QNLD
QUALITY NETWORK FOR INPATIENT LEARNING DISABILITY SERVICES
CCQI

AIMS
ACCREDITATION FOR INPATIENT MENTAL HEALTH SERVICES
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ROYAL COLLEGE OF PSYCHIATRISTS

Standards for adult inpatient learning disability services

Third edition: July 2016

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A manual of standards written primarily for:
Adult inpatient services for people with learning disabilities

Also of interest to:
People with learning disabilities
Family and friends of people with learning disabilities
Commissioners
Policy makers
Researchers

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This document contains the third edition of the standards for adult inpatient learning disability services. This is the first edition published under the name Quality Network for Inpatient Learning Disability Services (QNLD). This reflects the change in the structure of the programme following the introduction of a quality network cycle in 2009. These standards will be used for both quality improvement and accreditation processes (AIMS-LD) within the network.

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Foreword

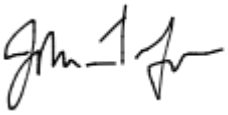
People with learning disabilities often face barriers in accessing health care, especially when staff lack the appropriate specialist knowledge, communication skills and learning disability awareness.

For those people who have a learning disability and a mental health problem, accessing good quality care can be even more difficult. Left untreated, these problems can become worse and have a devastating impact on a person's health and wellbeing. People with learning disabilities deserve good quality, timely and evidence-based mental health care, delivered by competent and compassionate staff and provided in a safe and therapeutic environment.

With changes afoot to the provision of mental health services for people with learning disability, never has it been more important to ensure that the care provided is of the highest standard. Staff should ensure that patients receive consistent and thorough assessment and care plans, centred on the person's needs, risks and strengths. Transitions between services should be handled smoothly and systematically, with attention being given to ensuring the patient's individual needs are well communicated between services and acted upon.

This set of standards sets out to describe how inpatient mental health units for people with learning disability can deliver good quality assessment, care, treatment and discharge planning. It is hoped that by following these standards and taking part in the Quality Network for Learning Disability mental health services (QNLD), services can build on the good work they are already doing and make improvements where these are needed. Once ready to do so, services can become officially accredited by the Royal College of Psychiatrists. This process might seem challenging but the QNLD project team are here to 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, achieving more together than they could alone.

We hope that members of QNLD 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 happy to help you.



Dr John Devapriam
Chair, QNLD Advisory Group and Accreditation Committee

Introduction

What is the Quality Network for Inpatient Learning Disability Services (QNLD)?

QNLD is a standards-based quality network that facilitates the sharing of good practice, provides a system of standards-based external peer-review and provides accreditation. It engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised. Services are supported to identify areas for improvement and set achievable targets for change.

Accreditation is offered to services that are fully prepared. It is recommend that a minimum of one year's membership is completed before services transfer to accreditation.

How have the QNLD standards been developed?

The standards for the Quality Network for Inpatient Learning Disability Services (QNLD) are developed from key documents and expert consensus as well as drawing from previous editions of the standards and the Standards for Inpatient Mental Health Services (Royal College of Psychiatrists, 2015) that have been recently published.

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:** criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;

- **Type 2:** criteria that a service would be expected to meet.

Membership pathway

QNLD Year I

In year one members complete a limited self-review, and the peer-review visit is focused on quality improvement, rather than a rigorous assessment of performance against the standards. The peer-review team meets with the members of the host team to discuss practice covered in two sections of the standards selected by the hosts. During these meetings, good practice is shared, and the results of the self-review of these sections of the standards are validated. The day also involves a tour of the host service and an open discussion on an area of practice that the host unit would like to improve upon.

QNLD Year II

Stage two is a more comprehensive process of both self- and peer-review and feedback is collected from patients, carers and staff. The peer-review visit covers all sections of the standards and meetings with different groups (senior clinicians, front line staff, patients and carers) take place. This process is intended to help members fully understand what is required once they progress to accreditation, and to identify any deficits in practice that might be barriers to accreditation. A summary of the results from the self-review will inform discussions at the visit by the peer-review team. The same review format is used in the accreditation stage.

Accreditation

When services move to the accreditation stage, 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 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.

The review cycle

*Stage 5 is only applicable to wards/units participating in the accreditation stage.

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;

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.

1. Admission and assessment

No.	Type	Standard	Reference
Access and referral			
1.1	1	Accessible information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on: • A simple description of the ward/unit and its purpose; • Admission criteria; • Clinical pathways describing access, discharge, timescales and treatment pathways; • Main interventions and treatments available; • Contact details for the ward/unit and hospital.	Core (1.1)
First hour of admission			
1.2	1	Staff make people feel welcome when they arrive on the unit.	GPP
1.3	1	On admission to the ward/unit, or when the patient is well enough, staff members show the patient around.	Core (3.3)
1.4	1	Staff members are easily identifiable (for example, by wearing appropriate identification).	Core (3.4)
First 4 hours of admission			
1.5	2	The patient is given an age appropriate 'welcome pack' or introductory information that contains the following: • A clear description of the aims of the ward/unit; • The current programme and modes of treatment; • The ward/unit team membership; • Personal safety on the ward/unit; • The code of conduct on the ward/unit; • Ward/unit facilities and the layout of the ward/unit; • What practical items can and cannot be brought in; • Clear guidance on the smoking policy in smoke-free hospitals and how to access smoking breaks off the hospital grounds; • Resources to meet spiritual, cultural and gender needs. *Guidance: The information is provided in an accessible format.*	Core (4.1)
1.6	1	Staff members explain the purpose of the admission to the patient.	Core (4.3)
1.7	1	The patient's carer or next of kin is contacted by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details.	Core (4.4)
1.8	1	Detained patients are given accessible information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes.	Core (4.5)
1.9	1	Patients are given accessible information on: • Their rights regarding consent to care and treatment; • How to access advocacy services (including independent mental capacity advocate and independent mental health advocate); • 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.	Core (4.6)
1.10	1	Where a patient is being admitted directly from the community, the admitting nurse checks that the referring agency gives clear details on and management plans for: • The security of the patient's home; • Arrangements for dependents (children, people they are caring for); • Arrangements for pets.	Core (4.7)

No.	Type	Standard	Reference
1.11	1	Patients have a comprehensive assessment which is started within 4 hours and completed within 1 week. This involves the multi-disciplinary team and includes patients': • Mental health and medication; • Psychosocial needs; • Strengths and weaknesses, which must include an adaptive functioning assessment and an assessment of sensory needs; • Personal preferences including coping strategies and challenges, traits and routines.	Core (4.8)
1.12	1	Patients have a comprehensive physical health review. This is started within 4 hours of admission, completed within 1 week, and reviewed on discharge. It includes: FIRST 4 HOURS • Details of past medical history; • Current medication, including side effects and compliance (information is sought from the patient history and collateral information within the first 4 hours. Further details can be sought from medical reconciliation after this); • Physical observations including blood pressure, heart rate and respiratory rate. FIRST 24 HOURS • Physical examination; • Height, weight; • Blood tests (can use recent blood tests if appropriate); • ECG. FIRST 1 WEEK • Details of past family medical history; • A review of physical health symptoms; • Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use. *Guidance: Staff should also check the status of the patient's annual health check.*	Core (4.9)
1.13	1	Patients are offered a staff member of the same gender as them, and/or a chaperone of the same gender, for physical examinations.	Core (4.10)
1.14	1	Patients are informed of the outcome of their physical health assessment and this is recorded in their notes. *Guidance: With patient consent, this can be shared with their carer.*	Core (4.11)
1.15	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.	Core (4.12)
1.16	1	The team discusses the purpose and outcome of the risk assessment with each patient and a management plan is formulated jointly.	Core (4.13)

No.	Type	Standard	Reference
Completing the admission process			
1.17	1	All patients have a documented diagnosis and clinical formulation. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.*	Core (5.1)
1.18	2	The community team (including the social worker) and the GP are informed about the patient's admission within five working days.	GPP

2. Care planning and treatment

No.	Type	Standard	Reference
Reviews and care planning			
2.1	1	There is a documented admission meeting within one week of the patient's admission. *Guidance: This could take the form of a ward round meeting or a Care Programme Approach meeting (or equivalent), should include the community team where possible and the patient is invited to attend.*	Core (6.4)
2.2	1	Actions from reviews are fed back to the patient (and carer, with the patient's consent) and this is documented.	Core (6.7)
2.3	1	Risk assessments and management plans are updated according to clinical need or at a minimum frequency.	Core (6.8)
2.4	1	Every patient has a written care plan, reflecting their individual needs. *Guidance: This clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance directives or stated wishes that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.*	Core (6.9)
2.5	1	Care plans are developed collaboratively with the patient. *Guidance: Patients' preferences are taken into account around the selection of medication, therapies and activities, and are acted upon as far as possible.*	Core (6.2, 8.1.2)
2.6	1	The patient and their carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.	Core (6.12)
2.7	1	The team reviews and updates care plans according to clinical need or at a minimum frequency.	Core (6.11)
Leave from the ward/unit			
2.8	1	The team develops a leave plan jointly with the patient that includes: • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave, escorted, accompanied, unescorted; • Contact details of the ward/unit. *Guidance: If there are concerns about a patient's cognition, the risk assessment includes consideration of whether the patient may be driving/using heavy machinery etc. and there is a plan in place to manage this.*	Core (7.1)
2.9	1	Staff members feel safe when escorting patients on leave.	Core (7.2)
2.10	1	Patients are sent on leave into the care of carers only with carer agreement and timely contact with them beforehand.	Core (7.3)
2.11	1	The team follows a protocol for managing situations where patients are absent without leave.	Core (7.4)
Care and treatment			
Therapies and activities			
2.12	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.*	Core (8.1.1)

No.	Type	Standard	Reference
2.13	1	Activities are provided 7 days a week and out of hours. *Guidance: Activities which are provided during working hours, Monday–Friday, are timetabled.*	Core (8.1.6)
2.14	2	Every patient has a personalised timetable of meaningful activities to promote social inclusion, which the team encourages them to engage with. *Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*	Core (8.1.7)
2.15	1	Every patient is engaged in active conversation at least twice a day by a staff member. *Guidance: This is an opportunity for patients to discuss any issues or difficulties they are experiencing.*	Core (8.1.8)
2.16	2	Each patient receives a pre-arranged session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns. *Guidance: Include family or carers where appropriate.*	Core (8.1.9)
2.17	1	Patients and carers are offered accessible information about challenging behaviour, autism, sensory needs, physical health needs and the patient's mental illness. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.*	Core (8.1.10)
2.18	2	There is a regular 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. Actions should be followed up at each meeting. The frequency is agreed with the patient group.*	Core (8.1.11)
2.19	2	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	Core (8.1.12)
2.20	1	Patients are able to leave the ward/unit to access safe outdoor space every day.	Core (8.1.13)
2.21	2	The team provides information, signposting and encouragement to patients to access local organisations for peer support and social engagement such as: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	Core (8.1.14)
2.22	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	Core (8.1.15)
2.23	1	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment.	Core (8.1.16)

No.	Type	Standard	Reference
Medication			
2.24	1	The indication(s) and rationale for prescribing psychotropic drugs is clearly stated, including whether the prescribing is off-label, polypharmacy or high dose.	Fac
2.25	1	Consent-to-treatment procedures (or best interest decision-making processes) should be followed and documented.	Fac
2.26	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. *Guidance: Best interest processes are followed if the patient does not have the capacity to consent.*	Core (8.2.2)
2.27	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.*	Core (8.2.3)
2.28	1	Review and evaluation of the need for continuation or discontinuation of the psychotropic drug should be undertaken on a regular basis (preferably every 3 months or less, at a minimum every 6 months) or whenever there is a request from patients, carers or other professionals.	Fac
2.29	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.	Core (8.2.4)
2.30	1	The team follows a policy when prescribing PRN (i.e. as required) medication.	Core (8.2.5)
2.31	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.	Core (8.2.6)
2.32	2	Patients have access to a specialised pharmacist and/or pharmacy technician to discuss medications.	Core (8.2.8)
2.33	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.*	Core (8.2.10)
Physical healthcare			
Physical healthcare, personal hygiene and substance misuse			
2.34	1	Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.*	Core (9.1.1)
2.35	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.	Core (9.1.2)

No.	Type	Standard	Reference
2.36	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency. *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor.*	Core (9.1.3)
Managing the physical health of patients on mood stabilisers or antipsychotics			
2.37	1	The physical health of long-stay patients who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the patient: • A personal/family history (at baseline and annual review); Lifestyle review (at every review); • Weight (every week for the first 6 weeks); • Waist circumference (at baseline and annual review); • Blood pressure (at every review); • Fasting plasma glucose/ HbA1c (glycated haemoglobin) (at every review); • Lipid profile (at every review).	Core (9.2.1)

3. Safety, discharge, capacity and consent

No.	Type	Standard	Reference
Risk and safeguarding			
3.1	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; • Recognising and responding to the signs of abuse or neglect.	Core (10.1)
3.2	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.	Core (10.2)
3.3	1	If a patient is identified as at risk of absconding, the team completes a plan, which includes clear instructions for alerting and communicating with carers, people at risk and the relevant authorities.	Core (10.3)
3.4	1	The team effectively manages violence and aggression on the ward/unit. *Guidance:* • *Staff members do not deliberately restrain patients in a way that affects their airway, breathing or circulation;* • *Restrictive intervention always represents the least restrictive option to meet the immediate need;* • *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;* • *The team does not use seclusion or segregation other than for patients detained under the Mental Health Act (or equivalent) or unless in an emergency as a last resort;** • *The team works to reduce the amount of restrictive practice used;* • *Providers report on the use of restrictive interventions to service commissioners, who monitor and act in the event of concerns.* **If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately.*	Core (10.4)
3.5	1	All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, have received training in immediate life support.	LD (5.48)
3.6	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team spends time with the patient reflecting on why this was necessary. The patient's views are sought and they are offered the opportunity to document this in their care record along with any disagreement with healthcare professionals.	Core (10.5)
3.7	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team makes sure that other patients on the ward/unit who are distressed by these events are offered support and time to discuss their experiences.	Core (10.6)
3.8	1	The team audits the use of restrictive practice, including face-down restraint. *Guidance: Audit data are used to compare the service to national benchmarks where possible.*	Core (10.7)

No.	Type	Standard	Reference
3.9	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.	Core (10.9)
Discharge planning and transfer of care			
3.10	2	Discharge planning is initiated at the first multi-disciplinary team review and a provisional discharge date is set.	Core (11.1)
3.11	1	Patients and their carer (with patient consent) are invited to a discharge meeting and are involved in decisions about discharge plans.	Core (11.2)
3.12	1	A letter setting out a clear discharge plan, which the patient takes home with them, is sent to the GP and any other 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.	Core (11.3)
3.13	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.	Core (11.4)
3.14	2	The inpatient team invites a community team representative to attend and contribute to ward rounds and discharge planning.	Core (11.5)
3.15	1	The team makes sure that patients who are discharged from hospital to the care of the community team have arrangements in place to be followed up within one week of discharge, or within 48 hours of discharge if they are at risk. *Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.*	Core (11.6)
3.16	1	When patients are transferred between wards/units there is a handover which ensures that the new team have an up to date care plan and risk assessment.	Core (11.7)
3.17	2	Where there are delayed transfers/discharges: • The team can easily raise concerns about delays to senior management; • Local information systems produce accurate and reliable data about delays; • Action is taken to address any identified problems.	Core (11.8)
Interface with other services			
3.18	1	There are coherent care pathways in place to support patients in accessing other mental health services. *Guidance: This might include inviting the mental health service to attend ward rounds and take part in joint care planning.*	Core (12.1, 12.3)
3.19	1	The team follows a joint working protocol with primary health care teams. *Guidance: This includes the team informing the patient's GP of any significant changes in the patient's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP and accessing summary care records.*	Core (12.2)

No.	Type	Standard	Reference
3.20	1	The team supports patients to access organisations which offer: • Housing support; • Support with finances, benefits and debt management. *Guidance: Housing advice and/or support is given to patients prior to discharge.*	Core (12.4)
3.21	2	There are protocols for joint working between learning disabilities and social care services.	LD (13.14)
Capacity and consent			
3.22	1	Capacity assessments are performed in accordance with current legislation.	Core (13.1)
3.23	1	Patients have an assessment of their capacity to consent to admission, care and treatment prior to admission and then within 24 hours of admission.	Core (13.2)
3.24	1	When patients lack capacity to consent to interventions, decisions are made in their best interests.	Core (13.3)
3.25	1	There are systems in place to ensure that the ward/unit takes account of any advance directives and statements that the patient has made.	Core (13.4)

4. Patient and carer experience

No.	Type	Standard	Reference
Patient involvement			
4.1	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 might include patient and carer surveys or focus groups.*	Core (14.1)
4.2	2	Patient representatives attend and contribute to local and service level meetings and committees.	Core (14.2)
Carer engagement and support			
Note: Carer involvement in the patient's care and treatment is subject to the patient giving consent and/or carer involvement being in the best interests of the patient.			
4.3	1	Carers are involved in discussions about the patient's care, treatment and discharge planning.	Core (15.1)
4.4	1	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.	Core (15.2)
4.5	2	Staff approach carers within 24 hours of the patient's admission to discuss concerns, family history and their own needs.	Core (15.3)
4.6	2	The team provides each carer with a carer's information pack. *Guidance: This includes the names and contact details of key staff members on the unit. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	Core (15.4)
4.7	2	Carers have access to a carer support network or group. This could be provided by the ward/unit or the team could signpost carers to an existing network. *Guidance: This could be a group/network which meets face-to-face or communicates electronically.*	Core (15.5)
4.8	1	The team follows a protocol for responding to carers when the patient does not consent to their involvement.	Core (15.6)
4.9	2	The ward/unit has a staff member designated as the carer lead or champion.	Core (15.7)
Treating patients with compassion, dignity and respect			
4.10	1	Patients are treated with compassion, dignity and respect.	Core (16.1)
4.11	2	Patients feel listened to and understood in consultations with staff members.	Core (16.2)
Provision of information to patients and carers			
4.12	1	Information provided to patients is available in an accessible format. *Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/ cognitive difficulties and learning disabilities. For example; easy read, audio and video materials, using symbols and pictures, using plain English, communication passports and signers. In verbal and written communication, staff should avoid using jargon. Information is culturally relevant.*	Core (17.1)

No.	Type	Standard	Reference
4.13	1	There are processes in place to facilitate the understanding of information given to patients throughout their stay. Guidance: *Staff regularly check patients' understanding of information provided.*	GPP
4.14	1	The ward/unit has access to professional interpreters and the patient's relatives are not used in this role unless there are exceptional circumstances. *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.*	Core (17.2)
Patient confidentiality			
4.15	1	Confidentiality and its limits are explained to the patient and carer on admission, in an accessible format. *Guidance: For carers this includes confidentiality in relation to third party information.*	Core (18.1)
4.16	1	All patient information is kept in accordance with current legislation. *Guidance: Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	Core (18.2)
4.17	1	The patient's consent to the sharing of clinical information outside the clinical team is recorded. If this is not obtained the reasons for this are recorded.	Core (18.3)

5. Environment and facilities

No.	Type	Standard	Reference
Ward/unit environment			
5.1	2	The ward has clear signage.	Core (19.1)
5.2	1	Male and female patients (self-defined by the patient) have separate bedrooms, toilets and washing facilities.	Core (19.2)
5.3	2	All patients have single bedrooms.	Core (19.3)
5.4	2	Patients are able to personalise their bedroom spaces.	Core (19.4)
5.5	2	The ward/unit has at least one bathroom/shower room for every three patients.	Core (19.5)
5.6	2	Laundry facilities are available to all patients.	Core (19.7)
5.7	1	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room.	Core (19.8)
5.8	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, charge points for mobile phones and electronic devices and internet access (where risk assessment allows this).*	Core (19.9)
5.9	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.*	Core (19.11)
5.10	1	Patients can wash and use the toilet in private.	Core (19.12)
5.11	1	Staff members respect the patient's personal space, e.g. by knocking and waiting before entering their bedroom.	Core (19.13)
5.12	1	Patients can make and receive telephone calls in private (subject to risk).	Core (19.14)
5.13	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.	Core (19.15)
5.14	1	There is a visiting policy which includes procedures to follow for specific groups including: • Children; • Unwanted visitors (i.e. those who pose a threat to patients, or to staff members).	Core (19.16)
5.15	1	Staff members follow a protocol when conducting searches of patients and their personal property.	Core (19.17)
5.16	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*	Core (19.18)
5.17	1	There are clear lines of sight to enable staff members to view patients. Measures are taken to address blind spots and ensure sightlines are not impeded, e.g. by using mirrors.	Core (19.19)
5.18	1	Staff, patients and visitors are able to raise alarms at any stage, i.e. using panic buttons, strip alarms, or personal alarms.	Core (19.22, 19.23)

No.	Type	Standard	Reference
5.19	1	A collective response to alarm calls is rehearsed at least 6 monthly.	Core (19.24)
5.20	1	All rooms are kept clean. *Guidance: All staff members are encouraged to help with this.*	Core (19.25)
5.21	2	Staff members and patients can control heating, ventilation and light. *Guidance: For example patients are able ventilate their rooms through the use of windows and have access to light switches and can request adjustments to control heating.*	Core (19.26)
5.22	1	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes.	Core (19.28)
5.23	1	The crash bag is maintained and checked weekly, and after each use.	Core (19.29)
5.24	2	The ward/unit has a designated room for physical examination and minor medical procedures.	Core (19.30)
5.25	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.	Core (19.31)
5.26	2	The ward/unit has at least one quiet room other than patient bedrooms for patients to relax in.	Core (19.32)
5.27	2	There is a designated space for patients to receive visits from children, with appropriate facilities such as toys, 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.*	Core (19.33)
5.28	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.	Core (19.34)
5.29	2	There are lounge areas that may become single-sex areas as required.	Core (19.35)
5.30	2	There are facilities for patients to make their own hot and cold drinks and snacks.	Core (19.37)
5.31	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.	Core (19.38)
5.32	2	Staff members ask patients for feedback about the food and this is acted upon.	Core (19.39)
5.33	2	Where smoking is permitted, there is a safe allocated area for this purpose.	Core (19.40)
5.34	2	Patients are consulted about changes to the ward/unit environment.	Core (19.42)

6. Leadership, workforce and governance

No.	Type	Standard	Reference
Leadership and culture			
6.1	1	Staff members and patients feel confident to contribute to and safely challenge decisions. *Guidance: This includes decisions about care, treatment and how the ward/unit operates.*	Core (20.6)
6.2	1	Staff members feel able to raise any concerns they may have about standards of care.	Core (20.7)
Team working			
6.3	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.	Core (21.1)
Staffing levels and skill mix			
6.4	1	The multidisciplinary team includes or has dedicated sessional time from: • Psychiatrists • Registered Nurses • Healthcare Assistants • Registered Psychologists • Occupational Therapists • Speech and Language Therapists • Social Workers	GPP
6.5	1	The ward/unit has a mechanism for responding to low staffing levels, when they fall below minimum agreed 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.	Core (22.2)
6.6	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.	Core (22.3)
6.7	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.	Core (22.4)
6.8	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.	Core (22.5)
Staff recruitment and induction			
6.9	2	Patient or carer representatives are involved in interviewing potential staff members during the recruitment process.	Core (23.1)
6.10	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.*	Core (23.3)

No.	Type	Standard	Reference
Appraisal, supervision and support			
6.11	1	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	Core (24.1)
6.12	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.*	Core (24.2)
6.13	2	Staff members in training and newly qualified staff members receive weekly supervision.	Core (24.3)
Staff wellbeing			
6.14	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.*	Core (25.1)
6.15	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.	Core (25.2)
6.16	2	Staff members have access to reflective practice groups.	Core (25.3)
Staff training and development			
6.17	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.	Core (26.2)
6.18		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:	Core (26.3)
6.19	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent);	Core (26.3a)
6.20	1	Physical health assessment; *Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input.*	Core (26.3b)
6.21	1	Recognising and communicating with patients with cognitive impairment, learning disabilities or developmental disabilities	Core (26.3c)
6.22	1	Statutory and mandatory training; *Guidance: Includes equality and diversity, information governance.*	Core (26.3d)
6.23	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	Core (26.3f)
6.24	2	Patients and carers are involved in delivering training to staff members.	Core (26.4)

No.	Type	Standard	Reference
6.25	1	All staff have received awareness training in how to communicate effectively with people within the context of a person centred approach. *Guidance: This should include:* • *The person's preferred means of communicating;* • *Use of different communication methods and visual aids;* • *Tone of voice, non-verbal communication and appropriate language;* • *Active listening techniques;* • *Recognising when people might be distressed, or suggestible/acquiescing;* • *The link between communication and challenging behaviour;* • *Checking the patient's comprehension of the information being given to them.*	LD (5.44)
Clinical outcome measurement			
6.26	2	Clinical outcome monitoring includes reviewing patient progress against patient-defined goals in collaboration with the patient.	Core (28.2)
Audit and service evaluation			
6.27	2	A range of local and multi-centre clinical audits is conducted which include the use of evidence based treatments, as a minimum.	Core (29.1)
6.28	2	When staff members undertake audits they: • Have some say in what audit topics are chosen; • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle.	Core (29.3)
The ward/unit learns from incidents			
6.29	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	Core (30.1)
6.30	1	Staff members share information about any serious untoward incidents involving a patient with the patient themself and their carer, in line with the Statutory Duty of Candour.	Core (30.2)
6.31	1	Staff members, patients and carers who are affected by a serious incident are offered a debrief and post incident support.	Core (30.3)
6.32	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.	Core (30.4)
6.33	2	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice.	Core (30.5)

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[1] For the full list of advisory group members please visit www.rcpsych.ac.uk/QNLD.

Key to references

These standards were derived from the following documents:

Core	Royal College of Psychiatrists (2015) Standards for Inpatient Mental Health Services.
Fac	Royal College of psychiatrists (2016) Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviour that challenge: practice guidelines. Faculty of Psychiatric of Intellectual Disability. Faculty Report.
GPP	'Good Practice Principle': established by expert consensus (see acknowledgements page for details of those who contributed).
LD	Royal College of Psychiatrists (2012). Accreditation for Acute Inpatient Mental Health Services (AIMS): Standards for Adult Inpatient Learning Disability Units – Assessment and Treatment Units (2nd Edition).

For more details on the source documents please email LD@rcpsych.ac.uk.

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