‘Recovery Road’ – MR, CAMHS Service User

QNIC Standards (with deaf specialist subset)
10th Edition

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Section 1: Environment and Facilities

Number	Type	Standard			
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*			
1.1.3	**2**	Waiting rooms/areas are provided			
1.1.4	**2**	There is indoor space for recreation which is large enough to accommodate all young people			
1.1.5	**1**	There is a designated safe outdoor space which young people are able to access every day, where clinically appropriate			
1.1.6	**2**	The ward/unit contains rooms for individual and group meetings			
1.1.7	**1**	The ward/unit has a designated dining area, which is			

		available during allocated mealtimes			
1.1.8 [DEAF]	**1**	Meal areas allow young people to communicate with each other and staff (round tables, good lighting)			
1.1.9	**2**	There is designated teaching space for education which can accommodate all young people in the unit			
1.1.10	**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; • It includes a means of two-way communication with the team; • It has a clock that patients can see			
1.1.11	**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.*			

1.1.12 [DEAF]	**2**	One computer is provided for every young person in and out of school			
1.1.13	**1**	Young people can 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.*			
1.1.14 [DEAF]	**1**	Young people have access to the internet for recreational purpose. This must include: • Access to videoconferencing • Robust safeguarding tech			
1.1.15	**3**	All young people can access a charge point for electronic devices such as mobile phones (where risk permits)			
1.1.16	**2**	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 options, young people's records, clinical outcome and service performance measurements			
1.1.17	**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)			
1.1.18	**2**	Parents/carers have access to refreshments at the unit			
1.1.19	**2**	Units can provide information for families about local accommodation			
1.1.20	**2**	Ward/unit-based staff members have access to a dedicated staff room			
1.1.21 [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			
1.1.22 [DEAF]	**2**	Television has subtitles available which are used and staff are aware of programmes with BSL interpretation and make these available.			
1.2	**The ward/unit is separate from adult units**				
1.2.1	**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; a safeguarding policy is in place to allow safe access to wider grounds within the ward/unit			
1.3	**Premises are designed and managed so that young people's rights, privacy and dignity are respected**				
1.3.1	**1**	All young people's information 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.			
1.3.2	**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.*			
1.3.3	**2**	All young people have single bedrooms			
1.3.4	**1**	Young people have separate toilets, washing facilities and bedrooms, split according to self-identified gender			
1.3.5	**2**	The unit has at least one bathroom/shower room for every three young people			
1.3.6	**3**	Every young person has an en-suite bathroom			
1.3.7	**2**	There is a separable gender-specific communal space which can be used as required			
1.3.8	**1**	The ward/ unit has a designated room for physical examination and minor medical procedures			
1.3.9	**2**	The ward/ unit has at least one quiet room or de-escalation space other than young people's bedrooms			

1.3.10	**2**	There is a designated space for young people to receive visitors who are children, with appropriate facilities such as toys and/or books			
1.3.11	**2**	There is a safe place for young people to keep their property			
1.3.12	**2**	There is a safe place for staff to keep their property			
1.3.13	**1**	Young people are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room, access to groups			
1.3.14	**1**	Staff members respect the young people's personal space, where risk permits, e.g. by knocking and waiting before entering their bedroom			
1.3.15 [DEAF]	**1**	Measures are in place to allow confidential conversations in a signed language such as British Sign Language (BSL).			
1.4	**The unit provides a safe environment for staff and young people**				
1.4.1	**1**	The team keeps medications in a secure place, in line with the organisation's medicine management policy			
1.4.2	**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			
1.4.3	**1**	An audit of environmental risk is conducted annually			

		and a risk management strategy is agreed *Guidance: This includes a ligature risk assessment.*			
1.4.4	**1**	Young people are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery			
1.5	**Young people are consulted about the unit environment and have choice when this is appropriate**				
1.5.1	**2**	Young people are consulted about changes to the ward/unit environment			
1.5.2	**2**	Young people can personalise their bedrooms *Guidance: For example, by putting up photos and pictures.*			
1.6	**There is equipment and procedures for dealing with emergencies in the unit**				
1.6.1	**1**	A collective response to fire drills is agreed by the team and is rehearsed six-monthly			
1.6.2	**1**	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly and after each use			
1.6.3	**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			

1.6.4 [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			
1.6.5 [DEAF]	**1**	All areas within the unit contain visual alarms or other systems alerting deaf staff and young people to fire			

Section 2: Staffing and Training

Number	Type	Standard			
2.1	**The number of nursing staff on the unit is sufficient to safety meet the needs of the young people at all times**				
2.1.1 [DEAF]	**1**	There are sufficient levels of staffing which can be adapted to reflect the acuity levels of the ward *Guidance: There is a minimum ward staff to patient ratio of 1:1 to 3:1 for the most highly disturbed cases*			
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 these 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			
2.1.5 [DEAF]	**3**	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			
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	**2**	A typical unit with 12 beds includes at least 1.5 WTE responsible clinician input, at least 0.5 WTE of which should be provided by an approved consultant psychiatrist. The remaining 1 WTE may be completed by a range of professions from within the senior MDT			
2.2.5	**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.*			
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 12 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 (e.g. 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 [DEAF]	**1**	The unit includes at least 0.5 WTE input from a language therapist			
2.2.11	**2**	There is dedicated sessional input from creative therapists			
2.2.12	**1**	A typical unit with 12 beds includes at least 0.5 WTE family therapist			
2.2.13 [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.*			
2.2.14 [DEAF]	**3**	Young people have access to specialist teachers for the deaf who teach alongside specialist teachers when needed			
2.2.15	**2**	A typical unit with 12 beds includes 1 WTE administrator (band 3 or above or local equivalent)			
2.2.16	**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			
2.2.17 [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)			
2.2.18	**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			
2.3	**Unit staff work effectively as a multi-disciplinary team**				
2.3.1	**1**	There are written documents that specify professional, organisational and line management responsibilities			
2.3.2	**1**	In a typical 12-bedded unit, there is time scheduled in staff rotas to allow 30-minute handover sessions between shifts to discuss the young people's needs, risks and management plans			
2.3.3	**1**	The team has integrated records for young people which can be accessed by all clinical staff			
2.3.4	**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			

2.3.5	**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.*			
2.3.6	**2**	The team has protected time for team-building and discussing service development at least once a year			
2.3.7	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive *Guidance: Staff 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.*			
2.3.8 [DEAF]	**1**	All deaf staff are referred for an Access to Work (ATW) assessment to ensure appropriate support in terms of communication and equipment			
2.3.9 [DEAF]	**3**	The service offers the opportunity for placements to deaf trainees and students from various disciplines			
2.4	**Training is provided for all staff**				
2.4.1	**2**	All qualified staff receive at least five days training			

		and continuing professional development activities per year in line with their professional body, in addition to mandatory training			
2.4.2 [DEAF]	**1**	Training is provided for all staff that is accessible and tailored for deaf and hearing staff			
2.5	**Staff are provided with a thorough training programme including:**				
2.5.1		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:			
2.5.1a	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent);			
2.5.1b	**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.*			
2.5.1c	**1**	Safeguarding vulnerable adults and children; *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*			
2.5.1d	**1**	Risk assessment and risk management; *Guidance: This includes assessing and managing*			

		suicide risk and self-harm, and prevention and management of aggression and violence.			
2.5.1e	**1**	Recognising and communicating with young people with cognitive impairment or learning disabilities;			
2.5.1f	**1**	Statutory and mandatory training; *Guidance: This includes equality and diversity, information governance, and basic life support.*			
2.5.1g	**2**	Parent/carer awareness, family inclusive practice and social systems, including parents/carers' rights in relation to confidentiality			
2.5.2 [DEAF]	**1**	Managing relationships and boundaries between young people and staff, including appropriate touch within the cultural norms of the deaf community			
2.5.3 [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.*			
2.5.4	**1**	All staff undergo specific training in 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			
2.5.5	**1**	All qualified nursing and medical staff that administer rapid tranquillisation have completed Intermediate Life Support training			
2.5.6	**1**	All staff members who administer medications have been assessed as competent to do so. Assessment is done using a competency-based tool and is repeated at least once every three years			
2.5.7	**2**	Shared in-house multi-disciplinary team training, education and practice development activities occur on the ward/unit at least every three months			
2.5.8	**3**	Non-clinical staff have received mental health awareness training			
2.5.9	**1**	All staff members who deliver therapies and activities are appropriately trained and supervised			
2.5.10 [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			
2.6	**Appropriate training methods are used to ensure staff training is effective**				

2.6.1	**3**	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity			
2.6.2	**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			
2.6.3 [DEAF]	**1**	All staff working within the hospital site with deaf patients undertake deaf awareness training as part of induction. In particular, reception staff have some basic BSL as a minimum			
2.6.4	**2**	Young people, parents/carers and staff members are involved in devising and delivering training face-to-face			
2.7	**All staff receive regular supervision totalling at least one hour per month from a person with appropriate experience**				
2.7.1	**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.			
2.7.2	**2**	All staff members receive line management supervision at least monthly			
2.7.3	**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			
2.7.4	**2**	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			
2.7.5	**1**	All newly qualified staff members are allocated a preceptor or mentor according to their professional body to oversee their transition onto the ward/unit			
2.7.6	**1**	All staff members receive an annual appraisal and personal development planning (or equivalent)			
2.7.7	**2**	Ward/unit managers and senior managers promote positive risk-taking to encourage the young person's recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this			
2.8	**There is a recruitment policy to ensure vacant posts are filled quickly with well-qualified and checked candidates**				

2.8.1	**2**	Appropriately experienced young person or parent/carer representatives are involved in the interview process for recruiting potential staff members			
2.8.2	**1**	Robust processes are in place to ensure that all unit staff, including temporary staff, undergo a Disclosure and Barring Service (DBS) check (or local equivalent) and are checked against the Protection of Children Act (POCA) register before appointment. Ongoing monitoring of this is carried out every three years			
2.8.3	**1**	Robust processes ensure that all staff with a professional regulatory body are checked for appropriate registration on recruitment and again at renewal date			
2.8.4	**2**	When posts are vacant or in the event of long term sickness or maternity leave, prompt arrangements are made for temporary staff cover			
2.8.5 [DEAF]	**1**	The deaf unit recruits deaf staff. This includes specific advertising in the 'deaf media' *Guidance: This includes a positive recruitment strategy for deaf staff at all levels aiming for a minimum of 20%.*			

Section 3: Access, Admission & Discharge

Number	Type	Standard			
3.1	**Assessment and treatment are offered without unacceptable delay**				
3.1.1	**1**	The service provides information about how to make a referral			
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**	There is a clear process in place for handling situations where agreed bed occupancy levels need to be exceeded that maintains the safety and integrity of the unit			
3.1.4	**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 title they prefer.*			
3.1.5	**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			
3.1.6 [DEAF]	**1**	Young people have an accessible, adapted risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others			
3.1.7	**1**	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner			
3.1.8	**1**	There is a documented CPA (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			
3.1.9 [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			
3.1.10 [DEAF]	**1**	The prior to- or on-admission assessment includes reference to communication needs, which are documented in the young person's notes			

3.1.11 [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			
3.2	**There is equity of access to inpatient units in relation to ethnic origin, social status, disability, physical health and location of residence**				
3.2.1	**1**	The unit meets the needs of young people from different ethnic, cultural and religious backgrounds			
3.2.2 [DEAF]	**2**	There is evidence of active positive promotion of Deaf culture and meeting of Deaf cultural needs, e.g. access to Deaf club			
3.2.3	**2**	The service actively supports families to overcome barriers to access			
3.2.4 [DEAF]	**1**	The ward/unit uses 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 unless there are exceptional circumstances			
3.2.5 [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)			

3.1.6 [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			
3.2.7	**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			
3.2.8 [DEAF]	**1**	In the event of admission to an acute physical healthcare hospital, the patient is supported by unit staff who can sign and/or interpreters			
3.3	**There are robust arrangements for collecting information from all agencies involved with the young person and their family**				
3.3.1	**1**	Unplanned admissions need an initial planning meeting with local services within five working days of admission			
3.3.2	**2**	Where young people are not admitted to the service, the reasons are explained to the referrer, and young people and parents/carers where appropriate			
3.3.3 [DEAF]	**2**	The unit formally records all referrals with respect to race, gender, home area and disability, language preferences and this is reviewed annually			
3.3.4	**1**	On admission, if a Local Authority has parental responsibility as a result of a care order, the service should identify a named clinician who should be responsible for consultation around care planning			
3.4	**Families are involved throughout assessment**				

3.4.1	**1**	During assessment staff involve parents/carers where appropriate			
3.4.2	**1**	Parents and carers are supported to access a statutory carers' assessment, provided by an appropriate agency			
3.4.3	**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			
3.5	**Before discharge, decisions are made about meeting any continuing needs**				
3.5.1	**1**	The inpatient team invites a community team representative to attend and contribute to relevant meetings e.g. CPA, discharge planning			
3.5.2	**1**	Any young person in inpatient care should have a transition meeting by age 17 and a half years			
3.5.3	**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			
3.5.4	**1**	Young people and their parent/carer (with the young person's consent) are invited to a discharge meeting and are involved in decisions about discharge plans			
3.5.5	**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/ 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.*			
3.5.6	**1**	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			
3.5.7	**1**	There is a procedure in place for taking action on delayed discharges			
3.5.8	**1**	The team makes sure that young people who are discharged from hospital have arrangements in place to be followed up within three days of discharge			
3.5.9	**1**	Mental health practitioners should carry out a thorough assessment of the young person's personal, social, safety and practical needs to reduce the risk of suicide on discharge			
3.5.10	**3**	Teams provide specific transition support to young people when their care is being transferred to another unit, to a community mental health team, 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.*			
3.5.11 [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			
3.5.12 [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.*			

Section 4: Care & Treatment

Number	Type	Standard			
4.1	**All young people are assessed for their health and social care**				

	needs				
4.1.1 [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 and referrals to Audiology are made when required.*			
4.1.2	**1**	If part or all of the examination is refused, the reason why has been recorded and repeated attempts have been made to complete this process			
4.1.3	**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.*			
4.1.4 [DEAF]	**1**	Access to health services (e.g. Dentist, GP) is supported by appropriate staff and qualified BSL interpreters to ensure effective communication			
4.1.5 [DEAF]	**1**	There is a procedure in place for referral to audiology if required and replacing hearing aid batteries			
4.2	**A comprehensive range of interventions is available to the young people on the unit**				
4.2.1	**1**	Young people begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within four weeks of admission. Any exceptions are			

		documented in the case notes			
4.2.2		Inpatient services have a range of interventions available. These include:			
4.2.2a	**1**	Medication			
4.2.2b	**1**	Individual therapy provided by a qualified therapist			
4.2.2c	**1**	Therapeutic group work			
4.2.2d	**1**	Family Therapy			
4.2.2e	**1**	Occupational therapy			
4.2.2f	**3**	Art/creative therapies			
4.2.2g [DEAF]	**1**	Language therapy			
4.2.3 [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			
4.2.4 [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			
4.3	**There is a structured programme of care and treatment**				

4.3.1	**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			
4.3.2	**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			
4.3.3	**1**	Young people's preferences are taken into account during the selection of medication, therapies and activities and acted upon as far as possible			
4.3.4	**1**	Young people and parents/carers have access to key members of the MDT outside of planned meetings to review their progress			
4.3.5	**2**	Young people receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management			
4.4	**Young people and parents/carers are involved in decisions about their treatment**				

4.4.1 [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*			
4.4.2	**1**	The team reviews and updates care plans according to clinical need or at a minimum frequency of a month			
4.4.3	**1**	All young people (or parents/carers for children) have the opportunity to sign their care plan upon review. If young people do not want to sign their care plans, this is documented			
4.4.4	**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			
4.4.5	**2**	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			
4.4.6	**1**	Young people and parents/carers are supported by staff members before (to prepare), during (to understand and contribute) and after (to feedback outcomes) any formal review of their care			
4.4.7	**2**	Parents and carers are offered individual time with staff members, within 48 hours of the young people's admission to discuss concerns, family history and their own needs			
4.5	**Young people can continue with their education whilst admitted**				
4.5.1	**1**	The unit provides the core educational subjects: Maths, English and Science			
4.5.2	**2**	The unit provides a broad and balanced curriculum that is suitable and flexible, appropriate to the students' needs			
4.5.3 [DEAF]	**1**	BSL, Deaf Studies and Deaf culture are delivered by a suitably experienced deaf professional			
4.5.4	**1**	Where the unit caters for young people over the age of 16, young people are able to continue with education			
4.5.5	**1**	Teaching staff complete an assessment of each young person's educational needs which is reviewed at each CPA review (or local equivalent)			

4.5.6	**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			
4.5.7	**1**	If the young person is receiving education, educational staff at the unit must liaise with the young person's own school in order to maintain continuity of education provision			
4.5.8	**1**	Where young people are returning to their local educational facility after discharge, education and unit staff support the young people with their reintegration			
4.5.9	**2**	The educational staff maintain communication with the young peoples' parents/carers, e.g. providing progress reports for each CPA review			
4.5.10	**3**	Educational outings are provided, as appropriate			
4.5.11 [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)			
4.5.12	**2**	Teachers and nursing staff have a handover at the beginning and end of each school day			
4.5.13	**1**	The unit must be part of an education organisation that is a registered examination centre			
4.6	**Outcome measurement is undertaken routinely using validated outcome tools**				

4.6.1	**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, SDQ etc)			
4.6.2	**1**	Outcome measurement tools are completed from the perspective of staff, young people and/or parents/carers			
4.6.3	**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			
4.6.4	**2**	Units contribute to a national dataset to allow for information sharing e.g. QNIC ROM			
4.7	**All young people at the unit are given a choice of healthy, balanced food**				
4.7.1	**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			
4.7.2	**2**	Staff ask young people for feedback about the food and this is acted upon			
4.7.3	**2**	Staff eat with the young people at mealtimes and the			

		cost of staff meals are covered by the organisation			
4.7.4	**2**	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			
4.8	**Young people are involved in decisions around their care and treatment, including leave from the unit**				
4.8.1	**1**	The team develops a leave plan jointly with the young person and 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.			
4.8.2	**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 young person • Alerts parent/carers, people at risk and the relevant authorities • Completes an incident form			
4.8.3	**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.			
4.8.4	**2**	Young people have access to relevant faith-specific and/or spiritual support, preferably through someone with an understanding of mental health issues			
4.8.5	**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			
4.8.6	**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*			
4.8.7	**1**	Every young person's PRN (i.e. as required) medication is reviewed weekly in terms of the frequency, dose, and reasons for prescribing			
4.8.8	**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 six weeks, at three months and then six-monthly unless a physical health			

		abnormality arises			
4.8.9	**2**	A specialist pharmacist should be a member of the MDT			
4.8.10	**1**	Young people with poor personal hygiene have a care plan that reflects their personal care needs			
4.8.11	**1**	Young people are involved in decisions about their level of observation by staff			
4.8.12	**2**	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them			
4.9	**Young people and their parents/carers are supported by staff and treated with respect**				
4.9.1	**1**	Staff members treat all young people and their parents/carers with compassion, dignity and respect			
4.9.2	**1**	Young people feel listened to and understood by staff members			
4.9.3	**1**	Parents/carers feel supported by the ward staff members			
4.9.4 [DEAF]	**1**	Staff demonstrate respect for Deaf culture (e.g. by signing at all times, developing BSL skills)			

Section 5: Information, Consent & Confidentiality

Number	Type	Standard			
5.1	**Young people and parents/carers can find out about the unit before the admission**				
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**	There is information available that is accessible for deaf families and visitors			
5.2	**Information is available to young people and parents/carers**				
5.2.1	**1**	The 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			
5.2.2 [DEAF]	**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 • How to access their own health records • Details of communication on the unit			
5.2.3	**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.*			
5.2.4 [DEAF]	**1**	All information should be in the preferred accessible format for the young person and their family			
5.2.5 [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			
5.3	**Each young person has a named nurse/key worker**				
5.3.1	**1**	Staff update parents/carers on their child's progress at a minimum of once a week, subject to confidentiality			

5.4	**Young people know the names of the staff team looking after them**				
5.4.1 [DEAF]	**2**	There is a board on display with the names, photographs and sign names of staff			
5.5	**Personal information about young people is kept confidential, unless this is detrimental to their care**				
5.5.1 **[DEAF]**	**1**	Confidentiality and its limits are explained to the young person and their parent/carer on admission, both verbally/signed and in writing. The young person's preferences for sharing information with third parties are respected and reviewed regularly			
5.5.2	**1**	Consent is sought prior to the disclosure of case material to parents/carers if the young person is assessed as able to make such a decision			
5.6	**All examination and treatment is conducted with the appropriate consent**				
5.6.1	**1**	Parental responsibility is recorded in the young person's notes			
5.6.2 [DEAF]	**1**	Young people and parents/carers are offered written, signed and verbal information about the young person's mental illness			
5.6.3	**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. When young people do not have capacity to consent, best interest			

		processes involving professionals and family (where appropriate) are followed. These assessments should be undertaken at every point that a young person is required to participate in decision making			
5.6.4	**1**	The team follows a protocol for responding to parents/carers when the young people does not consent to their involvement.			

<u>Section 6: Young People's Rights and Safeguarding Children</u>

Number	Type	Standard			
6.1	**If a young person is detained under the country's mental health legislation, the legal authority for admission and treatment is clear**				
6.1.1	**1**	The legal status (detained and informal) for each young person is recorded in their notes.			
6.2	**The unit is young person-centred and respects the rights of young people and their parents/carers**				
6.2.1	**1**	Young people are able to see a clinician on their own, although this may be refused in certain circumstances and the reasons why are explained			
6.3	**Young people and their parents/carers are informed about how to seek independent advice**				
6.3.1 [DEAF]	**1**	All young people have access to an advocacy service with appropriate communication support, including IMHAs (Independent Mental Health Advocates) for			

		those detained			
6.3.2 [DEAF]	**1**	There is information available for contacting advocacy which is suitable for deaf patients			
6.3.3 [DEAF]	**1**	A specialist deaf advocacy worker is available and can communicate with the young person in their chosen language			
6.3.4 [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			
6.4	**The unit operates within the appropriate legal framework in relation to the use of physical restraint**				
6.4.1	**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			
6.4.2	**1**	Staff members do not restrain young people in a way that affects their airway, breathing or circulation			
6.4.3 **[DEAF]**	**1**	A separate communicator is involved in the restraining process to ensure high quality communication is maintained throughout			
6.4.4	**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			
6.4.5	**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			
6.4.6	**1**	The multi-disciplinary team collects audit data on the use of restrictive interventions and actively works to reduce its use year on year *Guidance: Audit data are used to compare the service to national benchmarks where possible.*			
6.4.7	**1**	The unit follows organisational policies for untoward occurrences and critical incident reporting			
6.4.8	**1**	The team uses seclusion or segregation only as a last resort and for brief periods only			
6.5	**The unit complies with Local Safeguarding Children Board (LSCB) procedures (or equivalent outside of England and Wales) and with the guidance contained in "What to do if you're worried a child is being abused" (2015) document**				
6.5.1	**1**	It is recorded as to whether or not a young person has a child protection plan in place			
6.5.2	**1**	The unit has a named safeguarding lead and staff know who this is			

6.5.3	**1**	The unit has policies and procedures which are compatible with LSCB (or local equivalent) guidelines, including the conduct of reviews and procedures for working together			
6.5.4	**1**	Staff know what to do if there are safeguarding concerns and who to contact, during and out of working hours			
6.5.5	**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			
6.5.6	**1**	Young people and staff members feel safe on the ward			
6.6	**Unit staff work with the local authority to safeguard and promote the welfare of young people**				
6.6.1	**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 three months (in line with section 85 of the Children Act 1989)			
6.6.2	**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			

Section 7: Clinical Governance

Number	Type	Standard			
7.1	**All available information is used to evaluate the performance of the unit**				
7.1.1 [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			
7.1.2	**2**	Key clinical/service measures and reports are shared between the team and organisation clinical board, e.g. findings from serious incident investigations and examples of innovative practice			
7.1.3	**2**	Services are developed in partnership with appropriately experienced young person and parent/carer representatives, who have an active role in decision making			
7.1.4	**2**	The ward team use quality improvement methods to work on service improvements			
7.2	**Unit staff are involved in clinical audit**				
7.2.1	**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.			
7.2.2	**1**	There are dedicated resources, including protected staff time to support clinical audit within the directorate or specialist areas. When staff members undertake audits they should do the following: • Agree and implement action plans in response to audit reports • Disseminate information including audit findings and action plan • Complete the audit cycle			
7.2.3	**3**	The team, young people and parent/carers are involved in identifying priority audit topics in line with national and local priorities and young people feedback			
7.2.4	**2**	Measures are in place to record and audit referrals, terminated referrals and waiting lists			
7.3	**Unit staff learn from information collected on clinical risks**				
7.3.1	**1**	The senior management team for the service has operational responsibility to ensure that identified risks are acted upon			
7.3.2	**1**	The organisation has a risk management strategy			
7.3.3	**1**	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this			
7.3.4	**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			
7.3.5	**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			
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	**1**	There is a written admission procedure, which includes procedures for emergency referrals			
7.4.3	**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			
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 people			
7.4.5	**1**	There is an organisational policy for the use of rapid tranquilisation			
7.4.6	**1**	There is a policy on clinical risk assessment and			

		management			
7.4.7	**1**	There is a policy for responding to serious incidents requiring investigation			
7.4.8	**1**	The unit has policies and procedures for the management of bullies and for those who have been bullied, which covers both staff and young people			
7.4.9	**1**	There is a locked door policy which allows young people to be cared for in the least restrictive environment possible			
7.4.10	**1**	There are appropriate procedures where units close at weekends			
7.4.11	**2**	There is a clear policy on young people's smoking			
7.4.12 [DEAF]	**1**	There is a policy for the use of mobile phones, text phones, interpreted phone calls and other communication aids			
7.4.13	**1**	There is a policy detailing the use of the internet by young people on the unit			
7.4.14	**1**	There is a policy regarding the management of young people using drugs and alcohol			

7.4.15	**1**	The unit has a policy on the use of seclusion *Guidance: The unit should have a policy even if seclusion is not used. This should be in line with current legislation.*			
7.4.16	**1**	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency			
7.4.17	**1**	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence			
7.5	**There is a clear role for the service that is explicitly set in the context of a four-tier CAMHS strategy**				
7.5.1	**3**	Commissioners and service managers meet at least six-monthly			
7.5.2	**3**	The ward/unit has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice			
7.5.3	**2**	Key information generated from service evaluations and key performance indicator reports (e.g. reports on length of stay) are disseminated in a form that is accessible to all			
7.5.4	**3**	Young person representatives attend and contribute to local and service level meetings and committees			

7.5.5	**3**	The ward team actively encourage young people and parents/carers to be involved in quality improvement projects			

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