QNMHD
QUALITY NETWORK FOR INPATIENT MENTAL HEALTH SERVICES FOR DEAF PEOPLE

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Adult Inpatient Mental Health Services for Deaf People

Second Edition 2015

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A manual of standards written primarily for:
Adult inpatient mental health units for deaf people

Also of interest to:
People who are deaf with mental health issues
Carers of people who are deaf with mental health issues
Commissioners
Policy makers
Researchers

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Foreword

Approximately 1 in 1000 people are born profoundly Deaf or become Deaf prior to developing speech and verbal language[i]. Deaf people often face barriers in accessing healthcare, especially when healthcare professionals lack appropriate non-verbal communication skills and Deaf awareness.

Deaf people are twice as likely to experience mental health issues such as depression and anxiety compared to hearing people[ii] and it is vital that Deaf individuals can access good quality care when they need it, delivered by competent and compassionate staff.

This set of standards sets out to describe how inpatient mental health units for Deaf people can deliver good quality care. There are three inpatient units in the UK for Deaf people with mental health problems and these units have chosen to sign up to the national Quality Network for Mental Health Services for Deaf People (QNMHD), as a commitment to continually providing high quality care. By signing up to the network, member services will be reviewed against the standards through a process of self- and peer-review, collecting feedback from patients, carers and staff and receiving a supportive peer-review visit.

Over time, the units will work towards becoming officially accredited by the Royal College of Psychiatrists and the QNMHD project team will provide support throughout the process. By taking part in the network, staff and patients will be able share ideas, innovations and best practice suggestions with each other.

This new edition of the standards builds on the original set published in 2013 and aims to raise the quality of care even further. We hope that members of QNMHD will find these standards helpful. If staff would like advice on how to meet a particular standard, or have any feedback on the standards themselves, please contact the project team here at the College who will be delighted to hear from you.

Professor Mike Crawford

Director of the Royal College of Psychiatrists Centre for Quality Improvement

[i] http://www.stgeorgehealthcaregroup.org.uk/conditions/deafness.shtml
[ii] http://www.signhealth.org.uk/about-deafness/mental-health/

Introduction

The standards for the Quality Network for Inpatient Mental Health Services for Deaf People (QNMHD) are drawn from the following documents:

- Accreditation for Inpatient Mental Health Services (AIMS) Standards
- Quality Network for Forensic Mental Health Services - Standards for Deaf People in Medium Secure Care
- Designation Framework for Specialised Mental Health Services for Deaf People (Non-Secure)
- Standards for Inpatient Mental Health Services (CCQI)

The standards have been subject to consultation with all professional groups involved in the provision of acute inpatient mental health services and with service users and their representative organisations.

The standards cover the following topics:

- General standards
- Timely and purposeful admission
- Safety
- Environment and facilities
- Therapies and activities

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

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

- **Type 2:** standards that an accredited unit would be expected to meet;

- **Type 3:** standards that are desirable for a unit to meet.

Accreditation Decision

Data from the self- and peer-review are compiled into a summary report of the unit's strengths and areas for improvement. Once this has been verified by the review team who visited the unit and the host team, it will be taken to the next meeting of the *Accreditation Committee (AC)*, where they will consider the data and recommend an accreditation status for the unit.

There are three categories of accreditation status:

Level 1: "accredited"	The unit would *at the point of peer-review*: • meet all Type 1 standards; • meet at least 80% of Type 2 standards, with no significant gaps in any particular section of the standards; • meet 60% of Type 3 standards. Accreditation at Level 1 is valid for up to three years, subject to satisfactory completion of interim self-review.
Level 2: "accreditation deferred"	The unit would *at the point of peer-review*: • fail to meet one or more Type 1 standards but demonstrate the capacity to meet these within a short time; • fail to meet a substantial number of Type 2 standards but demonstrate the capacity to meet the majority within a short time.
Level 3: "not accredited"	The unit would *at the point of peer-review*: • fail to meet one or more Type 1 standards and not demonstrate the capacity to meet these within a short time; • fail to meet a substantial number of Type 2 standards and not demonstrate the capacity to meet these within a short time.

General principles

1. Deaf patients have the same access to healthcare, public health initiatives and services as hearing patients.

2. The environment and amenities are appropriately adapted for deaf people.

3. Policies and procedures including physical, procedural and relational security are adapted and accessible to meet the needs of deaf people.

4. Services are deaf aware and able to promote Deaf culture and British Sign Language (BSL).

5. Any clinical intervention with a deaf person is delivered by suitably qualified and experienced staff with appropriate skills in a signed language or with specialist deaf equipment/aids (e.g. pictograms, video relay service, and qualified interpreters).

Note: 'Accessible information' in this document means 'in a manner that is accessible to deaf people'.

Section1: General standards

Policies and protocols		
Number	**Type**	**Standard**
1	2	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.
2	2	Where there are deaf staff, relevant policies are made accessible by being, as appropriate, translated into BSL on DVD or communicated 'live' in BSL (or another signed language) and written in plain English.
3	2	Front-line staff members are involved in key decisions about the service provided. *Guidance: the views/opinions of deaf staff are represented at all meetings in relation to deaf services.*
4	1	The views/opinions of deaf staff are represented at all business development fora in relation to deaf services.
Communication		
5	1	Communication resources are available so that deaf staff can participate as fully as hearing staff in all aspects of the service, including clinical work, meetings and training sessions.
6	2	Deaf awareness training is provided to sufficient numbers of frontline staff so that at any one time there is at least one person in the service who is able to communicate with deaf visitors, carers, volunteers or members of staff.
7	1	Ward based staff have sufficient BSL qualifications accredited by Signature. *Guidance: Clinical staff should have Level 2 certification and non-clinical staff in direct contact with service users (including receptionists) should have Level 1 certification. Basic BSL skills should also be provided to all staff who need it during their induction.*
8	1	There is a communication policy stating that staff should use BSL at all times, when appropriate, to the best of their ability.
9	1	Only registered qualified interpreters are used to interpret in clinical sessions. These interpreters are qualified to Signature's BSL level 6, or at university post graduate level. They are a member of the National Register of Communication Professionals working with deaf and deafblind people (www.nrcpd.org.uk).
10	1	Sign language interpreters and other communication professionals are appropriately qualified, registered and experienced in mental health issues.
11	1	There is an inclusive policy in place during and outside of office hours. This means that at all times deaf service users, deaf staff

		and deaf volunteers do not feel excluded when in company with specialised inpatient providers who communicate without using sign language.
12	2	At the beginning of every shift there will be an assessment of communication needs and appropriate interpreting provided. It is the responsibility of the service to ensure that there is access to appropriate communication resources. Signing staff should not be used when an interpreter is needed.
13	1	Communication resources are available so that deaf service users are able to participate fully in their assessment, treatment and care planning. *Guidance: They are provided in BSL, visual materials are used and deaf staff deliver services.*
14	1	Patients and carers are offered information in an accessible format about the patient's mental illness. *Guidance: Information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.*
15	1	When communicating with patients and carers, health professionals avoid the use of jargon so that people understand them.
16	2	All information leaflets about the unit for patients and carers are reviewed yearly by a team involving either patients or carers.
17	3	The use of portable loop systems are promoted widely throughout the service, and made available to anyone who requires them.
18	2	Deaf service users, staff or carers who require communication support that is not in sign language (lip speakers, note takers, speech to text) can receive this if they wish.
19	1	Staff members are easily identifiable (for example, by wearing appropriate identification).
Staffing		
20	2	There is access to dedicated sessional or part-sessional administrative support which meets the needs of the ward.
21	1	The ward has an agreed minimum staffing level across all shifts which is met.
22	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.
23	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.

24	2	The ward/unit is staffed by permanent staff members, and bank and agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need.
25	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.
26	1	The unit has its own dedicated lead consultant who will provide expert input into key matters of service delivery, staff support and supervision, and overall service co-ordination. 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.
27	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 a psychiatric emergency; • attend the ward/unit within 1 hour during normal working hours; • attend the ward/unit within 4 hours when out of hours.
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.
29	2	The unit has access to the following referral services: • dental assessment and dental hygiene services; • visual reviews; • hearing reviews; • podiatry; • wound care services; • phlebotomy services; • specialist infection control services; • a tissue viability nurse; • specialist continence services.
Recruitment of staff		
30	1	Posts that would benefit from having the culturally competent skills of a deaf person are advertised through appropriate communication channels to access the deaf community. Job descriptions and person specifications are written in plain English/Easy Read and interpreting support is fully available for use during interviews.
31	1	Deaf job applicants are supported to ensure they can fully access the recruitment process, and are guaranteed an interview if they meet the minimum criteria for a post.
32	2	Patient or carer representatives are involved in interviewing potential staff members during the recruitment process.

Appraisal, supervision and staff support		
33	2	The unit has a clear system of monitoring and auditing supervision. This is reviewed every 12 months.
34	2	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.
35	2	All staff members receive monthly line management supervision.
36	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.*
37	2	Staff members in training and newly qualified staff members are offered weekly supervision.
38	1	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: 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.*
39	3	Staff members have access to reflective practice groups.
40	1	All staff are able to contact a senior colleague as necessary, 24 hours a day.
41	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.
42	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.*
Staff training and development		
43	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.
44	2	The ward ensures that all staff know: • how to use deaf equipment; • how to use an interpreter.
45	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.*

46	1	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.*
47	1	All staff working within the hospital site with deaf patients undertake deaf awareness training as part of their induction. In particular reception staff have some basic BSL as a minimum.
48	3	On call doctors who attend out of hours have deaf awareness training during induction.
49	1	All deaf staff are referred for an Access to Work (ATW) assessment to ensure appropriate support in terms of communication and equipment.
50	1	The service offers the opportunity for placements to deaf trainees and students from various disciplines.
51	1	Staff who undertake assessment and care planning have received training in: • care planning as part of the care management programme, including CPA (England and Wales) and discharge planning; • how to assess capacity and the Mental Capacity Act (England and Wales); • risk management and risk assessment; • self-harm and suicide awareness and prevention techniques; • locally agreed outcome measures; • procedures for assessing carers' needs; • physical health needs and referrals.
52	2	Staff members can access leadership and management training appropriate to their role and specialty.
53	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.
54	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).
55	1	The ward can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology receive ongoing training and supervision to provide a repertoire of problem-specific, low intensity psychological interventions in line with NICE guidance.
56	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.

57	2	The service takes part in networks specifically for clinicians working with Deaf patients (e.g. British Society for Mental Health and Deafness, National Deaf Services Clinical Governance meetings and maintains good links with other deaf services both secure and non-secure).
Advocacy		
58	1	The ward/unit has a working relationship with a range of advocacy services that includes the Independent Mental Capacity Advocate (IMCA) service.
59	1	The arrangements for deaf service advocacy will ensure deaf service users have the opportunity to choose an independent advocacy worker who: • is deaf, with experience in deaf mental health, or; • is hearing and signs to Level 6 with experience in deaf mental health, or; • is hearing and uses a registered qualified interpreter.
Feedback from patients and carers		
60	1	Patients/carers are given accessible information on how to raise concerns, complaints and compliments.
61	2	There is evidence of audit, action and feedback from complaints, suggestions and compliments.
62	1	Patients and their carers 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 should include questions on how 'deaf aware' the service is.*
63	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. Communication support is provided so that all patients can take part.*
64	3	Deaf service users are individually approached every six months and asked to rate the service's deaf awareness, access to information and communication support.
Reporting inappropriate/abusive care		
65	1	Systems are in place to enable staff members to quickly and effectively report incidents or concerns and managers encourage staff members to do this. *Guidance: For example, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.*

66	2	The patient (and their carer) is informed of the procedures that would be followed if a disclosure of abuse were made, and they are reassured that they would be taken seriously.
67	1	Staff receive up-to-date training and development consistent with their role in recognising the signs or symptoms associated with: • physical abuse; • sexual abuse; • emotional abuse; • financial abuse; • institutional abuse; • self-neglect; • neglect by others; • language abuse.

Section 2: Timely and purposeful admission

Information systems		
Number	**Type**	**Standard**
68	1	All patient information is kept in accordance with current legislation. *Guidance: Staff members ensure that no confidential data are visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*
69	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, length of stay, waiting times, discharge and service performance measurements.
Control of bed occupancy		
70	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.*
Access and referral		
71	1	Clear information is made available, in an accessible 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.
72	1	There is a specialist referral/admission panel that comprises of clinical staff with specialist skills and training in working with deaf people.
73	1	The service has the capacity to admit deaf men and women with mental health problems, personality disorder and learning disabilities, based on individual need.
74	1	Where appropriate, there are established links with Her Majesty's Prison Service, the Ministry of Justice, Courts and Medium/Low Secure Services to ensure seamless admissions and discharges.
Admission process		
75	1	Assessments for admission of a deaf person are carried out by a clinician with expertise in mental health and deafness who has the ability to co-work with a deaf professional if needed.

76	1	Patients have an assessment of their capacity to consent to admission, care and treatment within 24 hours of admission.
77	1	Staff members explain the purpose of the admission to the patient.
78	2	Before admission, or as soon as they arrive, a member of staff checks that the patient has any aids or equipment that they need.
79	1	On admission to the ward/unit, or when the patient is well enough, staff members introduce themselves and other patients.
80	1	The patient is introduced to a member of staff who will be their point of contact for the first few hours of admission.
81	1	On admission to the ward/unit, or when the patient is well enough, staff members show the patient around.
82	2	The patient is given a 'welcome pack' or introductory information in an accessible format 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.
83	2	Staff members explain the main points of the welcome pack to the patient and ask if they need further information on anything explained.
84	1	Detained patients are given accessible information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes.
85	1	Patients are given accessible 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 access their own health records.
Initial assessment and care planning		
86	1	A full physical examination is carried out as part of the admission process. *Guidance: This includes details of past medical history; current medication including side effects and compliance; physical observations including blood pressure, heart rate and respiratory rate.*

87	2	Further targeted examinations are undertaken if the physical history or physical symptoms demand (including blood tests, urinalysis, ECG, EEG, x-rays, brain imaging). This is undertaken promptly and a named individual is responsible for follow-up.
88	2	The patient's initial needs are assessed in relation to mobility, e.g. aids and adaptations, exercises etc., and these are recorded.
89	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.
90	2	The patient is able to involve the people they rely on for support (carers/relatives/neighbours/friends) in their assessment.
91	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.
92	1	The team discusses the purpose and outcome of the risk assessment with each patient and a management plan is formulated jointly.
93	1	The patient's assessment takes into account existing information and covers social and personal well-being. This would include any of the following that were relevant to the person: • their wishes and expectations regarding their admission; • communication needs; • family/social network/social needs; • the role of carers, supporters and advocates; • individual needs relating to gender, ethnicity, culture or spirituality; • pattern of daily life and activities/ability to carry out activities; • food preferences, including special dietary requirements; • any concerns over living situation/financial worries/employment status.
94	1	All care plans are negotiated with the patient, and are based on a comprehensive physical, psychological, social and cultural/spiritual assessment. They include a comprehensive risk and strengths assessment, taking into account patient preferences and goals.
95	1	The patient and their carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.

96	1	Care plans are accessible to deaf patients and if necessary adapted for deaf patients, e.g. using pictures, symbols or in BSL, DVD or other formats.
97	2	Clinical outcome monitoring includes reviewing patient progress against patient-defined goals in collaboration with the patient.
98	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.
99	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 who may be at risk and the relevant authorities.
Consent to interventions		
100	1	When the patient is assessed as lacking capacity and is treated against their will, this is conducted within the appropriate legal framework, and this is recorded.
Carers		
101	1	The patient's main carers are identified and contact details are recorded.
102	2	Carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns, family history and their own needs.
Continuous assessment		
103	2	Where an unmet need is identified there is a clear mechanism for reporting it.
104	2	If needs are identified that cannot be met by the ward team, then a referral is made to a service that can. The referral should be made within a specified time period after identifying the need, and the date of the referral recorded in the patient's notes.
105	1	Risk assessments and management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. those of professional bodies.
106	2	Ward/unit managers and senior managers promote positive risk-taking to encourage patient recovery and personal development.
Reviews		
107	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.
108	1	A documented CPA review/admission meeting is held within four weeks of the patient's admission.
109	1	Managers and practitioners have agreed minimum frequencies of clinical review meetings that comply with national standards, e.g. those of professional bodies.
110	1	Patients and carers are able to contribute and express their views during reviews.

111	2	Actions from reviews are fed back to the patient (and carer, with the patient's consent) and this is documented.
112	2	Patients have the opportunity to meet their consultant outside of reviews.
113	1	The practitioner develops the care plan collaboratively with the patient and their carer (with patient consent).
Discharge planning		
114	2	Discharge planning is initiated at the first multi-disciplinary team review and a provisional discharge date is set.
115	1	Patients and their carer (with patient consent) are invited to a discharge meeting and are involved in decisions about discharge plans.
116	2	The patient is given timely notification of transfer or discharge and this is documented in their notes.
117	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.
118	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.
119	2	The inpatient team invites a community team representative to attend and contribute to ward rounds and discharge planning.
120	3	In the event of admission to an acute physical healthcare hospital, unit staff provide help and support on caring for deaf patients.

Section 3: Safety

Protocols and procedures		
Number	**Type**	**Standard**
121	1	There is a written policy/procedure in relation to deprivation of liberty safeguards and how to seek authorisations.
122	1	The team follows a protocol for managing situations where patients are absent without leave.
123	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.
124	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.
Observation		
125	1	Patients are told 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.
Management of violence		
126	1	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/ harassment/violence.
127	1	The team audits the use of restrictive practice, including face-down restraint.
128	1	There is a policy and training for the prevention of, use and adaptation of physical restraint and seclusion with deaf people. *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.*

129	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 years' data.
130	2	There are systems in place to ensure that post-incident support and review are available and take place. The following groups are considered: • staff involved in the incident; • patients; • carers and family, where appropriate; • other patients who witnessed the incident; • visitors who witnessed the incident.
131	1	Staff members follow a lone working policy and feel safe when escorting patients on leave.
Management of alcohol and illegal drugs		
132	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.

Section 4: Environment and facilities

Safety		
Number	**Type**	**Standard**
133	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*
134	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery.
135	1	Facilities ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour.
136	2	There is secure, lockable access to a patient's room, with external staff override.
Alarm systems		
137	1	There is an alarm system in place (e.g. panic buttons) and this is easily accessible. *Guidance: Alarms are checked and serviced regularly.*
138	2	Alarm systems/call buttons/personal alarms are available to patients and visitors, and instructions are given for their use.
139	1	Furniture is arranged so that alarms can be reached and doors in rooms where consultations take place are not obstructed.
140	1	Flashing beacons are available throughout the premises alongside the audible alarm. This applies to offices, bedrooms, communal areas, toilets and meeting rooms for the benefit of deaf staff, service users and deaf visitors. The evacuation plan is tested regularly with staff and service users.
141	1	Deaf members of staff have a (vibrating) paging device to inform them that the alarm has been activated.
142	1	A collective response to alarm calls and fire drills is agreed by the team before incidents occur. This is rehearsed at least 6 monthly.
143	1	A flashing light is used to alert deaf members of staff that there is a visitor to the ward.
144	1	Any lift used by deaf staff or unaccompanied deaf visitors has a visual alarm installed in it together with clear instructions on what action needs to be taken should the alarm go off.
145	2	Alarm systems/call buttons/personal alarms are checked and serviced regularly.
Medical equipment		
146	1	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within three minutes.

147	1	The crash bag is maintained and checked weekly, and after each use.
148	2	The ward/unit has a designated room for physical examination and minor medical procedures.
Confidentiality		
149	1	In spaces where personal and confidential discussions are held, such as interview rooms and consulting/examination/treatment spaces conversations cannot be heard or seen outside of the room.
Seclusion		
150	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 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		
151	2	There are communal areas and meeting rooms with good lighting which support communication in sign languages.
152	2	The ward/unit entrance and key clinical areas are clearly signposted.
153	2	The entrance to ward areas and bedrooms has a visual alerting system.
154	2	There is at least one room for interviewing and meeting with individual patients and relatives, which is furnished with comfortable seating.
155	2	The unit has a process and an environment that provides safety, privacy and dignity during visits, and includes guidance on children visiting where permitted.
156	2	There is a designated space for patients to receive visits from children, with appropriate facilities such as toys and books. *Guidance: The children should only visit if they are the offspring of or have a close relationship with the patient and it is in the child's best interest to visit.*
157	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.

158	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.*
159	2	The ward offers a range of semi-private and public spaces outside the private bedroom.
160	2	There are lounge areas that may become single-sex areas as required.
161	2	Where smoking is permitted, there is a safe allocated area for this purpose.
Catering		
162	1	There is a designated dining area, which is reserved for dining only during allocated mealtimes.
163	1	There is water/soft drinks available to patients 24 hours a day.
164	2	There are facilities for patients to make their own hot and cold drinks and snacks. *Guidance: Any restrictions are individually care planned and not implemented as a blanket rule.*
165	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. *Guidance: Staff should provide any necessary help with feeding and access to food.*
Dignity		
166	1	Male and female patients (self-defined by the patient) have separate bedrooms, toilets and washing facilities.
167	1	All patients have access to lockable storage, which may include their own individual rooms or access to a safe on the ward.
168	1	Patients can wash and use the toilet in private.
169	2	Laundry facilities are available to all patients.
170	2	The team provides information, signposting and encouragement to patients to access local organisations such as: • voluntary organisations; • community centres; • local religious/cultural groups; • peer support networks; • recovery colleges. *Guidance: Staff should have good, up-to-date knowledge of local organisations.*

171	1	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. copies of faith books, access to a multi-faith room. *Guidance: where deaf patients have contact with spiritual leaders support with communication is provided.*
172	1	There is a system in place to ensure that, where required, all patients are able to use an appropriate and well-maintained hearing aid.
173	1	Staff ensure that hearing aids are working and patients are wearing their glasses if required.
174	2	All doors (with the exception of the bathrooms and toilets) are fitted with an observation panel.
175	1	The patient's privacy and dignity is ensured when receiving intimate care.
176	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. *Guidance: A list of prohibited/restricted items is displayed visually for all to see. There is a statement of how prohibited/restricted items may differ where there are deaf patients (e.g. mobile phones, webcams, Skype, emails to facilitate communication).*
177	1	Staff members follow a protocol when conducting searches of patients and their personal property.
178	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 or referral to a podiatrist.*
Patient comfort		
179	2	The unit has arrangements to control avoidable noise and distracting visual stimuli.
180	2	There is an alternative (such as night lights) to bright fluorescent lighting in bedrooms, providing different levels of lighting which both the patients and staff can control.
Activity equipment		
181	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, computers and internet access (where risk assessment allows this).*
182	2	Patients are able to bring their personal electrical equipment into the unit, and a procedure is in place to ensure this is checked and meets safety regulations.

Outside space		
183	2	The unit has direct access to an outside space for exercise and access to fresh air, which is safe and has seating.
Staff		
184	2	Ward/unit-based staff members have access to a dedicated staff room.

Section 5: Therapies and activities

Medication		
Number	**Type**	**Standard**
185	1	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.
186	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.
187	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.*
188	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.
189	1	The team follows a policy when prescribing PRN (i.e. as required) medication.
190	2	Patients have access to a specialised pharmacist and/or pharmacy technician to discuss medications. This includes appropriate communication support.
191	3	Carers have access to a pharmacist and/or pharmacy technician to discuss medications.
192	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.
193	1	There is an agreed policy and procedure for the covert administration of medicines.
194	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.*
195	1	At the point of admission or transfer, medicines reconciliation is assessed.
Engagement		
196	2	Patients have a minimum of twice-weekly documented sessions with their Primary or Allocated Nurse to review their progress.
197	1	When communicating important information to patients, staff are able to dedicate adequate time.

Staffing		
198	2	The patient has access to an Occupational Therapist/Activity Therapist for assessment during the first 72 hours.
199	2	Staff are given planned and protected time to make sure activities and interventions are provided regularly and routinely.
Provision of activities and therapies		
200	1	Activities are provided 7 days a week and out of hours. *Guidance: Activities which are provided during working hours, Monday–Friday, are timetabled. Facilities for creative work, hobbies and special interests should be available.*
201	2	Patients have access to a minimum of twenty-five hours of meaningful activity per week.
202	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.
203	2	Manuals and visuals used during therapy sessions are provided in plain English and Easy Read/widget. Multimedia materials include sign language inserts and visual stimulation.
204	2	Deaf service users should not be prevented or delayed in accessing therapy (individual or group) because of a lack of availability of interpreters.
205	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.*
206	1	Therapy is available in BSL, if appropriate to the patient's communication needs. This is delivered directly in BSL or at least with the appropriate use of an interpreter and/or communication facilitator.
207	2	Therapy and private areas are appropriate for visual and gestural language whilst maintaining confidentiality.
208	2	Life skills training, incorporating psycho-education on topics relating to Activities of Daily Living (ADLs), interpersonal communication, relationships, coping with stigma, stress management and anger management is available.
209	2	Television has subtitles available which are used and staff are aware of programmes with BSL interpretation and make these available.

Group activities and therapies		
210	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, Monday to Friday.
211	2	Every patient has a personalised timetable of meaningful activities to promote social inclusion, which the team encourages them to engage with. *Guidance: This might include activities such as education, employment, volunteering, leisure activities and caring for dependants.*
212	2	There is evidence of active positive promotion of Deaf culture and meeting of Deaf cultural needs, e.g. access to Deaf club.

Appendix 1: Acknowledgements

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Appendix 2: Glossary of terms and abbreviations

Allocated nurse	The nurse responsible for the patient's care for the duration of a shift.
BSL	British Sign Language – a manual language with its own grammar and structure.
Capacity	The ability to understand and give legal consent to an action or arrangement.
Care plan	A written plan outlining a patient's needs whilst in inpatient care, and who will be responsible for providing this care.
Carer	Refers to people who care for or support the deaf person with mental health problems. This includes family carers, advocates, befrienders, associates, paid staff (see also **family carer**).
Clinical governance	A systematic approach to maintaining and improving the quality of patient care.
Clinical supervision	Supervision with a skilled professional to review clinical practice.
Consent	Agreement to an action or arrangement.
CPA	Care Programme Approach: The process mental health service providers use to coordinate care for mental health patients.
Deaf with a capital D:	Is used to denote people who use BSL as their first language and see themselves as part of a cultural minority group.
Deprivation of Liberty Safeguards (DoLS)	These are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the Mental Capacity Act 2005 and apply to people in care homes or hospitals where they may be deprived of their liberty.
Family carer	This term is used to refer specifically to non-professional and unpaid carers.
Managerial supervision	Supervision with a line manager to review work practices.
MDT	Multi-Disciplinary Team - all health professionals involved in patient care.
MHA	Mental Health Act.
Mental Health Act Section 117	Under section 117, health authorities and local social services have a legal duty to provide aftercare for patients who have been on sections 3, 37, 47 or 48, but who have left hospital.

Named nurse	This is a nurse who will have a special responsibility for a patient while they are in hospital.
NICE	National Institute for Health and Clinical Excellence.
Patient	For the purposes of this document, the term 'patient' has been used to differentiate deaf people who are receiving care on the ward from other people in the standards, such as staff and carers.
PRN	'Pro re nata' (as required). This refers to being prescribed medication when it's needed, rather than regularly at the same time each day.

Appendix 3: Bibliography

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