AIMS

ACCREDITATION FOR INPATIENT MENTAL HEALTH SERVICES

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Acute Inpatient Services Working-Age Adults (AIMS-WA) – 6th Edition

Sixth Edition: June 2017 (This version was updated on 28th September 2017)

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The standards are also available on our website

Standards and criteria have been categorised as follows:

Type 1: Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence based care and treatment.

Type 2: expected standards that all services should meet;

Type 3: desirable standards that high performing services should meet.

Content

Foreword

We are pleased to introduce the sixth edition of the AIMS-WA standards and appreciate the continuing collaborative effort to improve the quality of the inpatient mental health services for working-age adults.

These standards have been reviewed and developed in consultation with stakeholder groups which allowed us to consider and include the views of both clinic staff and service users.

The standards are intended to provide staff with a clear and comprehensive description of best practice in inpatient mental health services for working-age adults. They are reviewed on a regular basis, so please give the project team any comments, using the form provided at the back of this booklet.

We would like to thank our stakeholders – clinicians as well as service user and carer representatives for their effort, advice and support in producing this edition of standards.

These standards will be applied each year in self- and external peer-review by AIMS-WA member services. If you work in inpatient mental health services, we hope you will continue to support the network and join in the review cycle.

The AIMS-WA Team

Introduction

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

The standards have been developed for the purposes of review and accreditation as part of the Accreditation for Inpatient Mental Health Services (AIMS) scheme, however, they can also be used as a guide for new or developing services. Please refer to the AIMS Accreditation Process document for information on the process of accreditation.

Who are these standards for?

These standards are designed to be applicable to inpatient mental health services for working age and can be used to assess the quality of general adult teams.

Categorisation of standards

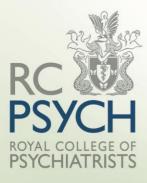To support their use in the accreditation process, each standard has been categorised as follows:

• 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 is aspirational and it is unlikely that any service would meet them all. To achieve accreditation, a service must meet 100% type 1 standards, at least 80% type 2 standards and 60% type 3 standards. AIMS facilitates quality improvement and supports teams to achieve accreditation.

The standards are also available on our website www.rcpsych.ac.uk/AIMS-WA

Terms used in this document

In this document, the inpatient mental health service is referred to as 'the team'. People who are cared for by inpatient mental health services are referred to as 'service users' and their loved ones are referred to as 'carers', 'family/family members' or 'friends'.

Section 1

General Standards

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MENTAL HEALTH SERVICES

NUMBER	TYPE	STANDARD	BSI NUMBER
		Leadership and Culture	
1.1	1	There are written documents that specify professional, organisational and line management responsibilities.	20.1
1.2	3	The organisation's leaders provide opportunities for positive relationships to develop between everyone. *Guidance: This could include patients and staff members eating together or using shared facilities.*	20.4
1.3	1	Staff members and patients feel confident to contribute to and safely challenge decisions. *Guidance: This includes decisions about care, treatment and how the ward/unit operates.*	20.6
1.4	1	Staff members feel able to raise any concerns they may have about standards of care.	20.7
		Team Working	
1.5	2	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises.	2.1
1.6	2	The team has protected time for team-building and discussing service development at least once a year.	2.2
		General Management	
1.7	2	The team attends business meetings that are held at least monthly.	27.1
1.8	3	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	27.2
		Commissioning and Financial Management	
1.9	2	The ward/unit is explicitly commissioned or contracted against agreed ward/unit standards. *Guidance: This is detailed in the Service Level Agreement, operational policy, or similar, and has been agreed by funders.*	31.1
1.10	3	Commissioners and service managers meet at least six-monthly.	31.2

		Policies and Protocols	
1.11	2	Front-line staff members are involved in key decisions about the service provided.	27.3
1.12	2	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.	27.4
1.13	2	Managers audit the implementation of new policies and procedures relating to the ward/unit and provide feedback to MDT staff.	-
		Staffing Levels	
1.14	1	The ward/unit adheres to agreed minimum staffing levels that comply with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	22.1
1.15	1	The ward/unit has a mechanism for responding to low staffing levels, including: - 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.	22.2
1.16	2	The ward/unit is staffed by permanent staff members, bank and agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need.	22.3
1.17	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 include: - levels of observation; - sickness and absence; - training; - supervision; - escorts; - consultation, outreach and liaison functions; - the need to promote patients' independence; - therapeutic engagement; - acuity levels; - conformance with local human resources guidance; - staff capabilities; - clinical meetings.	-
1.18	2	There has been a review of the staff members 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.	22.6
1.19	1	The ward/unit actively supports staff health and well-being.	25.1

		Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.	
1.20	1	The nominated person in charge of the shift is the point of contact for consultation, negotiation, and decision-making for all ward/unit operational matters.	-
1.21	1	An experienced member of staff is assigned to maintain general observation in patient areas, 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.	-
Recruitment and Retention of Staff			
1.22	2	If the ward/unit uses bank and agency staff members, the service manager monitors their use on a monthly basis. An overdependence on bank and agency staff members' results in action being taken.	22.4
1.23	2	Patient or carer representatives are involved in interviewing potential staff members during the recruitment process.	23.1
MDT Staff			
1.24	1	Specific sessions are set aside in the consultant's job plan to ensure sufficient time is available for their consistent and regular input to the team and related forums.	-
1.25	2	There is visible and accessible leadership at ward/unit level, e.g. Consultant, Modern Matron, Nurse Consultant.	-
1.26	1	There is access to dedicated sessional or part-sessional administrative support which meets the needs of the ward/unit.	-
Access to Other Staff/Services			
1.27	2	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	8.1.12
1.28	1	The ward/unit is able to access interpreters, signers and other methods of facilitating communication.	-
1.29	2	The Ward/unit Manager has control over funds for day-to-day operational needs.	-

Appraisal, Supervision and Staff Support

1.30	1	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	24.1
1.31	1	The ward/unit has clear clinical supervision guidelines which incorporate supervision contracts between supervisor and supervisee.	-
1.32	1	All clinical staff members receive 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.*	24.2
1.33	2	Staff members in training and newly-qualified staff members are offered weekly supervision.	24.3
1.34	2	The quality and frequency of clinical supervision is monitored quarterly by the clinical director (or equivalent).	24.4
1.35	2	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.	24.5
1.36	1	All staff members receive monthly line management supervision.	24.6
1.37	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.	25.2
1.38	2	Staff members have access to reflective practice groups.	25.3

Staff Induction

1.39	1	Staff members receive an induction programme specific to the ward/unit that covers: - the purpose of the ward/unit; - the team's clinical approach; - the roles and responsibilities of staff members; - the importance of family and carers; - care pathways with other services. *Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme.*	23.2

1.40	2	New staff members, including bank and agency staff, receive an induction based on an agreed list of core competencies. *Guidance: This should include 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.*	23.3
1.41	1	All newly qualified staff members are allocated a preceptor to oversee their transition onto the ward/unit. *Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas-prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body. See http://www.rcn.org.uk/__data/assets/ pdf_file/0010/307756/Preceptorship_framework.pdf for more practical advice.*	23.4
1.42	2	All new staff members are allocated a mentor to oversee their transition onto the ward/unit/unit.	23.5
Staff Education and Training			
1.43	1	All staff members who administer medications have been assessed as competent to do so. Assessment is repeated on a yearly basis using a competency-based tool.	8.2.6
1.44	1	The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: - safeguarding vulnerable adults and children; - assessing and managing suicide risk and self-harm; - prevention and management of aggression and violence.	10.1
1.45	2	Staff members can access leadership and management training appropriate to their role and specialty.	20.2
1.46	1	Staff members receive training consistent with their role, which is recorded in their personal development plan and is accordance with local guidelines. This training includes:	
1.47	2	Care planning as part of the care management programme, including CPA (or local equivalent) and discharge planning;	
1.48	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent);	26.3.a
1.49	1	physical health assessment; *Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input.*	26.3.b

1.50	2	How to assess capacity;	-
1.51	1	Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities;	26.3.c
1.52	1	Statutory and mandatory training; *Guidance: Includes equality and diversity, information governance.*	26.3.d
1.53	2	Clinical outcome measures;	26.3.e
1.54	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality;	26.3.f
1.55	2	Procedures for assessing carers' needs, including ensuring a carer's assessment has been completed.	-
1.56	1	Clinical staff receive training and support from staff with appropriate clinical skills to provide basic psychological and psychosocial interventions (including, but not limited to, conflict resolution/de-escalation, engagement activity scheduling, group facilitation).	-
1.57	2	The ward/unit can demonstrate that qualified staff from nursing, occupational therapy, psychiatry and clinical psychology receive ongoing training and supervision to provide a repertoire of problem-specific, low-intensity psychological interventions in line with NICE guidance.	-
1.58	3	The ward/unit can demonstrate that qualified staff from nursing, occupational therapy, 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.	-
1.59	2	Staff members have access to study facilities (including books and journals on-site or online) and time to support relevant research and academic activity.	26.1
1.60	1	Clinical staff members have received formal training to perform as a competent practitioner, or, if still in training, are practising under the supervision of a senior qualified clinician.	26.2
1.61	2	Patients, carers and staff members are involved in devising and delivering training face-to-face.	26.4
1.62	3	Shared in-house multi-disciplinary team training, education and practice development activities occur on the ward/unit at least every three months.	26.5

		Advocacy	
1.63	1	The ward/unit has a working relationship with a range of advocacy services that includes the IMCA service.	-
		Compliments, Complaints and Incidents	
1.64	1	There are clear policies and procedures for managing complaints.	-
1.65	1	Information is available for patients/carers about: - 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. This is publicised and readily available.	-
1.66	1	Patients and their careers are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service. *Guidance: This might include patient and carer surveys or focus groups.*	14.1
1.67	2	Patient representatives attend and contribute to local and service level meetings and committees.	14.2
		Serious Incidents	
1.68	1	Staff members share information about any serious untoward/unit incidents involving a patient with the patient themselves and their carer, in line with the Duty of Candour agreement.	30.2
1.69	1	Staff members, patients and carers who are affected by a serious incident is offered a debrief and post-incident support.	30.3
1.70	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.	30.4
1.71	2	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice.	30.5

		Reporting Inappropriate/Abusive Care		
1.72	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.		10.9
1.73	1	There are protocols/procedures/strategies in place for the confidential reporting or 'whistleblowing' on abuse or inappropriate care.		-
		Audit and Service Evaluation		
1.74	2	A range of local and multi-centre clinical audits is conducted which include the use of evidence-based treatments, as a minimum.		29.1
1.75	3	The team, patients and carers are involved in identifying priority audit topics in line with national and local priorities and patient feedback.		29.2
1.76	2	When staff members undertake audits they: - agree and implement action plans in response to audit reports; - disseminate information (audit findings, action plan); - complete the audit cycle.		29.3
1.77	2	Key information generated from service evaluations and key measure summary reports (e.g. reports on length of stay) are disseminated in a form that is accessible to all.		29.4
		Smoking		
1.78	1	There is support for staff and patients to assist with the smoking policy, including: - 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/organisation's policy, and monitor levels of comprehension; - advice about the potential effects of smoking cessation on serum Clozapine levels and appropriate monitoring.		-
1.79	1	Where smoking is permitted, there is a safe allocated area for this purpose, away from non-smokers.		19.40

Section 2

Timely and Purposeful Admission

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NUMBER	TYPE	STANDARD	BSI NUMBER
2.1	1	Clear information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on: - a simple description of the ward/unit and its purpose; - admission criteria; - clinical pathways describing access and discharge; - main interventions and treatments available; - contact details for the ward/unit and hospital.	1.1
2.2	1	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. *Guidance: For carers, this includes confidentiality in relation to third party information.*	18.1
2.3	1	The patient's consent to the sharing of clinical information outside the clinical team is recorded. If this is not obtained the reasons for this are recorded.	18.3
2.4	2	There are protocols for transfer or shared care between learning disability and generic mental health services.	-
Control of Bed Occupancy			
2.5	1	Senior clinical staff members make decisions about patient admission or transfer. They can refuse to accept patients if they fear that the mix will compromise safety and/or therapeutic activity. *Guidance: Senior clinical staff members include the Ward/unit* *Manager or nurse in charge.*	2.1
2.6	1	There is a clear process in place for handling situations where agreed bed occupancy levels need to be exceeded.	2.2
Referrals			
2.7	1	The aims of admission are agreed among the referring team, the ward/unit team and the patient and carers.	-
On or Before Admission			
2.8	1	There is an identified and documented contact or link person for each agency involved with each patient.	-
2.9	2	Information on previous care planning and interventions are sourced by the ward/unit staff/team within one working day of admission.	-

2.10	2	All community assessment documentation is available to the admitting team when the patient arrives on the ward/unit, including mental health and current risk assessments and stated purpose of admission.	-
		Admission Process	
2.11	1	On admission to the ward/unit staff members introduce themselves and other patients.	3.2
2.12	1	On admission to the ward/unit, or when the patient is well enough, staff members show the patient around.	3.3
2.13	1	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them.	17.4
2.14	2	The patient is given an age appropriate 'welcome pack' or introductory information that contains the following: - a clear description of the aims of the ward/unit; - the current programme and modes of treatment; - the ward/unit team membership; - personal safety on the ward/unit; - the code of conduct on the ward/unit; - ward/unit facilities and the layout of the ward/unit; - what practical items can and cannot be brought in; - clear guidance on the smoking policy in smoke-free hospitals and how to access smoking breaks off the hospital grounds; - resources to meet spiritual, cultural and gender needs.	4.1
2.15	2	Staff members explain the main points of the welcome pack to the patient and ask if they need further information on anything explained.	4.2
2.16	1	Staff members explain the purpose of the admission to the patient.	4.3
2.17	1	Patients are given verbal and written information on: - their rights regarding consent to care and treatment; - how to access advocacy services; - how to access a second opinion; - how to access interpreting services; - how to raise concerns, complaints and compliments; - how to access their own health records.	4.6
2.18	1	Detained patients are given verbal and written information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes.	4.5

2.19	1	Where a patient is being admitted directly from the community, the admitting nurse checks that the referring agency gives clear details on and management plans for: - the security of the patient's home; - arrangements for dependents (children, people they are caring for); - arrangements for pets.	4.7
2.20	1	Staff members address patients using the name and title they prefer.	3.1
2.21	1	Staff members are easily identifiable (for example, by wearing appropriate identification).	3.4
2.22	1	The patient's carer is contacted by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details.	4.4
2.23	1	All patients have a documented diagnosis and a clinical formulation. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.*	5.1
Capacity and Consent			
2.24	1	When patients lack capacity to consent to interventions, decisions are made in their best interests.	13.3
2.25	1	There are systems in place to ensure that the ward/unit takes account of any advance directives that the patient has made.	13.4
Initial Assessment			
2.26	1	Patients have a comprehensive assessment which is started within four hours and completed within one week. This involves the multi-disciplinary team and includes patients': - mental health and medication; - psychosocial needs; - strengths and weaknesses.	4.8

2.27	1	Patients have a comprehensive physical health review. This is started within four hours of admission and is completed within one week, or prior to discharge. It includes: First four hours: - details of past medical history; - current medication, including side effects and compliance (information is sought from the patient history and collateral information within the first four hours. Further details can be sought from medical reconciliation after this); - physical observations including blood pressure, heart rate and respiratory rate. First 24 hours: - physical examination; - height, weight; - blood tests (can use recent blood tests if appropriate); - ECG. First one week: - details of past family medical history; - a review of physical health symptoms and a targeted systems review; - lifestyle factors, e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.	4.9
2.28	1	Patients are offered a staff member of the same gender as them, and/or a chaperone of the same gender, for physical examinations.	4.10
2.29	1	Patients 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.*	9.1.1
2.30	1	Where the patient is found to have a physical condition which may increase their risk of collapse or injury during restraint this is: - clearly documented in their records; - regularly reviewed; - communicated to all MDT members; - evaluated with them and, where appropriate, their carer/advocate.	-
2.31	1	Patients have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and includes a comprehensive assessment of: - risk to self; - risk to others; - risk from others; - public protection and safeguarding issues.	4.12

2.32	1	Patients have an assessment of their capacity to consent to admission, care and treatment within 24 hours of admission.	13.2
2.33	1	Patients are informed of the outcome of their physical health assessment and this is recorded in their notes. *Guidance: With patient consent, this can be shared with their carer.*	4.11

		Care Planning		

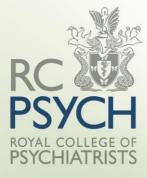| 2.34	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	5.2
2.35	1	Every patient has a written care plan, reflecting their individual needs. *Guidance: This clearly outlines:* *- agreed intervention strategies for physical and mental health;* *- measurable goals and outcomes;* *- strategies for self-management;* *- any advance directives or stated wishes that the patient has made;* *- crisis and contingency plans;* *- review dates and discharge framework.*	6.9
2.36	1	The practitioner develops the care plan collaboratively with the patient and their carer (with patient consent).	6.10
2.37	2	Care plans give consideration to the monitoring of sleep duration and quality, the enhancement of sleep (including via sleep hygiene) and the minimisation of night-time sedative drugs (for patients prescribed regular or as-required night-time sedation).	-
2.38	2	The team has the capacity to offer service users a psychological assessment and formulation delivered by a psychologist, based on clinical need.	-
2.39	1	The patient and their carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.	6.12
2.40	1	The ward/unit organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: - assessment; - care and treatment (particularly relating to prescribing psychotropic medication); - referral to a specialist perinatal team/unit unless there is a specific reason not to do so.	9.1.6

		Management of Risk	
2.41	1	The team discusses the purpose and outcome of the risk assessment with each patient and a management plan is formulated jointly.	4.13
2.42	1	If a patient is identified as at risk of absconding, the team completes a crisis plan, which includes clear instructions for alerting and communicating with carers, people at risk and the relevant authorities.	10.3
		Carers	
2.43	1	The patient's main carer is identified and contact details are recorded.	-
2.44	1	Carers are involved in discussions about the patient's care treatment and discharge planning.	15.1
2.45	1	Carers are advised on how to access a statutory carer's assessment, provided by an appropriate agency.	15.2
2.46	2	Staff members make contact with carers to arrange an appropriate time to discuss the carer's own needs, concerns and family history within 48 hours of the patient's admission.	15.3
2.47	2	The team provides each carer with a carer's information pack. *Guidance: This includes the names and contact details of key staff members on the unit. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	15.4
2.48	2	Carers have access to a carer support network or group. This could be provided by the ward/unit or the team could signpost carers to an existing network. *Guidance: This could be a group/network which meets face-to-face or communicates electronically.*	15.5
2.49	1	The team follows a protocol for responding to carers when the patient does not consent to their involvement.	15.6
2.50	2	The ward/unit has a designated staff member dedicated to carer support (carer lead).	15.7
		Continuous Assessment	
2.51	2	If needs are identified that cannot be met by the ward/unit team, then a referral is made to a service that can. The referral is made within a specified time period after identifying the need, and the date of the referral is recorded in the patient's notes.	-

2.52	1	Capacity assessments are performed in accordance with current legislation.	13.1
2.53	1	There is a standardised process for the assessment of mental capacity, using a formal document/standardised assessment tool.	-
		Interface with Other Services	
2.54	1	There are joint working protocols/care pathways in place to support patients in accessing the following services: - accident and emergency; - social services; - local and specialist mental health services e.g. liaison, eating disorders, rehabilitation; - secondary physical healthcare.	12.1
2.55	1	The team follows a joint working protocol/care pathway with primary health care teams. *Guidance: This includes the team informing the patient's GP of any significant changes in the patient's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP.*	12.2
2.56	1	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution team in ward/units/units that have access to one. *Guidance: This includes the team inviting the Home Treatment Team to attend ward/unit rounds, to screen for early discharge, to undertake joint acute care reviews and to jointly arrange supported leave.*	12.3
2.57	1	The team supports patients to access organisations which offer: - housing support; - support with finances, benefits and debt management. *Guidance: Housing advice and/or support is given to patients prior to discharge.*	12.4
		Reviews	
2.58	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.	21.1

2.59	1	Managers and practitioners have agreed minimum frequencies of clinical review meetings that comply with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	6.1
2.60	2	The ward/unit has agreed standards for reviews.	-
2.61	1	Patients are facilitated and supported to prepare for any formal review of their care.	6.2
2.62	2	Patients are supported to lead their own care review.	6.3
2.63	1	There is a documented admission meeting within one week of the patient's admission. *Guidance: This could take the form of a ward/unit around meeting* *or a Care Programme Approach (CPA) meeting (or equivalent).*	6.4
2.64	2	Patients are made aware of the standards for reviews.	-
2.65	1	Full MDT clinical review meetings occur once a week.	-
2.66	1	Multi-disciplinary team (MDT) members introduce themselves to the patient and carer at every MDT review where they are present.	6.5
2.67	1	Patients and carers are able to contribute and express their views during reviews.	6.6
2.68	2	A CMHT/crisis team representative is invited to the first review.	-
2.69	1	Actions from reviews are fed back to the patient (and carer, with the patient's consent) and this is documented.	6.7
2.70	2	Patients are able to meet their consultant outside of reviews.	-
2.71	1	Risk assessments and management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	6.8
2.72	1	The team reviews and updates care plans according to clinical need or at a minimum frequency that complies with College Centre for Quality Improvement specialist standards.	6.11

		Leave	
2.73	1	The team develops a leave plan jointly with the patient 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. *Guidance: If there are concerns about a patient's cognition, the risk assessment includes consideration of whether the patient may be driving/using heavy machinery etc. and there is a plan in place to manage this.*	7.1
2.74	1	Staff members follow a lone working policy and feel safe when escorting patients on leave.	7.2
2.75	1	Patients are sent on leave into the care of carers only with carer agreement and timely contact with them beforehand.	7.3
2.76	1	The team follows a protocol for managing situations where patients are absent without leave.	7.4
		Discharge Planning	
2.77	2	Discharge planning is initiated at the first multi-disciplinary team review and a provisional discharge date is set.	11.1
2.78	2	Managers and practitioners have agreed standards for transfer/discharge planning.	-
2.79	1	Patients and their carer (with patient consent) are invited to a discharge meeting and are involved in decisions about discharge plans.	11.2
2.80	1	A letter setting out a clear discharge plan, which the patient takes home with them, is sent to all relevant parties before or on the day of discharge. The plan includes details of: - care in the community/aftercare arrangements; - crisis and contingency arrangements including details of who to contact; - medication; - details of when, where and who will follow up with the patient.	11.3
2.81	1	The team follows a protocol to manage informal patients who discharge themselves against medical advice. This includes: - recording the patient's capacity to understand the risks of self-discharge; - putting a crisis plan in place; - contacting relevant agencies to notify them of the discharge.	11.4

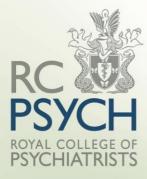| 2.82	2	The inpatient team invites a community team representative to attend and contribute to ward/unit rounds and discharge planning.	11.5
2.83	1	The ward/unit has a referral process for outpatient psychology, CMHT-based or otherwise.	
2.84	1	The team makes sure that patients who are discharged from hospital to the care of the community team have arrangements in place to be followed up within one week of discharge, or within 48 hours of discharge if they are at risk. *Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.*	11.6
2.85	1	When patients are transferred between ward/units/units there is a handover which ensures that the new team have an up to date care plan and risk assessment.	11.7
2.86	2	Where there are delayed transfers/discharges: - the team can easily raise concerns about delays to senior management; - local information systems produce accurate and reliable data about delays; - action is taken to address any identified problems.	11.8

Section 3

Safety

AIMS

ACCREDITATION FOR INPATIENT
MENTAL HEALTH SERVICES

NUMBER	TYPE	STANDARD	BSI NUMBER
3.1	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*	19.18
3.2	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency. *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor.*	9.1.3
		Observation	
3.3	1	There is a policy on patient safety and the use of therapeutic interventions and observation that includes: - 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 daily); - how the patient's 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.	-
3.4	1	Patients are informed about the level of observation that they are under, how it is instigated, the review process and how their own patient perspectives are taken into account?	10.2
3.5	2	Within 72 hours of the patient's admission, the frequency of night-time observations are discussed in an MDT meeting, in collaboration with the patient, and reassessed at least weekly.	-
		Management of Violence	
3.6	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.	22.5
3.7	1	Staff members follow a protocol when conducting searches of patients and their personal property.	19.17
3.8	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	30.1

3.9	1	The team effectively manages patient violence and aggression. *Guidance:* *1) Staff members do not deliberately restrain patients in a way that affects their airway, breathing or circulation.* *2) Restrictive intervention always represents the least restrictive option to meet the immediate need.* *3) Individualised support plans, incorporating behaviour support plans, are implemented for all patients who are known to be at risk of being exposed to restrictive interventions.* *4) The team does not use seclusion or segregation other than for patients detained under the Mental Health Act (or equivalent).* *5) The team works to reduce the amount of restrictive practice used.* *6) Providers report on the use of restrictive interventions to service commissioners, who monitor and act in the event of concerns.*	10.4
3.10	1	Staff members do not restrain patients in a way that affects their airway, breathing or circulation.	-
3.11	1	Individualised support plans, incorporating behaviour support plans, are implemented for all patients who are known to be at risk of being exposed to restrictive interventions. *Guidance: The support plans are developed using functional analyses/applied behaviour analyses to understand, manage and prevent incidents.*	-
3.12	1	The team does not use seclusion or segregation other than for patients detained under the Mental Health Act (or equivalent) or unless in an emergency as a last resort. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act is undertaken immediately.	-
3.13	1	Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs monitored by staff members and any deterioration is responded to.	-
3.14	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team spends time with the patient reflecting on why this was necessary. The patient's views are sought and they are offered the opportunity to document this in their care record along with any disagreement with healthcare professionals.	10.5

3.15	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team makes sure that other patients on the ward/unit who are distressed by these events are offered support and time to discuss their experiences.	10.6
3.16	1	The team audits the use of restrictive practice, including face-down restraint.	10.7
3.17	1	A collective response to alarm calls and fire drills is agreed by the team before incidents occur. This is rehearsed at least six-monthly.	19.24
3.18	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.	-
3.19	1	Staff members know how often patients are restrained and how this compares to benchmarks, e.g. by participating in multi-centre audits or by referring to their previous year's data.	10.8

Management of Alcohol and Illegal Drugs

3.20	1	The ward/unit has a policy for the care of patients with dual diagnosis that includes: - liaison and shared protocols between mental health and substance misuse services to enable joint working; - drug/alcohol screening to support decisions about care/treatment options; - liaison between mental health, statutory and voluntary agencies; - staff training; - access to evidence-based treatments; - considering the impact on other patients of adverse behaviours due to alcohol/drug abuse.	9.1.5
3.21	2	Ward/unit managers and senior managers promote positive risk-taking to encourage patient recovery and personal development.	20.5

Section 4

Environment and Facilities

NUMBER	TYPE	STANDARD	BSI NUMBER
4.1	2	The ward/unit entrance and key clinical areas are clearly signposted.	19.1
4.2	2	All patients have single bedrooms.	19.3
4.3	2	The ward/unit has at least one bathroom/shower room for every three patients.	19.5
4.4	3	Every patient has an en-suite bathroom.	19.6
4.5	3	All patients can access a charge point for electronic devices such as mobile phones.	19.10
4.6	1	There is a visiting policy which includes procedures to follow for specific groups including: - children; - unwanted visitors (i.e. those who pose a threat to patients, or to staff members).	19.16
4.7	2	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/ treatment, patient records, clinical outcome and service performance measurements.	19.27
4.8	2	There are facilities for patients to make their own hot and cold drinks and snacks.	19.37
4.9	1	Hot drinks are available to patients 24 hours a day upon request. Any restrictions are individually care planned and not implemented as a blanket rule.	-
4.10	3	Patients are consulted about changes to the ward/unit environment.	19.42
Environmental Safety			
4.11	1	There are clear lines of sight to enable staff members to view patients. *Guidance: Measures to address blind spots can include mirrors, CCTV, increased staffing in areas without clear lines of sight.*	19.19
4.12	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery.	19.20
4.13	1	Facilities ensure routes of safe entry to and exit from the ward/unit in the event of an emergency related to disturbed/violent behaviour.	-

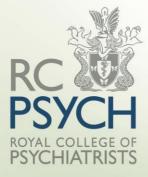|			
4.14	2	There is secure, lockable access to a patient's room, with external staff override.	-
4.15	1	Furniture is arranged so that alarms can be reached and doors are not obstructed.	19.21
Alarm Systems			
4.16	1	There is an alarm system in place (e.g. panic buttons) and this is easily accessible to staff.	19.22
4.17	2	Alarm systems/call buttons/personal alarms are available to patients and visitors, and instructions are given for their use.	19.23
4.18	2	Alarm systems/call buttons/personal alarms are checked and serviced regularly, as per local policy and manufacturer recommendation.	-
Medical Equipment			
4.19	1	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within three minutes.	19.28
4.20	1	The crash bag is maintained and checked at least weekly, and after each use.	19.29
4.21	2	The ward/unit has a designated room for physical examination and minor medical procedures.	19.30
Confidentiality			
4.22	1	All patient information is kept in accordance with current legislation. *Guidance: 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.*	18.2
4.23	2	In spaces where personal and confidential discussions are held, such as interview rooms and consulting/examination/treatment spaces, conversations cannot be heard outside of the room.	-
Seclusion			
4.24	1	There is a clear written policy on the use of seclusion, which complies with the MHA and NICE CG25.	-
4.25	1	In ward/units/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;	19.31

		- it has direct access to toilet/washing facilities; - it is safe and secure – it does not contain anything that could be potentially harmful; - it includes a means of two-way communication with the team; - it has a clock that patients can see.	
		Use of Rooms and Space	
4.26	1	All fixtures, fittings and equipment are in a good state of repair.	-
4.27	1	All rooms, including bathrooms, are kept clean. *Guidance: All staff members are encouraged to help with this.*	19.25
4.28	2	Areas which need to be quiet are located as far away as possible from any sources of unavoidable noise.	-
4.29	2	There is at least one room for interviewing and meeting with individual patients and relatives, which is furnished with comfortable seating.	-
4.30	2	The ward/unit is managed to allow optimum use of available space and rooms.	-
4.31	2	There is a designated space for patients to receive visits from children, with appropriate facilities such as toys, books.	19.33
4.32	2	A separate area is made available to receive patients with police escorts (this may be a designated 136 suite off the ward/unit if available).	-
4.33	2	There is a designated area or room (de-escalation space) that the team may consider using, with the patient's agreement, specifically for the purpose of reducing arousal and/or agitation. *Guidance: This area is in addition to the seclusion room, and may be the patient's own room if they are the sole occupier.*	19.34
4.34	2	The ward/unit environment is sufficiently flexible to allow for specific individual needs in relation to gender. (N/A for single-sex ward/units.)	-
4.35	2	The ward/unit environment is sufficiently flexible to allow for specific individual needs in relation to ethnicity.	-
4.36	1	The environment complies with current legislation (Equality Act 2010) on disabled access. *Guidance: Relevant assistive technology equipment, such as*	19.11

		hoists and handrails, are provided to meet individual needs and to maximise independence.	
4.37	1	Male and female patients (self-defined by the patient) have separate bedrooms, toilets and washing facilities. *Guidance: Male patients should not have to pass through female areas to access the bathrooms or their bed space, and vice versa.*	19.2
4.38	2	The ward/unit has at least one quiet room other than patient bedrooms.	19.32
4.39	2	There are lounge areas that may become single-sex areas as required.	19.35
4.40	2	Social spaces are located to provide views into external areas.	-
4.41	2	Patients are able to personalise their bedroom spaces.	19.4
Catering			
4.42	2	The dining area is big enough to allow patients to eat in comfort and to encourage social interaction, including the ability for staff to engage with and observe patients during mealtimes.	-
4.43	1	The ward/unit has a designated dining area, which is reserved for dining only during allocated mealtimes.	19.36
4.44	1	Water and soft drinks are available to patients 24 hours a day.	-
4.45	2	Staff members ask patients for feedback about the food and this is acted upon.	19.39
4.46	2	Healthy meals or snacks are available outside of mealtimes.	-
4.47	1	Patients 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.	19.38
Dignity			
4.48	2	All patients have access to lockable storage, which may include their own individual rooms or access to a safe on the ward/unit.	-
4.49	2	There is access to the day room at night for patients who cannot sleep.	-

4.50	1	Patients can access resources that enable them to meet their individual self-care needs, including ethnic- and gender-specific requirements.	-
4.51	1	Patients can wash and use the toilet in private.	19.12
4.52	1	Patients with poor personal hygiene have a care plan that reflects their personal care needs. *Guidance: This could include encouragement to have regular showers and to shave, referral to a dentist for oral dentition, referral to a podiatrist for foot care.*	9.1.4
4.53	1	Staff members respect the patient's personal space, e.g. by knocking and waiting before entering their bedroom.	19.13
4.54	1	Patients can make and receive telephone calls in private, subject to appropriate risk assessment.	19.14
4.55	1	Staff members follow a policy on managing patients' use of cameras, mobile phones and other electronic equipment, to support the privacy and dignity of all patients on the ward/unit.	19.15
4.56	1	Laundry facilities are available to all patients.	19.7
4.57	1	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room.	19.8
4.58	2	Patients have access to the following within or near to the ward/unit/hospital site: - physical activity and exercise; - musical activities and equipment; - multi-faith prayer/worship room; - banking facilities; - library facilities; - basic shop (with escorts for shop visits if required); - internet access; - access to a private telephone.	-
		Patient Comfort	
4.59	2	Staff members and patients can control heating, ventilation and light.	19.26
4.60	2	There is an alternative (such as nightlights) to bright fluorescent lighting in bedrooms, providing different levels of lighting which both patients and staff can control.	-

4.61	1	The design of windows considers safety and patient comfort and is consistent with Health Building Notes.	-
		Provision of Information	
4.62	1	The ward/unit actively supports staff health and well-being. *Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	27.1
4.63	2	Information leaflets about relevant mental health problems and treatments are available. These are also available in different formats and languages when required.	U44.2
4.64	2	Information is available for staff and patients/carers about mental health and local public and voluntary sector services that are available which include: - services and expected waiting times; - facilities; - advocacy services; - local support/advice organisations for patients and carers; - health promotion.	U44.3
4.65	2	Information is up-to-date and regularly supplied to all relevant service areas in sufficient quantity.	-
4.66	1	Patients and carers are offered written and verbal information about the patient's mental illness. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward/unit around or in a psychoeducation group.*	8.1.10
4.67	1	The ward/unit has access to interpreters and the patient's relatives are not used in this role unless there are exceptional circumstances. *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.*	17.2
4.68	2	The ward/unit uses interpreters who are sufficiently knowledgeable to provide a full and accurate translation.	17.3
		Activity Equipment	
4.69	2	All patients 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,*	19.9

		computers and internet access (where risk assessment allows this).	
		Outside Space	
4.70	1	Patients are able to leave the ward/unit to access safe outdoor space every day.	8.1.13
4.71	2	Where smoking is permitted, there is a safe allocated area for this purpose, away from non-smokers.	19.40
		Staff Facilities	
4.72	2	Ward/unit-based staff members have access to a dedicated staff room.	19.41
4.73	2	All staff have access to a locker or locked area to store personal belongings.	-

Section 5

Therapies and Activities

NUMBER	TYPE	STANDARD	BSI NUMBER
		Medication	
5.1	1	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.	-
5.2	1	Patients are offered evidence-based pharmacological and psychological interventions and any exceptions are documented in the case notes. *Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base.*	8.1.1
5.3	1	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.	8.1.2
5.4	1	Patients have access to occupational therapy.	8.1.3
5.5	2	Patients have access to art/creative therapies.	8.1.4
5.6	1	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment.	8.1.16
5.7	1	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded.	8.2.1
5.8	1	Patients and their carers (with patient consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications and to self-manage as far as possible.	8.2.2
5.9	1	Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	8.2.3
5.10	2	Patients have access to a specialised pharmacist and/or pharmacy technician to discuss medications.	8.2.8
5.11	3	Carers have access to a specialised pharmacist and/or pharmacy technician to discuss medications.	8.2.9
5.12	1	When patients experience side effects from their medication, this is engaged with and there is a clear care plan in place for managing this.	8.2.4

5.13	1	The team follows a policy when prescribing PRN (i.e. as required) medication.	8.2.5
5.14	1	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	8.2.7
5.15	1	The safe use of high-risk medication is audited, at least annually and at a service level. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines.*	8.2.10
5.16	1	The team gives targeted lifestyle advice and provides health promotion activities for patients. This includes: - smoking cessation advice; - healthy eating advice; - physical exercise advice and opportunities to exercise.	9.1.2
5.17	1	Long-stay patients who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at three months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the patient: - a personal/family history (at baseline and annual review); - lifestyle review (at every review); - weight (every week for the first six weeks); - waist circumference (at baseline and annual review); - blood pressure (at every review); - plasma glucose/ HbA1c (glycated haemoglobin) (at every review); - lipid profile (at every review).	9.2.1
5.18	1	For patients who have not successfully reached their physical health targets after three months of following lifestyle advice, the team discusses a pharmacological intervention and recommends it to them. This is documented in the patient's notes. *Guidance: This is done in collaboration with other practitioners (e.g. a dietitian) and according to NICE guidelines.*	9.2.2
Engagement			
5.19	1	Every patient is engaged in active conversation at least twice a day by a staff member. *Guidance: This is an opportunity for patients to discuss any issues or difficulties they are experiencing.*	8.1.8
5.20	2	Each patient receives a pre-arranged one-hour session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.	8.1.9

5.21	1	Patients are treated with compassion, dignity and respect. *Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.*	16.1
5.22	1	Patients feel listened to and understood in consultations with staff members.	16.2
Staffing			
5.23	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.	-
5.24	1	Patients have access to staff trained and supervised to deliver psychological interventions for at least one half-day (four hours) per week per ward/unit.	-
5.25	2	Patients have access to staff trained and supervised to deliver psychological interventions for more than one day per week per ward/unit.	-
5.26	3	Patients have access to complementary therapies, in accordance with local policy and procedures.	8.1.5
5.27	2	Staff are given planned and protected time to ensure activities and interventions are provided regularly and routinely.	-
5.28	2	Healthcare assistants, occupational therapy support workers, volunteers and activity workers are involved in facilitating a broad range of therapeutic and leisure activities both on and off the ward/unit.	-
Therapeutic Milieu			
5.29	2	There is a weekly minuted community meeting that is attended by patients and staff members. *Guidance: This is an opportunity for patients to share experiences, to highlight issues 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.*	8.1.11
5.30	3	The therapeutic value of positive relationships is recognised, and these are promoted both on and off the ward/unit.	-
5.31	3	Staff recognise that all behaviour is a form of communication.	-

5.32	3	There are opportunities for staff and patients to engage in spontaneous activities together.	-
5.33	3	Both staff and patients are involved in making decisions about and maintaining the physical environment.	-
5.34	3	Engagement and purposeful activity is actively encouraged.	-
5.35	3	Staff and patients are supported to ask questions and challenge decisions about care.	-
5.36	3	There are forums to promote peer-support for both staff and patients.	-
Provision of Therapies and Activities			
5.37	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	8.1.15
5.38	2	Systems are in place to regularly review with patients and staff the quality and provision of therapeutic and social activities.	-
5.39	2	The frequency, regularity and diversity of activities is monitored.	-
5.40	2	All patients are offered specific psychosocial interventions appropriate to their presenting needs and in accordance with national standards (i.e. NICE).	-
5.41	1	At least one staff member linked to the ward/unit is delivering one basic, low-intensity psychological intervention (e.g. anxiety management).	-
5.42	2	At least one staff member linked to the ward/unit (e.g. clinical psychologist or occupational therapist) is delivering one problem-specific, high-intensity psychological intervention.	-
5.43	3	At least one staff member linked to the ward/unit (e.g. clinical psychologist or psychotherapist) is delivering two or more problem-specific, high-intensity psychological interventions (to correspond to two or more diagnostic criteria as per NICE guidance).	-

5.44	1	Activities are provided seven days a week and out-of-hours. *Guidance: Activities which are provided during working hours, Monday- Friday, are timetabled. The provision of activities could involve voluntary sector, peer-support workers etc. rather than employed staff.*	8.1.6
5.45	2	Gender-sensitive groups are provided.	-
Group Therapies and Activities			
5.46	2	Group activities are protected and not interrupted.	-
5.47	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.	-
5.48	2	Every patient has the opportunity to create a personalised timetable of meaningful activities to promote social inclusion, which the team encourages them to engage with. *Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*	8.1.7
5.49	2	Patients are able to access regular group meetings that have a psychoeducational focus either on or off the ward/unit. *Guidance: e.g. relapse prevention, smoking cessation, awareness on drug and alcohol use.*	-
5.50	3	Carers are able to access regular group meetings that have a psychoeducational focus.	-
5.51	3	The ward/unit recruits former patients as volunteers, and current or former patients facilitate recovery and other groups.	-
External Therapies and Activities			
5.52	2	Patients are able to leave the ward/unit to attend activities elsewhere in the building and, with appropriate supports and escorts.	-
5.53	2	The team provides information, signposting and encouragement to patients to: - voluntary organisations; - community centres; - local religious/cultural groups; - peer support networks; - recovery colleges.	8.1.14
5.54	3	Patients have access to weekly inreach/outreach visits to community centres promoting recovery and social inclusion.	-

		Outcome Measures	
5.55	1	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	28.1
5.56	2	Clinical outcome monitoring includes reviewing patient progress against patient-defined goals in collaboration with the patient.	28.2
5.57	2	Outcome data is used as part of service management and development, staff supervision and caseload feedback. *Guidance: This should be undertaken every six months as a minimum.*	28.3

AIMS-WA Standards Feedback Form

We hope that you have found the AIMS-WA standards useful and would very much appreciate your feedback. Your comments will be incorporated, with the approval of the AIMS-WA Reference Group, into future editions of this publication.

1.	Have you found these standards useful? 	☐	Yes	☐	No

Comments:

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2.	Do you have suggestions for new sections or topic areas you would like to see included in future versions?

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3.	Do you have suggestions for new standards or criteria you would like to see included in future versions?

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4.	Do you have any general suggestions about this document that would improve its usefulness?

_____

_____

5.	What is your profession?

_____

Thank you for taking the time to complete this form. Your comments will be considered carefully. Please return to: AIMS-WA, Royal College of Psychiatrists' Centre for Quality Improvement, 21 Prescot Street, London, E1 8BB. Fax: 020 3701 2761

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