

**QED Inpatient starter form**

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| Trust/Organisation: | Click here to add text |
| Ward/Unit name: | Click here to add text |
| Ward/Unit address:  | Click here to add text |
| Ward/Unit Telephone number: | Click here to add text |
| Number of beds: | Click here to add text |

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| Primary contact details*This is the person to whom we will send* ***all*** *communications, including the final accreditation decision, unless otherwise specified)* |
| Title: | Click here to add text |
| First name: | Click here to add text | Surname: | Click here to add text |
| Job title/designation | Click here to add text |
| Address: | Click here to add text |
| Telephone number: | Click here to add text |
| Email address: | Click here to add text |

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| Secondary contact details *Please give Ward/Unit Manager contact details, or a second suitable link person* |
| Title: | Click here to add text |
| First name: | Click here to add text | Surname: | Click here to add text |
| Job title/designation | Click here to add text |
| Address: | Click here to add text |
| Telephone number: | Click here to add text |
| Email address: | Click here to add text |



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| Peer-reviewers*Please list any reviewers from your ward/unit who are accreditation trained and will be able to visit another service this year* |
| Name | Role | Email address |
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| Please list the names of additional staff members who would like the opportunity to train as peer-reviewers*Please note that it is a condition of membership to provide at least two peer-reviewers from your ward – one nurse and one member of the MDT (e.g. psychologist, psychiatrist, occupational therapist)* |
| Name | Role | Email  |
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| Peer-review date booking*Please choose three suitable dates in at least four months’ time in order to give your team enough time to complete the self-review and data collection process.**Please select dates that enable maximum participation from the MDT, frontline staff and ward/unti management.* |
| Date one : |  |
| Date two : |  |
| Date three : |  |
| * **I confirm that the ward/unit team have discussed and agreed that staff will be available to receive a peer-review visit on the dates above.**
* **We understand that the QED Project Team will confirm one of these dates with us, and that once agreed, the date cannot be changed.**
* **We accept that if we choose to cancel the review on the date agreed, the ward/unit may be liable to cancellation/re-scheduling charges.**
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| Staffing*Please detail how many members of staff of the following professions have regular input onto the ward. Please give actual numbers of staff and whole time equivalents.* |
| Profession | Number | WTE |
| Administrator: |  |  |
| Dietitian: |  |  |
| Nursing assistant: |  |  |
| Occupational therapist: |  |  |
| OT support worker, assistant psychologist or student nurse: |  |  |
| Other clinical (e.g. physiotherapist): |  |  |
| Other non-clinical (e.g. social worker, chaplain): |  |  |
| Pharmacists/pharmacy technicians: |  |  |
| Psychiatrists: |  |  |
| Psychologists: |  |  |
| Registered nurses: |  |  |
| Total:  |  |  |

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| Minimum staffing levels |
| Shift | Qualified | Unqualified  |
| Early |  |  |
| Late |  |  |
| Night  |  |  |

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| Email discussion group*Please list any staff members in your service who would like to be part of the QED mailing list and Knowledge Hub platform* |
| Name | Role | Email |
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Please complete and return this form to Hannah Lucas (Hannah.Lucas@rcpsych.ac.uk)**.**

**Please note: It is your responsibility to notify us of any changes to the information provided on this form.**