs; or training for young people on how to manage transitions.*	9.5
3.3.4	**1**	The inpatient team invites a representative from the young person's community team to attend and contribute to relevant meetings e.g. CPA, discharge planning.	
3.3.5	**1**	A transition meeting takes place by the time the young person reaches the age of 17 and a half years.	
3.3.6	**1**	When a young person transfers to adult services, unit staff invite adult services and other involved agencies to a joint review to ensure an effective handover takes place and there is a protocol for collaborative working.	
3.3.7	**1**	Young people discharged from inpatient care have their care plan or interim discharge summary sent to everyone identified as involved in their ongoing care within 24 hours of discharge. *Guidance: The plan includes details of:* *• Care in the community /*	9.2

		aftercare arrangements; *• Crisis and contingency arrangements including details of who to contact;* *• Medication including monitoring arrangements;* *• Details of when, where and who will follow up with the patient.*	
3.3.8	**2**	A discharge summary is sent within a week to the young person's GP and others identified as involved in their ongoing care, including why the young person was admitted and how their condition has changed, diagnosis, medication and formulation.	9.3
3.3.9	**1**	The inpatient team makes sure that young people who are discharged from hospital have arrangements in place to be followed up within three days of discharge.	9.4
3.3.10	**1**	Parents/carers (with the young person's consent) are involved in discussions and decisions about the young person's care, treatment and discharge planning.	13.1

Care & Treatment

#	Type	Deaf Standard	CCQI Core
4.1	**All young people have a written care plan as part of the Care Programme Approach (or local equivalent)**		
4.1.1	**1**	Every young person has a written care plan, reflecting their individual needs. Staff members collaborate with young people and parents/carers (with the young person's consent) when developing the care plan and they are offered a copy. *Guidance: The care plan clearly outlines:* *• Agreed intervention strategies for physical and mental health;* *• Measurable goals and outcomes;* *• Strategies for self-management;* *• Any advance directives or statements that the patient has made;*	4.3

		• *Crisis and contingency plans;* • *Review dates and discharge framework.*	
4.1.2 [DEAF]	**1**	Every young person has a written and visual care plan, reflecting their individual needs. Staff members collaborate with young people and parents/carers (with the young person's consent) when developing the care plan and they are offered a copy Guidance: Care plans are accessible to deaf patients and if necessary adapted for deaf patients e.g. using pictures, symbols or in BSL on DVD or other formats. The care plan clearly outlines: • Agreed intervention strategies for physical and mental health • Measurable goals and outcomes • Strategies for self-management • Any advance directives or statements that the patient has made • Crisis and contingency plans • Review dates and discharge framework	
4.1.3	**1**	Young people have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality) and parents/carers, as appropriate. The assessment considers risk to self, risk to others and risk from others.	2.6
4.1.4 [DEAF]	**1**	Assessments for admission of a deaf person are carried out by a clinician with expertise in mental health and deafness alongside a deaf professional	

4.1.5 [DEAF]	**1**	The prior to- or on-admission assessment includes reference to communication needs, which are documented in the young person's notes	
4.1.6 [DEAF]	**1**	If appropriate to the patient's communication needs, the admission assessment is carried out either directly in BSL (or another signed language) or with a fully qualified and registered interpreter with a minimum of three years' post-qualification experience	
4.1.7	**1**	Young people are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This should be documented in the young person's care plan.	7.2
4.1.8	**1**	Young people have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.*	7.1
4.1.9	**1**	Where a young person is identified as having a learning disability or autistic spectrum condition after being admitted to the unit, staff identify and notify all relevant agencies in order to initiate the C(E)TR process. *Guidance: This should include the relevant commissioner (Provider Collaborative, NHSEI Specialised Commissioner, or Clinical Commissioning Group), Local Authority, GP, and the Community CAMHS Team.*	
4.1.10 [DEAF]	**1**	Therapy is delivered in BSL, if appropriate to the young person's communication needs. This is delivered directly in BSL or at least with the appropriate use of an interpreter and/ or communication facilitator	
4.1.11 [DEAF]	**1**	All assessments and interventions should be accessible and meaningful and based on a thorough communication profile which outlines the needs of all young people and their families	
4.2	**There is a structured programme of care and treatment**		
4.2.1	**1**	Every young person has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with.	6.1.6

4.2.2	**2**	Young people receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management.	6.1.5
4.2.3	**2**	The team provides information and encouragement to young people to access local organisations for peer support and social engagement. This is documented in the young person's care plan and includes access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	6.1.12
4.2.4 [DEAF]	**2**	The team provides information and encouragement to young people to access local organisations for peer support and social engagement. This is documented in the young person's care plan and includes access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges; • Deaf clubs and community activities	
4.2.5 [DEAF]	**1**	The team follows a joint working protocol/care pathway with the ND CAMHS Specialist Outreach services Guidance: This includes the team inviting the Home Treatment Team to attend ward rounds, to screen for early discharge, to undertake joint acute care reviews and to jointly arrange supported leave.	
4.2.6	**2**	There is a minuted ward community meeting that is attended by young people and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the group of young people. *Guidance: This is an opportunity for young people to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.*	6.1.9
4.2.7	**2**	Young people have access to relevant faith-specific and/or spiritual support, preferably through someone with an understanding of mental health issues.	6.1.10

4.2.8	**1**	All young people are proactively offered access to an advocacy service, including IMHAs (Independent Mental Health Advocates) for those detained.	10.4
4.2.9 [DEAF]	**1**	There is information available for contacting advocacy which is suitable for deaf patients	
4.2.10 [DEAF]	**1**	A specialist deaf advocacy worker is available and can communicate with the young person in their chosen language	
4.2.11 [DEAF]	**1**	Information provided on complaints is accessible to deaf people and assures young people and parents/carers that if they complain they will not be discriminated against and their care will not be compromised	
4.2.12	**1**	Young people and parents/carers know who the key people are in their team and how to access them if they have any questions.	4.1
4.2.13	**1**	Each young person is offered a pre-arranged session with their key worker (or a designated member of the nursing team) at least once a week to discuss progress, care plans and concerns.	6.1.7
4.2.14	**1**	Staff update parents/carers on their child's progress at a minimum of once a week, subject to confidentiality.	
4.2.15 [DEAF]	**2**	There is evidence of active positive promotion of Deaf culture and meeting of Deaf cultural needs, e.g. access to Deaf club	
4.3	**Young people can continue with their education whilst admitted**		

4.3.1	**1**	All young people have a personal education plan which reflects the focus on wider progress and well-being in education in addition to academic progress.	
4.3.2	**1**	The unit provides the core educational subjects: maths, English and science.	
4.3.3	**2**	The unit provides a broad and balanced curriculum that is suitable and flexible, appropriate to the students' needs.	
4.3.4	**1**	Where the unit caters for young people over the age of 16, young people are able to continue with education.	
4.3.5	**1**	If the young person is receiving education, educational staff at the unit liaise with the young person's own school in order to maintain continuity of education provision.	
4.3.6 [DEAF]	**1**	BSL, Deaf Studies and Deaf culture are delivered by a suitably qualified deaf professional *Guidance: The professional can be in training*	
4.3.7	**1**	Where young people are returning to their local educational facility after discharge, education and unit staff support the young people with their reintegration.	
4.3.8	**2**	The educational staff maintain communication with the young peoples' parents/carers, e.g. providing progress reports for each CPA review.	
4.3.9	**3**	Educational outings are provided, as appropriate.	
4.4.10 [DEAF]	**1**	Teachers contribute to multi-disciplinary meetings and take an active part in the therapeutic milieu in liaison with the care team (as per the care plan in place)	
4.3.11	**2**	Teachers and nursing staff have a handover at the beginning and end of each school day.	
4.3.12	**1**	The unit is part of an education organisation that is a registered examination centre.	
4.4	**Outcome measurement is undertaken routinely using validated outcome tools**		

4.4.1	**1**	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible (e.g. HoNOSCA).	23.1
4.4.2	**2**	Staff members review young people's progress against self-defined goals in collaboration with the young person and parents/carers where appropriate at the start of treatment, during clinical review meetings and at discharge.	23.2
4.4.3	**2**	Units contribute to a national dataset to allow for information sharing, e.g. QNIC ROM.	
4.5	**All young people at the unit are given a choice of healthy, balanced food**		
4.5.1	**1**	Young people are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.	17.22
4.5.2	**2**	Staff ask young people for feedback about the food and this is acted upon.	
4.5.3	**3**	Staff eat with the young people at mealtimes and the cost of staff meals are covered by the organisation.	
4.5.4	**3**	Where there is a therapeutic benefit, there are arrangements for families to eat at mealtimes and the cost of the meal is covered by the organisation.	
4.6	**Leave is planned collaboratively with the young person and their parent/carer**		
4.6.1	**1**	The team develops a leave plan jointly with the young person and their parent/carer that includes: • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave; • Contact details of the ward/unit and crisis numbers.	5.1; 5.2

4.6.2	**1**	When young people are absent without leave, the team (in accordance with local policy): • Activates a risk management plan; • Makes efforts to locate the patient; • Alerts parents/carers, people at risk and the relevant authorities; • Completes an incident form.	5.3
4.7	**Medication is prescribed safely and monitored routinely**		
4.7.1	**1**	When medication is prescribed, the risks (including interactions) and benefits are reviewed, a timescale for response is set and the young person's consent is recorded.*Guidance: Leaflets and information around medication being prescribed, the risks and benefits should be provided to young people and parents/carers (with the young person's consent).*	6.2.1
4.7.2	**1**	Young people have their medication reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	6.2.2
4.7.3	**1**	Every young person's PRN (i.e. as required) medication is reviewed weekly in terms of the frequency, dose, and reasons for prescribing.	6.2.3
4.7.4	**1**	Young people in hospital for long periods of time who are prescribed mood stabilisers or antipsychotics, have the appropriate physical health assessments at the start of treatment (baseline), at three months, and then six-monthly unless a physical health abnormality arises.	7.4

Information, Consent & Confidentiality			
#	**Type**	**Deaf Standard**	**CCQI Core**
5.1	**Young people and parents/carers are provided with key information about the ward/unit**		

5.1.1	**2**	The service has a website which provides information about the unit that young people and parents/carers can access prior to admission.	
5.1.2 [DEAF]	**1**	The information available is accessible for deaf families and visitors	
5.1.3	**2**	Young people are given an information pack on admission that contains the following: - A description of the service; - The therapeutic programme; - Information about the staff team; - The unit code of conduct; - Key service policies (e.g. permitted items, smoking policy); - Resources to meet spiritual, cultural or gender needs.	3.1
5.1.4	**1**	Young people are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: Their rights regarding admission and consent to treatment • Their rights under the Mental Health Act • How to access advocacy services (including independent mental capacity advocates and independent mental health advocates) • How to access a second opinion • How to access interpreting services • How to raise concerns, complaints and compliments	2.3

		• How to access their own health records • Details of communication on the unit	
5.1.5	**1**	Confidentiality and its limits are explained to the young person and their parent/carer on admission, both verbally and in writing. The young person's preferences for sharing information with third parties are respected and reviewed regularly.	16.1
5.1.6	**2**	Young people are offered information on their human rights in relation to restrictive practices and the redress they can have in relation to this.	
5.1.7	**1**	Young people and parents/carers are offered written and verbal information about the young person's mental illness.	6.1.8
5.1.8 [DEAF]	**1**	Young people and parents/carers are offered holistic written, signed and verbal information about the young person's mental illness or developmental disorder	
5.1.9	**2**	The team provides each parent/carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	13.4

5.1.10 [DEAF]	**1**	All information should be in the preferred accessible format for the young person and their family	
5.1.11	**1**	Parents and carers are supported to access a statutory carers' assessment, provided by an appropriate agency.	13.2
5.1.12	**2**	The ward/unit uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The young person's relatives are not used in this role unless there are exceptional circumstances.	15.1
5.1.13 [DEAF]	**1**	The ward/unit works with spoken language interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The young people's relatives are not used in this role	
5.1.14 [DEAF]	**2**	All young people should be able to communicate fully with at least one member of staff in their first language (e.g. BSL). Where additional staff cannot communicate in the young person's first language, there should be an interpreter available for every shift (at night, part of the shift)	
5.1.15 [DEAF]	**1**	Assessment and treatment are adapted for use with deaf people, e.g. they are delivered in BSL, visual materials are used and deaf staff deliver services	
5.1.16 [DEAF]	**1**	Provision should be made for information to be available in BSL, plain English, or through an interpreter, and across a range of formats	

5.1.17 [DEAF]	**1**	In the event of admission to an acute physical healthcare hospital, the young person is supported by unit staff who can sign and/or interpreters	
5.2	**All examination and treatment is conducted with the appropriate consent**		
5.2.1	**1**	Assessments of young people's capacity (and competency for young people under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation and documented in the young person's notes. These assessments should be undertaken at every point that a young person is required to participate in decision making.	11.1
5.2.2	**1**	The team follows a protocol for responding to parents/carers when the young person does not consent to their involvement.	16.3

Young People's Rights and Safeguarding Children

#	Type	Deaf Standard	CCQI Core
6.1	**Young people and their parents/carers are supported by staff and treated with respect**		
6.1.1	**1**	Staff members treat all young people and their parents/carers with compassion, dignity and respect.	14.1
6.1.2	**1**	Young people feel listened to and understood by staff members.	14.2
6.1.3	**1**	Parents/carers feel supported by the ward staff members.	13.5
6.1.4 [DEAF]	**1**	Staff demonstrate respect for Deaf culture (e.g. by signing at all times, developing BSL skills)	
6.2	**The ward/unit complies with national guidance on safeguarding young people**		
6.2.1	**1**	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the ward.	8.1

6.2.2	**1**	If a young person raises safeguarding concerns or someone else raises concerns about them, staff inform them of the likely process that will be followed by the unit and other agencies.	
6.2.3	**1**	Young people are involved in decisions about their level of observation by staff.	8.2
6.2.4	**1**	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.	8.4
6.2.5	**1**	Parental responsibility is recorded in the young person's notes.	
6.2.6	**1**	It is recorded as to whether or not a young person has a child protection plan in place.	
6.2.7	**1**	The young person's local authority is alerted if the whereabouts of the person with parental responsibility is not known or if that person has not contacted the young person.	
6.2.8	**1**	The young person's local authority (or equivalent) is made aware if a young person remains on the unit for a consecutive period of 3 months (in line with section 85 of the Children Act 1989).	
6.3	**Restrictive practice is used in line with appropriate legal frameworks and only as a last resort**		
6.3.1	**1**	Young people are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery. *Guidance: This includes avoiding the use of blanket rules and any restrictions should be assessed based on individual risk.*	17.13
6.3.2	**1**	The team uses seclusion or segregation only as a last resort and for brief periods only.	8.6

6.3.3	**1**	Staff members do not restrain young people in a way that affects their airway, breathing or circulation.	8.3
6.3.4 [DEAF]	**1**	A separate communicator is involved in the restraining process to ensure high quality communication is maintained throughout	
6.3.5	**1**	Young people who are involved in episodes of restrictive physical intervention, or compulsory treatment including tranquilisation, have their vital signs monitored by nursing staff in collaboration with medics and any deterioration is responded to.	8.7
6.3.6	**1**	Parents/carers are informed about all episodes of restrictive interventions within 24 hours. If for any reason this does not occur, reasons are documented in the young person's notes	
6.3.7	**1**	In order to reduce the use of restrictive interventions, young people who have been violent or aggressive are supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions	8.5
6.3.8	**1**	The multi-disciplinary team collects audit data on the use of restrictive interventions and actively works to reduce its use year on year through use of audit and/or quality improvement methodology. *Guidance: Audit data are used to compare the service to national benchmarks where possible.*	8.8
6.3.9	**1**	Staff members, young people and parents/carers who are affected by a serious incident, including control and restraint and rapid tranquilisation, are offered post incident support.	21.4

Clinical Governance			
#	**Type**	**Deaf Standard**	**CCQI Core**
7.1	**Services are developed in collaboration with the ward team, young people, parents/carers, and other key stakeholders**		
7.1.1	**2**	There is a well-attended business meeting held within the team at least monthly in which information and learning can be disseminated, and the business of care on the ward can be discussed. *Guidance: This meeting is at unit level and should also be used as a mechanism to feed in and out of the patient community meeting.*	
7.1.2	**3**	The ward/unit has a meeting, at least annually, with all stakeholders to consider topics such as referral themes, service developments, issues of concern and to re-affirm good practice	
7.1.3	**2**	Services are developed in partnership with appropriately experienced service user and carers who have an active role in decision making.	12.2
7.2	**The team engages in audit and quality improvement initiatives to identify areas for improvement and implement change**		
7.2.1	**1**	Young people and their parents/carers are encouraged to feed back confidentially about their experiences of using the service, and this feedback is used to improve the service.	12.1
7.2.2 [DEAF]	**1**	There are mechanisms in place to ensure that deaf young people and family members are able to feed back confidentially about their experiences of using the service, and this feedback is used to improve the service	
7.2.3	**2**	Measures are in place to record and audit referrals, terminated referrals and waiting lists.	
7.2.4 [DEAF]	**2**	The unit formally records all referrals with respect to race, gender, home area and disability, language preferences and this is reviewed annually	

7.2.5	**3**	A range of local and multi-centre clinical audits is conducted, which include the use of evidence-based treatments as a minimum. *Guidance: This could include an audit of the safe prescription of high-risk medication, for example.*	
7.2.6	**3**	The team, young people and parent/carers are involved in identifying priority audit topics in line with national and local priorities, and feedback received.	
7.2.7	**2**	The team uses quality improvement (QI) methods to implement service improvement.	24.4
7.2.8	**2**	The team actively encourages young people and parents/carers to be involved in QI initiatives.	24.5
7.3	**Unit staff learn from information collected on clinical risks**		
7.3.1	**1**	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	24.1
7.3.2	**1**	When mistakes are made in care, this is discussed with the young person themselves and their parent/carer, in line with the Duty of Candour agreement.	24.2
7.3.3	**1**	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	24.3
7.4	**The unit has a comprehensive range of policies and procedures**		
7.4.1	**1**	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.	
7.4.2 [DEAF]	**1**	There is a policy for the use of mobile phones, text phones, interpreted phone calls, video relay services and other communication aids	
7.4.3	**1**	There are policies and procedures on the management of aggression and violence and the use of physical restraint. *Guidance: This policy should specifically reference working with children and young people.*	

7.4.4 [DEAF]	**1**	There are policies and procedures on the management of aggression and violence and the use of physical restraint which includes the prevention of, use, and adaption of physical restraint with deaf young people	
7.4.5	**1**	There is a policy on the use of rapid tranquilisation. *Guidance: This policy should specifically reference working with children and young people.*	
7.4.6	**1**	The unit has a policy on the use of seclusion and long-term segregation. *Guidance: The unit should have a policy even if seclusion is not used. This should be in line with current legislation.*	
7.4.7	**1**	When a ward/unit is on the same site as an adult ward/unit, there are policies and procedures in place to ensure young people are safely using shared facilities and allow them safe access to wider grounds within the ward/unit.	

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