Standards for Inpatient Mental Health Services

Second edition, 2017

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COLLEGE CENTRE FOR QUALITY IMPROVEMENT CCQI

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Contents

Foreword

I am pleased to introduce the Royal College of Psychiatrists' second edition of core standards for inpatient mental health services. These standards, which have been closely aligned to the patient experience, are designed to be used across all mental health services to improve the quality of care provided. The standards cover important areas such as: providing timely evidence-based care and treatment, supporting patients/carers and treating them with dignity, looking after staff, evaluating and improving services.

These standards allow healthcare professionals across mental health settings to have a shared understanding of good quality care. Patients will be clearer about what they can expect from mental health services, regardless of the setting. The standards should lead to less unwanted variation between services and overall better care for patients.

These standards have been developed in the landscape of other important pieces of work including PAS 1616 (Healthcare – Provision of clinical services – Specification) (1) and the CQC standards (2). These standards have formed the basis for developing a shorter set of standards as per the recommendation from the report led by Lord Crisp entitled; *Improving acute inpatient psychiatric care for adults in England (3).*

I would like to thank the many patients, carers, healthcare professionals and CCQI (College Centre for Quality Improvement) staff who have worked to develop this second set of core standards.

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References

1) BRITISH STANDARDS INSTITUTION. *PAS 1616:2016. Healthcare-Provision of clinical services-Specification.* 2016.

2) CQC. *Fundamental standards* http://www.cqc.org.uk/content/fundamental-standards (Accessed 1.5.17).

3) CRISP N. *Improving acute inpatient psychiatric care for adults in England.* July 2015. http://media.wix.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf (Accessed 22.4.17).

Introduction

Description and scope of the standards

The second edition of the core standards for inpatient mental health services has been revised by the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI). It is based on the first edition which was created by the CCQI and the British Standards Institution (BSI).

The inpatient standards cover access to the ward/unit and what a good admission looks like (which includes assessment, care, treatment and discharge planning). They also cover ward/unit environment, staffing and governance.

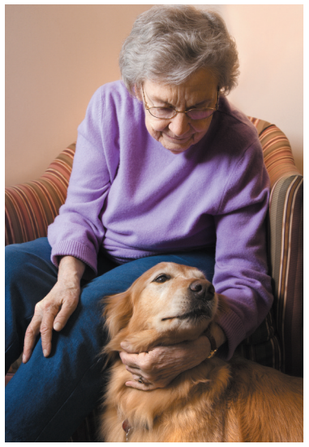
How the standards were developed

A literature review was undertaken to identify any evidence published since 2015 which could be used to update standards from the first edition, and create new standards. The standards then underwent a consultation process. As a first step, each standard was rated according to critical to quality (defined as proximity to patient experience), clarity and measurability on a scale of 1-5 (1=low, 5=high). The rating was done by a small team of experts which included a patient representative. Those standards which scored low for proximity to patient experience were discussed and a decision was made about whether they could be removed. The resulting set of standards were all defined as being critical to quality (defined as proximity to patient experience). Those standards which scored low for clarity and measurability were also discussed; they were improved where possible, and on occasions removed (for example, if a standard could not be measured this would be removed).

The next step in the consultation process was to seek feedback from a wide range of stakeholders. A steering group made up of clinical, patient and carer experts enabled representation from a wide range of professions and specialties. Feedback was also sought from other sources including CCQI staff and the chair persons of the CCQI advisory groups. The standards were then edited based on this feedback.

The following principles were used to guide the development of these standards:

- Access: Patients have access to the care and treatment that they need, when and where they need it.
- Compassion: All services are committed to the compassionate care of patients, carers and staff.
- Valuing relationships: The value of relationships between people is of primary importance.
- Patient and carer involvement: Patients and carers are involved in all aspects of care.
- Learning environment: The environment fosters a continuous learning culture.
- Leadership, management, effective and efficient care: Services are well led and effectively managed and resourced.
- Safety: Services are safe for patients, carers and staff.



How the core standards will be used

The core standards will be used by the clinical audits, quality networks and accreditation programmes within the CCQI. Each project will take on the relevant core standards which will be used alongside their own specialist standards.

Use of terminology

The core inpatient standards use the terms 'patient' and 'carer'. The decision was made to use these terms during the consultation process for the first edition of the core standards. When projects come to take on these standards, they will be able to change these terms to best suit their specialty. For example, child and adolescent mental health services may wish to replace the term 'patient' with 'young person'.

Some of the standards have a 'p' next to their number which denotes a 'placeholder' standard. When projects come to take on the placeholder standards, they will be expected to adapt the standards to meet their specialty requirements. For example, early intervention services would be expected to adapt some of the placeholder standards such that they align with the NHS England access and waiting time standards (1).

Criteria

All criteria are rated as Type 1, 2 or 3.

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

Type 2: Expected standards that most services should meet.

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

References

1) NHS ENGLAND. *Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16.* 2015. https://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf (Accessed 22.4.17).

Number	Type	Standard	Ref
1		**Access**	
1.1	1	Clear information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on: • A simple description of the ward/unit and its purpose; • Admission criteria; • Clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for the ward/unit and hospital.	1, 2, 3, 4, 5, 6
1.2p	2	When a referral is received by the ward, the patient is admitted within an agreed timeframe. If this timeframe is breached, this is escalated to the senior management team.	5, 7
1.3	1	Senior clinical staff members (ward/unit manager/nurse in charge) make decisions with managers about patient admission or transfer, taking into account safety and/or therapeutic activity on the ward.	4, 5, 8
1.4	1	Staff members follow a clear policy when admitting young people under the age of 18. The policy includes: • When it is appropriate, and not appropriate, to admit young people under the age of 18; • Arrangements to ensure that young people receive age-appropriate care (this includes guidance on when and how to access the local CAMHS team); • Arrangements to ensure the safety and safeguarding of young people on the ward.	5, 9
1.5	2	Patients returning from ward leave are able to access a bed on their ward within 6 hours.	5
2		**First 12 hours of admission**	
2.1	1	On admission to the ward/unit, patients feel welcomed by staff members. *Guidance: Staff members:* • *Show patients around and introduce themselves and other patients;* • *Offer patients refreshments;* • *Address patients using the name and title they prefer.*	4, 5, 10, 11
2.2	1	Staff members wear their organisational ID when working on the ward and this is easily visible.	12
2.3	1	Staff members explain/reiterate the purpose of the admission to the patient within the first 12 hours of admission or as soon as is practically possible.	4, 5
2.4	1	The patient's carer is contacted by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details.	4

Number	Type	Standard	Ref
2.5	1	All patients are given verbal and written information on their legal status and their rights under the Mental Health Act (or equivalent). This is documented in their notes.	6, 13, 14
2.6	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes; • Their rights regarding consent to care and treatment; • How to access advocacy services (including independent mental capacity advocates and independent mental health advocates); • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.	4, 6, 12, 13, 14, 15
2.7	1	Patients have a comprehensive initial 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 and psychological needs; • Strengths and areas for development.	4, 12, 15, 16
2.8a		Patients have a comprehensive physical health review. This is started within 4 hours of admission, or as soon as is practically possible. The assessment is completed within 1 week, or prior to discharge. It includes: **FIRST 4 HOURS** • Details of past medicines reconciliation history; • Current medication, including side effects and adherence (information is sought from the patient history and available collateral information within the first 4 hours. Further details can be sought from medical reconciliation after this); • Consideration of whether the patient is at risk of withdrawal from drugs/alcohol; • Physical observations including blood pressure, heart rate and respiratory rate.	4, 5, 17, 18
2.8b		**FIRST 24 HOURS** • Physical examination; • Height, weight; • Blood tests (Can use recent blood tests if appropriate); • ECG.	4, 5, 17, 18
2.8c		**FIRST 1 WEEK** • Details of past family medical history; • A review of physical health symptoms and a targeted systems review; • Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.	4, 5, 17, 18
2.9	1	Patients are asked for their preference of staff member to act as a chaperone for physical examinations. This is provided if feasible and if not the reasons for this are documented.	4, 14

Number	Type	Standard	Ref
2.10		Patients have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers: • Risk to self; • Risk to others; • Risk from others.	4, 6, 19, 20
2.11		When a patient has been admitted directly and suddenly from the community, the admitting nurse checks that the referring agency (in collaboration with the patient or carer wherever possible) has: • Checked the security of the patient's home; • Made arrangements for dependents; • Made arrangements for pets and any other essential issues.	10

3 Completing the admission process

3.1	2	The patient is given a '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; • Resources to meet spiritual, cultural and gender needs; • A description of how the ward team will communicate with the patient and their carers and what opportunities they will have to meet with the team. *Guidance: The information pack is co-designed with patients.*	4, 14, 21
3.2	1	All patients have a documented diagnosis and a clinical formulation. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.*	4, 5, 22

4 Reviews and care planning

4.1	1	Patients are informed of the staff member who is their first point of contact for each shift. This should be someone who understands the patient's condition and with whom the patient can meet with on a one-to-one basis to discuss any issues or difficulties they are experiencing.	23
4.2	1	Patients know who their keyworker is and how to contact them if they have any questions.	23
4.3p	1	Managers and practitioners comply with agreed minimum frequencies of clinical review meetings.	4, 10

Number	Type	Standard	Ref
4.4	1	Patients are supported by staff members, before (to prepare), during (to understand) and after (to feedback outcomes) any formal review of their care.	5, 24
4.5	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).*	10
4.6p	1	Risk assessments and risk management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	4, 25
4.7	1	Every patient has a written care plan, reflecting their individual needs. Staff members actively seek to collaborate with patients and their carers (with patient consent) when developing the care plan. *Guidance: The care plan clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance directives or statements that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.*	1, 2, 4, 12, 27, 28
4.8	1	The patient (and their carer, with the patient's consent) are offered a copy of the care plan and the opportunity to review this.	12, 29
5		**Leave from the ward/unit**	
5.1	1	The team and patient jointly develop a leave plan that includes: • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave; • Contact details of the ward/unit and crisis numbers.	4, 5, 29
5.2	1	Staff members feel safe when escorting patients on leave.	4, 26
5.3	1	Patients are only sent on leave into the care of their carers by mutual agreement with their carers, and timely contact with them beforehand.	8
5.4	1	When patients are absent without leave, the team (in accordance with local policy): • Activate a risk management plan; • Make efforts to locate the patient; • Alert carers, people at risk and the relevant authorities; • Complete an incident form.	4, 5

Number	Type	Standard	Ref
6		**Care and treatment – therapies and activities**	
6.1.1p	1	Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within a timeframe which complies with national standards e.g. as set by NHS or professional bodies. Any exceptions are documented in the case notes.	4, 5, 13, 30, 31, 32
6.1.2a, p	1	Input from psychologists and accredited psychological therapists is sufficient to: • Provide assessment and formulation of patients' psychological needs; • Ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway;	33, 34, 35
6.1.2b, p	2	• Support a whole team approach to the provision of a stepped care model that provides patients with the appropriate level of psychological intervention for their needs.	33, 34, 35
6.1.3p	1	Input from occupational therapists is sufficient to: • Provide an occupational assessment for those patients who require it; • Ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs through a defined pathway.	5, 14
6.1.4	2	Patients have access to art/creative therapies.	5, 14
6.1.5	3	Life skills training is available for patients. This could include psychoeducation on: • Topics about activities of daily living; • Interpersonal communication; • Relationships; • Coping with stigma; • Stress management and anger management.	5, 8
6.1.6	1	A range of accessible activities are provided 7 days a week, including evenings and bank holidays. *Guidance: Activities which are provided during working hours, Monday- Friday, are timetabled.*	4, 5, 10, 12, 36, 37
6.1.7	2	Every patient has a personalised timetable of activities to promote social inclusion, which the team encourages them to engage with. *Guidance: The patient and team should agree this together and this could include lesiure activities, caring for dependants, educational, volunteering or employment opportunities.*	4, 10, 12, 36
6.1.8	1	Each patient receives a pre-arranged 1-hour session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.	4, 10, 28, 38
6.1.9	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment. Guidance: *Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psychoeducation group. Written information could include leaflets or websites.*	3, 4, 5, 6, 10, 28, 39

Number	Type	Standard	Ref
6.1.10	2	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. *Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.*	4, 5, 10
6.1.11	2	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	29
6.1.12	1	Patients are able to leave the ward/unit to access safe outdoor space every day.	10, 36
6.1.13	2	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	4, 10, 30, 40
6.1.14	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	32, 41, 42
6.1.15	1	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.	11, 29

6.2 Care and treatment – medication

6.2.1	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	4, 5
6.2.2	1	Patients (and their carers, with patient consent) are helped to understand the purpose, expected outcomes, interactions, limitations and side effects of their medications. This is to enable them to make informed choices and to self-manage as far as possible.	3, 5, 29, 40
6.2.3	1	Patients on acute wards have their medications reviewed at least weekly. Patients on non-acute wards have their medications reviewed as necessary and as a minimum at each ward round. 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.*	4, 5, 29
6.2.4	1	When patients experience side effects from their medication, there is a care plan, which has been developed with the patient, for managing this.	4
6.2.5	1	The prescribing staff member follows a policy when prescribing PRN (i.e. as required) medication.	17

Number	Type	Standard	Ref
6.2.6	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.	10
6.2.7	1	The service collects data on the safe prescription of high risk medications such as; lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines. The service uses this data to make improvements and continues to monitor the safe prescription of these medications on an ongoing basis.	4
6.2.8	2	Patients, carers and prescribers are able to contact a specialised pharmacist and/or pharmacy technician to discuss medications.	29

7 Physical healthcare

7.1	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.*	29, 43, 44
7.2	1	Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan.	3, 21, 43, 44
7.3	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.*	4
7.4	1	Patients who are prescribed mood stabilisers or antipsychotics are offered and encouraged to have the appropriate physical health assessments at the start of treatment (baseline). If they are in hospital for long periods of time, the appropriate physical health assessments should be done at 6 weeks, at 3 months and then annually (or 6 monthly for young people) unless a physical health abnormality arises.	3, 5, 45, 46, 47

8 Risk and safeguarding

8.1	1	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the ward. *Guidance: Staff members should consider whether sexual incidents that are said to be consensual have been the result of coercion or exploitation or where a person's capacity to consent may have been affected by their mental health. Where there is any doubt the incident must be investigated. Links must be established with the police in serious untoward incidents and to child protection and vulnerable adult policies.*	5, 48
8.2	1	Patients are told about the level of observation that they are under, how it is instigated and the review process.	4, 14
8.3	1	Staff members do not restrain patients in a way that affects their airway, breathing or circulation.	13, 19, 49

Number	Type	Standard	Ref
8.4	1	Individualised support plans, incorporating behaviour support plans, are implemented for all patients who are known to be at risk of being exposed to restrictive interventions. *Guidance: The support plans are developed using functional analyses/applied behaviour analyses to understand, manage and prevent incidents.*	4, 13, 19, 49
8.5	1	The team does not use seclusion or segregation other than for patients detained under the Mental Health Act (or equivalent) or unless in an emergency as a last resort.* *If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Mental Health Act (or equivalent) should be undertaken immediately.	13, 19, 49
8.6	1	Patients who are involved in episodes of control and restraint, or compulsory treatment including rapid tranquilisation, have their vital signs monitored by staff members and any deterioration is responded to.	13, 19, 49
8.7	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team makes sure that the patient, and any other patients on the ward/unit who are distressed by the event, are offered support and time to discuss their experiences.	12, 13, 19, 49
8.8	1	The multi-disciplinary team collects audit data on the use of restrictive interventions and actively works to reduce its use year on year. *Guidance: Audit data are used to compare the service to national benchmarks where possible.*	4, 49
8.9	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.	10, 26, 50

9 Discharge planning and transfer of care

9.1	2	Discharge planning is initiated at the first multidisciplinary team review.	4, 29, 51
9.2	2	The inpatient team invites a community team representative, and any other relevant professionals, to attend and contribute to ward rounds and discharge planning. *Guidance: If the representative is unable to attend in person, teleconferencing facilities may be used.*	4, 51, 52
9.3	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 including monitoring arrangements; • Details of when, where and who will follow up with the patient.	4, 10, 51

Number	Type	Standard	Ref
9.4	1	When a patient is discharged, the inpatient team ensures that they are followed up by a mental health specialist within 48 hours. *Guidance: Follow up is likely to be by a member of the inpatient, home treatment or community team and can be in person or on the telephone. The exact timing will depend on clinical need and there is a policy in place to manage situations where this does not happen.*	5, 53, 54
9.5	1	When patients are transferred between wards/units/teams there is a handover which ensures that the new team have an up to date care plan and risk assessment.	55
9.6	3	Teams provide specific transition support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. *Guidance: The team provides:* • *Transition mentors;* • *Transition support packs;* • *Training for patients on how to manage transitions.*	5, 51
9.7	2	There is a dedicated discharge liaison worker to prevent and progress delayed discharges.	4, 5, 29
9.8	1	When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, in a non-threatening manner, taking their wishes into account as far as possible.	5
9.9	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; • Ensuring the patient has a safe method of transport to return home.	4, 5, 10

10 Interface with other services

10.1	1	Patients are supported by staff members to access care from other mental and physical health services to meet their needs. This includes; • Accident and emergency; • Social services; • Local and specialist mental health services e.g. liaison, eating disorders, rehabilitation; • Secondary physical healthcare.	3, 23, 51
10.2	3	The team supports patients to attend an appointment with their community GP whilst an inpatient.	5

Number	Type	Standard	Ref
10.3	1	The team supports patients to access support with finances, benefits, debt management and housing. *Guidance: The team should have joint working protocols with relevant organisations. Housing advice and/or support is given to patients prior to discharge.*	4, 5, 23
10.4	1	Patients with drug and alcohol problems have access to specialist help e.g. Dual diagnosis services.	5, 10, 56
10.5	1	The ward/unit/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.	1, 4
10.6	1	All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates) for those detained.	5, 13

11 Capacity and consent

11.1	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation.	4, 5, 6, 10, 13, 57
11.2	1	There are systems in place to ensure that the ward/unit takes account of any advance decisions or statements that the patient has made. *Guidance: These are accessible and staff members know where to find them.*	4, 5, 13, 57

12 Patient involvement

12.1	2	Patients and their carers are encouraged to feed back confidentially about their experiences of using the service, and their feedback is used to improve the service. *Guidance: Feedback is independently sought (i.e. not by the clinical team).Their feedback is triangulated with other feedback to make it as accurate as possible. Staff members are informed of patient feedback.*	6, 37
12.2	2	Services are developed in partnership with patient and carer representatives. *Guidance: This might involve patient and carer representatives attending and contributing to local and service level meetings and committees.*	4, 8
12.3	1	Patients are actively involved in shared decision making about their mental and physical health care, treatment and discharge planning and supported in self-management.	3, 6, 14, 40, 37

Number	Type	Standard	Ref
13		**Carer engagement and support**	
13.1	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	3, 58, 59
13.2	1	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.	4, 60
13.3	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.	4, 15, 59
13.4	1	The team provides each carer with carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	3, 4, 58, 59
13.5	1	Carers are able to access support through the ward. *Guidance: This could be through the provision of/signposting to carer support networks or groups. It could be through the provision of a designated staff member dedicated to carer support.*	4, 8, 29, 59, 61

Number	Type	Standard	Ref
14		**Treating patients with compassion, dignity and respect**	
14.1	1	Staff members treat patients and carers with compassion, dignity and respect. *Guidance: This includes respect of a person's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*	37, 62
14.2	1	Patients do not feel stigmatised by staff members.	5, 58, 63, 64
14.3	1	Patients feel listened to and understood by staff members.	23
14.4	1	Staff members are knowledgeable about, and sensitive to, the mental heath needs of patients from minority or hard-to-reach groups. This may include: • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • Lesbian, gay, bisexual or transgender people; • Travellers.	5, 63, 64, 65
14.5	3	The ward has a designated equalities champion.	5

Number	Type	Standard	Ref
15		**Provision of information to patients and carers**	
15.1	1	Information for patients and carers is written simply and clearly, and can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.	13, 26, 66, 67
15.2	1	The ward/unit uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. 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.*	4, 5, 14, 26
15.3	1	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon.	4, 29
16		**Patient confidentiality**	
16.1	1	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. *Guidance: This includes sharing information outside of the clinical team and confidentiality in relation to third party information (for carers).*	4, 14, 67
16.2	1	Patients' preferences for sharing information with their carer are established, respected and reviewed throughout their care.	11, 15
16.3	1	The team follows a protocol for responding to carers when the patient does not consent to their involvement.	4, 11
16.4	1	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	14, 67
17		**Ward/unit environment**	
17.1	1	Male and female patients have separate bedrooms, toilets and washing facilities.	4, 10, 13, 68
17.2	2	All patients have single bedrooms.	68
17.3	2	Patients are able to personalise their bedroom spaces. *Guidance; For example by putting up photos and pictures.*	58
17.4	2	The ward/unit has at least one bathroom/shower room for every three patients.	58
17.5	3	Every patient has an en-suite bathroom.	4

Number	Type	Standard	Ref
17.6	1	Laundry facilities are available to all patients.	29
17.7	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, access to groups.	10, 24, 69, 70
17.8	2	All patients can access a range of current culturallyspecific 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.*	29
17.9	3	Patients can access a charge point for electronic devices such as mobile phones.	4
17.10	1	The environment complies with current legislation (Equality Act 2010 or equivalent) on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	10, 58, 62, 71
17.11	1	Patients can wash and use the toilet in private, unless risk assessment deems they require constant observation or support with this.	10, 67
17.12	1	Staff members respect the patient's personal space, e.g. by knocking and waiting before entering their bedroom.	10, 67
17.13	1	Patients can make and receive telephone calls in private, subject to risk assessment.	10, 67
17.14	1	People use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy. *Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.*	13, 67
17.15	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).	4, 14
17.16	1	Staff members follow an agreed protocol when conducting searches of patients and their personal property.	24
17.17	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes a ligature risk assessment*	10, 72
17.18	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.	10
17.19	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. When patient transfer/discharge to less restrictive environments is delayed, the team monitors this and makes efforts to overcome these delays.	5, 10, 39

Number	Type	Standard	Ref
17.20	1	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms.	4, 10, 14
17.21	1	Staff members follow an agreed response to alarm calls.	4, 10, 14
17.22	1	All rooms are kept clean. *Guidance: All staff members are encouraged to help with this.*	4, 67, 73
17.23	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, they have access to light switches and they can request adjustments to control heating.*	10
17.24	1	Emergency medical resuscitation equipment, as required by Trust/organisation guidelines, is available within three minutes and is maintained and checked weekly, and after each use.	74
17.25	2	The ward/unit has a designated room for physical examination and minor medical procedures.	10
17.26	1	In wards/units where seclusion is used, there is a designated room that meets the following requirements: • It allows clear observation; • It is well insulated and ventilated; • It has adequate lighting, including a window(s) that provides natural light; • It has direct access to toilet/washing facilities; • It has limited furnishings (which include a bed, pillow, mattress and blanket or covering); • It is safe and secure – it does not contain anything that could be potentially harmful; • It includes a means of two-way communication with the team; • It has a clock that patients can see.	10, 13
17.27	2	The ward/unit has at least one quiet room other than patient bedrooms.	10
17.28	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.	10
17.29	1	There is a separable gender-specific communal space which can be used as required.	10, 13
17.30	2	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day.	75
17.31	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.	24, 75
17.32	2	Ward/unit-based staff members have access to a dedicated staff room.	10
17.33	3	Patients and staff members are consulted about changes to the ward/unit environment.	4, 5

Number	Type	Standard	Ref
18		**Leadership, team-working and culture**	
18.1	2	Staff members can access leadership and management training appropriate to their role and specialty.	4, 7, 10
18.2	2	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet together to think about team dynamics and develop their clinical practice.	4, 5
18.3	3	The team has received training in reflective practice and maintaining a psychologically informed environment.	4, 5
18.4	2	Ward/unit managers and senior managers promote positive risk-taking to encourage patient recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this.	4, 5, 8
18.5	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns.	4, 67, 76, 77
18.6	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.	4, 10
18.7	3	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises.	4, 78

Number	Type	Standard	Ref
19		**Staffing levels**	
19.1	1	The ward/unit has a mechanism for responding to low/unsafe 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.	4, 79
19.2	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.	7, 80
19.3	1	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency.	4, 14

20		Staff recruitment, induction and supervision	
20.1	2	Patient or carer representatives are involved in the interview process for recruiting potential staff members. *Guidance; This could include co-producing interview questions or sitting on the interview panel.*	5, 10
20.2	1	New staff members, including bank staff members, 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.*	13, 41, 79, 82
20.3	2	All new staff members are allocated a mentor to support their transition onto the ward/unit.	4, 5, 10
20.4	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.*	4, 10, 42
20.5	2	All staff members receive line management supervision at least monthly.	4
20.6	2	Staff members in training and newly qualified staff members receive weekly line management supervision.	4, 5

21		Staff wellbeing	
21.1	1	The ward/unit actively supports staff health and wellbeing. *Guidance; For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	41, 79, 83, 84, 85
21.2	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance; They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	4, 10, 86
21.3	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	15, 81, 87, 88

22		Staff training and development	
22.1		Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:	
22.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent);	13, 57, 58
22.1b	1	Physical health assessment. *Guidance: This could include training in understanding:* • *Physical health problems;* • *Physical health observations;* • *When to refer the patient for specialist input;.*	3, 4, 88
22.1c	1	Risk assessment and risk management. *Guidance: This should include:* • *Safeguarding vulnerable adults and children;* • *Assessing and managing suicide risk and self-harm;* • *Prevention and management of aggression and violence;* • *Prevent training;* • *Recognising and responding to the signs of abuse, exploitation or neglect;*	5, 19, 20, 89
22.1d	1	Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities;	4, 26
22.1e	1	Statutory and mandatory training. *Guidance: Includes equality and diversity, information governance, basic life support;*	5, 10
22.1f	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	15, 59
22.2	2	Patients and carers are involved in delivering staff training face-to-face.	12

23		Clinical outcome measurement	
23.1	1	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	5, 58
23.2	2	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	4, 42, 58
23.3	2	The ward's clinical outcome data are reviewed at least 6 monthly. The data is shared with commissioners, the team, patients and carers, and used to make improvements to the service.	5, 42

24		The ward/unit learns from incidents	
24.1	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	4, 43, 44, 87, 90
24.2	1	Staff members share information about any serious untoward incidents involving a patient with the patient themself and their carer, in line with the Duty of Candour agreement.	91
24.3	1	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	6, 24, 88, 90

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