RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NEURO
QUALITY NETWORK FOR NEUROPSYCHIATRY SERVICES

Quality Standards for Neuropsychiatry Services

2nd Edition

Editors: Dr Mike Dilley, Dr Dan Silva, Jemini Jethwa and Hannah Lucas-Motley

Publication date: January 2026 | Publication no. CCQI4125

Contents

First edition: October 2024

Second edition: January 2026

Publication number: CCQI4125

Correspondence:

Quality Network for Neuropsychiatry services

Royal College of Psychiatrists' Centre for Quality Improvement

21 Prescot Street

London E1 8BB

Tel: 0208 618 4061

Email: neuro@rcpsych.ac.uk

Web: Quality Network for Neuropsychiatry services (QN-Neuro) (rcpsych.ac.uk)

This document can be downloaded from our website.

Introduction

What is the Quality Network for Neuropsychiatry Services (QN-Neuro)?

QN-Neuro is a quality improvement programme for services in the UK working with people experiencing neurological disorders and associated psychiatric symptoms and/or acquired or traumatic brain injury with psychiatric complications.

The Quality Network for Neuropsychiatry Services (QN-Neuro) launched in 2024, aiming to standardise the quality of care being provided by neuro services across the UK.

QN-Neuro is run by a central team at the College Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists. As well as identifying and acknowledging services that have high standards, a quality network shares best practice to facilitate service improvement. The QN-Neuro project team provides year-round support to help members maximise opportunities for learning and development.

How have the QN-Neuro standards been developed?

The standards against which services are measured have been developed with reference to the literature, current guidance on best practice, and in consultation with key stakeholders including service users, clinicians, service leads and national charities*. To comment on the standards, suggest changes, or provide suggestions for new standards, please email neuro@rcpsych.ac.uk.

*Thank you to all the individuals that contributed towards the development of the first edition of standards for neuro services, we are very grateful for all the valuable input we have received!

How are the QN-Neuro standards measured?

Services are measured against the quality standards through self- and peer review. During the self-review, a service checklist is completed and questionnaires are given to staff that work in the service and people who have used the service. Where possible, standards are evaluated by more than one tool so any discrepancies in the data can be identified and discussed.

Staff, patient and carer feedback is anonymous and returned directly to the QN-Neuro team who collate and analyse the data, producing a booklet that forms the basis of discussion for the peer review visit. Findings from the review process are fed back to the service, and they are given the opportunity to make improvements and provide comments. The QN-Neuro team can provide support

and advice with this. During the peer review, a review team consisting of neuro service professionals and a QN-Neuro representative visits the service for a day in order to verify the self-review data, consider the service in its unique context and exchange information about best practice. Where needed, support is provided to the host team to make further improvements.

Standard types:

Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment. All of these need to be met in order for the service to be accredited.

Type 2: standards that an accredited service would be expected to meet. Services will need to meet at least 80% to achieve accreditation and will be expected to develop action plans for any standards that are not met.

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

Quality Standards for Neuro Services

Section 1: Admission and assessment

Prior to admission

No.	Type	Standard
1	1	There is easily accessible and up-to-date information about the service in the public domain for patients, carers and referrers to view in advance of admission. This includes contact details for the service, information for referrers about how to make a referral and, where relevant, information on waiting times.
2	1	Patients receive a pre-admission multidisciplinary assessment which includes consideration of their neurological, neurobehavioural, neurocognitive, and psychosocial needs.
3	1	Staff liaise with the referring service to establish a handover of key information about the patient, including: - Their neurological condition (e.g. scans, Glasgow Coma Scale score, location and severity of stroke); - Their physical and mental health; - Any cognitive difficulties (including any neuropsychological test results); - Risk assessments; - Any existing care plans or behavioural agreements.
4	1	Patients have a comprehensive physical health review conducted by a neurologist or other appropriate specialist prior to admission, which takes into account comorbid neurological health and any other medical issues. This includes an assessment of neurodisability, falls and seizures, where relevant. *Guidance: Where this cannot be completed prior to admission, the reason is recorded and the assessment is conducted as soon after admission as is practicably possible.*
5	1	Appropriate equipment is sourced to support any physical needs identified in the patient's physical health assessment.
6	1	Prior to admission, an initial multidisciplinary care plan is developed.
7	2	Patients and their carers (where appropriate) are offered the opportunity to visit the service prior to admission, either in person or through a structured virtual tour that provides equivalent orientation to the environment, facilities, and team.
8	2	Prior to admission, patients and their carers are given an information pack, in an appropriate format, that contains the following: • A description of the service; • The therapeutic programme; • Information about the staff team; • The unit code of conduct; • Key service policies (e.g. permitted items, smoking policy);

		• Resources to meet spiritual, cultural or gender needs.
9	1	People are only admitted when they require assessments, interventions or treatment that can only feasibly be provided in hospital. There is a clearly stated purpose for the admission developed with and taking into account views of the patient and their carer.

On admission

No.	Type	Standard
10	1	Assessments of patients' capacity to consent to care and treatment in hospital are performed and regularly reviewed in accordance with relevant legislation.
11	1	On admission to the ward/unit, patients feel welcomed by staff members who explain why they are in hospital. *Guidance: Staff members show patients around and introduce themselves and other patients, offer them refreshments and address them using their preferred name and pronouns.*
12	1	With patient consent, the patient's carer is contacted as soon as possible by a staff member on the ward to notify them of the admission and to provide them with contact details for the ward and visiting times. *Guidance: The patient is asked who needs to know they are in hospital.*
13	1	Patients are given accessible written information which staff members talk through with them as soon as practically possible. The information includes: - Their rights regarding admission and consent to treatment; - Their rights under relevant mental health legislation; - How to access advocacy services; - How to access a second opinion; - How to access interpreting services; - How to view their health records; - How to raise concerns, complaints and give compliments.
14	1	Patients have a comprehensive mental health assessment which is started within four hours of admission. For patients already receiving care in the community, their existing mental health formulation and care plan is reviewed and updated. The process involves the patient, their carer(s), community care providers and the multidisciplinary team, and includes consideration of the patient's: - Biological needs including mental health and medication;

		- Psychological needs including cognitive and neurodisability, behaviour that challenges and strengths and areas for development; - Social needs including religious traditions, spiritual beliefs, advance choices and reasonable adjustments.
15	1	Patients have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. If all or part of the examination is declined, the reason is recorded and repeated attempts are made. Following the physical health review, the physical health care plan is developed or updated. Guidance: The comprehensive physical health review is guided by the principles and components set out in the NCEPOD report 'A Picture of Health' (2022) recommendations 1-3. People carrying out physical health assessments and investigations are mindful of sensory sensitivities to touch and pain..
16	1	Patients have a risk assessment and safety plan which is co-produced (where the patient is able to participate), involves carers, is updated regularly, and is shared, where appropriate, with relevant agencies. *Guidance: This assessment and plan consider risk to self, risk to others, risk from others, and physical health risks, detailing the types of harm that could occur, when they are likely to occur, and how they may be mitigated.*
17	1	On admission, any arrangements needed around the following are completed and communicated to the patient: • The security of the patient's home; • Arrangements for dependants (children, people they are caring for); • Arrangements for pets.
18	3	Within 24 hours of the patient's admission, pharmacy staff undertake a full medicines reconciliation, including all medications for physical as well as mental health. *Guidance: For people admitted over a weekend, this may take up to 72 hours.*
19	1	People admitted to the ward outside the area in which they live have regular reviews of their placement. *Guidance: The minimum frequency of reviews is determined by the care setting. In acute care settings the review would be at, minimum, weekly.*

Section 2: Care and treatment

Reviews and care planning

No.	Type	Standard
20	1	Patients know who the key people are in their team, including their named nurse, and how to contact them if they have any questions.
21	1	Patients have a formal review of care or ward round within one week of admission which includes time to discuss the patient's questions, concerns and goals. Patients are supported to attend and engage with this process in advance of the review.

22	1	Multidisciplinary formulation of the patient's function, needs and risks is established across their neurological, physical, neurobehavioural, neurocognitive, communication and psychosocial domains.
23	1	Every patient has a written, formulated-based care plan, reflecting their individual needs. Staff members collaborate with patient and their carer(s) to agree the purpose of admission and admission goals, develop the care plan, and they are offered a copy. *Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.*
24	1	The purpose of admission, care plan, discharge plan and estimated discharge date are reviewed and updated regularly with the patient and their carer. *Guidance: If the purpose of admission is close to being met, additional focus is given to discharge planning to avoid the discharge being delayed.*
25	2	Patients are supported to develop a positive behaviour support plan, which is overseen by a qualified psychologist.
26	1	Each patient is offered protected time at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.
27	2	The ward uses a regular structured meeting (e.g. MDT huddle/ management round) to agree, allocate and follow up actions needed to progress the patient's management plan towards planned discharge. *Guidance: In acute care settings this is a daily meeting.*

Clinical outcome measurement

No.	Type	Standard
28	1	Clinical outcome measurement is collected at two time points (at assessment and discharge). *Guidance: This includes patient-reported outcome measurements where possible.*
29	2	Patient-centred and value-based goals are agreed with the patient at the start of treatment wherever possible. Where not possible, goals are agreed initially by the MDT. Progress is reviewed collaboratively with the patient during clinical review meetings and at discharge. *Guidance: Goals are determined with consideration of carers' and family members' input, legal representation, and advanced directives where relevant.*
30	2	The service's clinical outcome data are collated, analysed and reported at least bi-annually. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.

Therapies and activities

No.	Type	Standard
31	1	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to their bio-psychosocial needs and the identified goals for the admission. *Guidance: Patients already receiving mental health support in the community have their care plan updated reflecting their change in needs and interventions to be received in an inpatient setting.*
32	2	Every patient has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. *Guidance: The timetable covers seven days including unstructured activity time. It may include activities such as physical activity, education, employment, volunteering, faith- or spirituality-related activities, and other occupations such as leisure activities and caring for dependants.*
33	2	Patients receive psychoeducation to enhance skills in areas such as activities of daily living, interpersonal communication, relationships, sleep hygiene, coping with stigma, and stress and anger management.
34	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient's formulation and treatment.
35	2	There is a minuted ward community meeting that is attended by patients and multi-disciplinary staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. Actions from the meeting are followed up. *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. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.*
36	1	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.
37	1	Patients have access to safe outdoor space every day.

Medication

No.	Type	Standard
38	1	Where clinically appropriate, patients have a staged, programmed, self-medication care plan in place.
39	1	When medication is prescribed, the risks and benefits are discussed with the patient and carer. The following are discussed and recorded: - The intended outcome of the intervention; - Timescale for response; - Monitoring requirements; - Patient consent and capacity to consent.

40	1	Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, adherence, safety, and management of side effects, including during medication changes and deprescribing. Guidance: Side effect monitoring tools can be used to support reviews.
41	1	Every patient's PRN medication is reviewed weekly: frequency, dose and indication.
42	3	Patients, carers and prescribers are able to meet with a pharmacist to discuss medications.

Physical healthcare

No.	Type	Standard
43	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.*
44	1	Patients who are prescribed mood stabilisers, anticonvulsants or antipsychotics have the appropriate physical health assessments and investigations at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon.
45	1	Multidisciplinary care plans are in place for the management of dysphagia, pressure sores, wound care, and PEG/RIG/catheter care.
46	1	Staff are able to provide physical health monitoring, record this accurately, and appropriately escalate can when early warning sign thresholds are met.
47	1	Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating and physical activity. They are offered, and can access through the ward, smoking cessation and/or drug and alcohol services. These are documented in the patient's care plan.

Accessing the community

No.	Type	Standard
48	1	The team and patient jointly develop a community access plan, which is shared with the patient, that includes: - A risk assessment and risk management plan that includes an explanation of what to do if problems arise in the community; - Conditions of the community access plan; - Contact details of the ward/unit and crisis numbers; - Ability to access a bed on return; - How the ward will check in with the patient on their wellbeing when accessing the community. *Guidance: The plan should include reference to any physical safety considerations.*

49	1	Staff agree community access plans with the patient's carer allowing them sufficient time to prepare. Carers are given an opportunity to provide feedback after the period of leave to inform ongoing care and leave planning.
50	3	Patients, according to their care plan, have regular access to longer outdoor activities facilitated by staff. *Guidance: Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rain wear. Staff should be able to facilitate this at least twice a week in a group or individually.*
51	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.
52	1	When patients are unexpectedly absent from the ward, the team (in accordance with local policy): - Activates a risk management plan; - Makes efforts to locate the patient; - Alerts carers, people at risk and the relevant authorities; - Escalates as appropriate.

Interface with other services

No.	Type	Standard
53	2	The team supports patients to attend appointments with their community GP or hospital specialist if they need to whilst an inpatient, if they are admitted in the local area.
54	1	The team supports patients to access support with finances, benefits, debt management and housing needs.
55	1	The ward/ unit/ organisation has a care pathway for patients who are pregnant or in the post-partum period. *Guidance: Women who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there are exceptional circumstances.*
56	1	Patients are offered access to an advocacy service and supported to work with them.

Section 3: Discharge planning and transfer of care

No.	Type	Standard
57	1	Proactive discharge planning with the patient and their carer takes place from point of admission, focusing on identifying any barriers to

		discharge and what post-discharge support needs to be in place at point of discharge.
58	1	Mental health practitioners carry out a thorough assessment of the person's personal, social, safety and practical needs to reduce the risk at the point of discharge. *Guidance: Where possible, this should be completed in partnership with carers.*
59	3	Patients have all medications (including physical health medications) reviewed prior to discharge to ensure that medication is optimised and evidence-based, and that inappropriate medications are withdrawn. Review or end dates for prescriptions initiated in hospital are included in discharge documentation.
60	1	The team sends a copy of the patient's care plan or interim discharge summary to everyone identified in the plan as involved in their ongoing care (including carers, with patient consent) within 24 hours of discharge. *Guidance: The plan includes details of:* *- Care in the community/aftercare arrangements;* *- Crisis and contingency arrangements, including details of who to contact;* *- Medication, including prescribing, dispensing and monitoring arrangements;* *- The patient's positive behavioural support plan;* *- Details of when, where and with whom the patient's follow-up will take place.*
61	2	A discharge summary is sent, within a week, to the patient's GP and others concerned (with the patient's consent), The summary includes why the patient was admitted and how their condition has changed, and their diagnosis, medication and formulation.
62	1	The team makes sure that patients who are discharged from hospital have arrangements in place before they leave the hospital to be followed up within 72 hours of discharge. *Guidance: Face-to-face 72 hour follow-up is arranged where possible.*
63	2	Teams provide 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: When the transition is to another organisation or different care pathway, the team provides transition mentors, transition support packs, or education for patients on how to manage transitions.*
64	1	Follow-up appointments for the patient post-discharge are arranged with community services prior to the patient being discharged. The details of when, where and with whom this follow-up will take place are given to the patient and their carer in written format.

65	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, taking their wishes into account as far as possible. *Guidance: Staff explore with the patient and their carer alternative community options to see if they could be a safe and viable alternative.*

Section 4: Risk and safeguarding

No.	Type	Standard
66	1	Patients are involved (wherever possible) in decisions about their level of therapeutic observations by staff. *Guidance: Patients are also supported to understand how the level can be reduced. Where restrictions are applied and there is a lack of capacity to consent, the appropriate legal framework is also considered.*
67	2	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.
68	2	Staff collect data on patients' behaviour frequency, triggers and consequences of behaviour and this data is used to inform positive behaviour support plans.
69	1	Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long-term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018.
70	1	In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions.
71	1	The team uses seclusion only as a last resort and for the shortest period possible until a less restrictive management option can be utilised. All incidences of seclusion are recorded and these are reviewed in team governance meetings.
72	1	In units where long term segregation is used, the area used conforms to standards as prescribed by the Mental Health Act and Mental Capacity Act Codes of Practice. *Guidance: This includes patients having access to meaningful and therapeutic activity and outdoor space.*
73	3	Patients in seclusion or long-term segregation have access to independent, specialist-trained advocacy and specialist free legal advice.

74	1	Patients who are involved in episodes of restraint, or compulsory treatment including tranquilisation, have their vital signs, including respiratory rate, monitored by staff members and any deterioration is immediately responded to in line with unit policy. *Guidance: If all vital signs cannot be taken because of the patient's presentation, observable signs including respiratory rate and reason for omission of a full set of observations is recorded.*
75	1	When a young person under the age of 18 is admitted: - There is an named CAMHS clinician who is available for consultation and advice; - The local authority or local equivalent is informed of the admission; - The CQC or local equivalent is informed if the patient is detained; - A single room is used; - Transfer to an age appropriate environment is facilitated as soon as possible.

Section 5: Patient and carer engagement

Patient involvement

No.	Type	Standard
76	1	The service routinely asks patients and carers for their feedback about their experiences of using the service, and this is used to make improvements. *Guidance: The service also communicates to patients and carers the actions taken in response to their feedback.*
77	1	Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics. *Guidance: Complaints, compliments and other feedback sources include the option to share demographic information.*
78	2	Services are developed in partnership with patients and carers who have relevant lived experience, and who take an active role in informing decision-making.

Treatment with dignity and respect

No.	Type	Standard
79	1	Staff members treat all patients and carers with compassion, dignity and respect.
80	1	Patients feel listened to and understood by staff members.

81	1	Reasonable adjustments are made, if required, for patients with disability, neurodiversity and/or people with a learning disability. Any reasonable adjustments are recorded in patients notes.
82	1	For patients with a learning disability and/or who are autistic, staff make use of existing information about their care needs and use them in care planning and communication. *Guidance: Health passports or similar tools should be used.*

Carer engagement and support

No.	Type	Standard
83	1	Carers are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents.
84	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.
85	2	Carers are offered individual time with staff members, within 48 hours of the patient's admission, to discuss concerns, their own needs and to share and receive information.
86	2	The team provides each carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. in a carers' 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.*
87	2	Carers are provided with feedback, information and support at least once a week and have a designated point of contact within the service.
88	2	Carers feel supported by the ward staff members.

Provisions of information to patient and carers

No.	Type	Standard
89	1	Information is provided in a variety of formats to ensure it is accessible for people with neuropsychiatric conditions.
90	1	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties, including their family or carers, are respected and reviewed regularly.
91	1	The team knows how to respond to carers when the patient does not consent to their involvement. *Guidance: The ward may receive information from the carer in confidence.*
92	2	The ward/unit works with 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: If the patient's first language is not English, an assessment is made as to whether they can accurately describe their symptoms, difficulties and needs. If not, an interpreter is booked for subsequent reviews.* *In Wales, services and communication (written and spoken) comply with the Welsh Language Act.*

Section 6: Service environment

No.	Type	Standard
93	1	Accessible key information about the ward is clearly displayed. *Guidance: This includes clear signage, pictures and names of ward staff members, and the ward activity timetable.*
94	1	Male and female patients have separate bedrooms, toilets and washing facilities. Room allocation is able to accommodate a spectrum of genders. *Guidance: Where room allocation could present risks to the patient or to vulnerable others, this is risk-assessed and all practical steps taken to accommodate patient preference. If patient preference cannot be safely accommodated, this is discussed between the patient and clinical team and agreement made on the most appropriate environment for care. Care and safety planning is carried out with the patient to address how to best to support them in this context.*
95	2	All patients have single bedrooms.
96	3	Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment.
97	2	Patients are able to personalise their bedroom spaces. Guidance: This may include allowing photos and pictures to be displayed and other personalisations in line with the service's infection control policy.
98	2	The ward/unit has at least one bathroom/shower room for every three patients.
99	3	Every patient has an en-suite bathroom. *Guidance: Where ensuite bathrooms are available, these are prioritised for people whose clinical need requires access.*
100	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, or access to groups.
101	2	Patients can access a range of current culturally specific resources for entertainment, which reflect the ward/unit's population.
102	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.*
103	1	Where needed to support disability management or rehabilitation, environmental adaptations can be put in place in the unit environment. *Guidance: Examples include fall mats, non-slip flooring, adjustable lighting, and neuro-accessible design features such as colour-coded doors and corridors to aid orientation and reduce cognitive load.*
104	1	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.
105	1	Patients can 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 safety plans. *Guidance: Patients can access a charge point for electric devices. 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.*
106	1	A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management.
107	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. *Guidance: This includes avoiding the use of blanket rules and assessing risk on an individual basis.*
108	1	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms. There is an agreed response when the alarm is raised.
109	2	Staff members and patients can control heating, ventilation and light on the ward/unit. *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. Dimmable lighting is available.*
110	1	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.

111	2	The ward/unit has a designated room for physical examination and minor medical procedures. *Guidance: The room has a couch for physical examination.*
112	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 include a bed, pillow, mattress and blanket or covering); - It is safe and secure, and 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. *Guidance: Wards that do not have seclusion facilities ensure that local policies fully describe alternatives to seclusion and how patients' safety, dignity, privacy and health and well-being needs will be met.*
113	2	The ward/unit has at least one therapy room where staff can see patients in a private space other than the patient's bedroom.
114	2	Ward/unit-based staff members have access to a dedicated staff room.
115	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.*
116	2	Patients are consulted about changes to the ward/unit environment.
117	2	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.
118	2	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. *Guidance: Hot drinks may be available on a risk-assessed basis.*
119	1	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements, feeding guidelines and which are also sufficient in quantity. Meals are varied and reflect the individual's neurodisability, cultural and religious needs.

Section 7: Staffing

The multidisciplinary team complement

No.	Type	Standard
The unit is appropriately staffed in line with the BSPRM (British Society of Physical Rehabilitation Medicine) Minimum Staffing Provision for Specialist Inpatient Rehabilitation Services. The team includes:		
120	1	A consultant accredited in rehabilitation medicine and/or psychiatry. *Guidance: If a psychiatrist, the consultant has knowledge and skills relevant to the specialism.*
121	1	Non-consultant medical input.
122	1	Nurse(s), including RGNs and RMNs in neurobehavioural settings.
123	1	Physiotherapist(s).
124	1	Practitioner Psychologist(s). *Guidance: Practitioner psychologists should have completed, or be working towards, the requirements for entry onto the British Psychological Society's Specialist Register of Clinical Neuropsychologists (SRCN).*
125	1	Occupational therapist(s)
126	1	Speech and language therapist(s).
127	1	Social worker(s)/discharge coordinator(s).
128	1	Dietician(s).
129	1	Clerical staff.
130	1	Trained therapy assistant(s).
131	2	A pharmacist
132	2	The team has access to rehab engineers and other professions as appropriate to their caseload.
133	1	The team has access to a neurologist for patients requiring review.
134	2	The ward has appropriate administrative support and infrastructure in place to release clinical time to care. *Guidance: The ward has a dedicated administrator.*

Staffing levels

No.	Type	Standard
135	2	The ward has a staffing model that ensures activities in therapeutic/recreational timetables are routinely delivered and that patient leave, exercise, access to the outdoors and faith-based needs can be facilitated in line with the RCPsych core standards. *Guidance: The ward may draw on a range of roles including therapies staff, peer workers, healthcare assistants, activity co-ordinators and/or they may partner with organisations such as voluntary, community, faith and social enterprise (VCFSE) sector organisations to meet this standard.*
136	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. *Guidance: Staffing levels should comply with the British Society of Physical and Rehabilitation Medicine (BSPRM) guidelines.*
137	2	The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need or short-term absence of permanent or regular bank/agency staff. *Guidance: There should be, at minimum, one permanent qualified nurse on each shift at all times.*
138	2	If the staff vacancy rate exceeds 15%, there is a workforce recruitment and retention plan in place.
139	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 urgent situation. *Guidance: Video consultation for advice/assessment may be used in exceptional circumstances, which include rural settings.*

Recruitment, induction and supervision

No.	Type	Standard
140	2	Patient or carer representatives are involved in the interview process for recruiting potential staff members. *Guidance: The representatives should have experience of the relevant service.*

141	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as met.
142	1	New members of staff or those changing wards who prescribe or undertake therapeutic engagement and observations receive an induction which includes: - Principles around positive engagement with patients; - When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this; - Actions to take if the patent absconds; - Trauma-informed principles.
143	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. Clinical supervision should be in addition to managerial supervision. If the two are provided together, there is a clear differentiation between them.*
144	2	All staff members receive individual line management supervision at least monthly. *Guidance: Managerial supervision should be in addition to clinical supervision. If the two are provided together, there is a clear differentiation between them.*

Staff training and development

No.	Type	Standard
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:		
145	1	The use of relevant mental health and capacity legal frameworks.
146	1	Physical health assessment and management, including management of the physically deteriorating patient. *Guidance: This could include training in understanding physical health problems, undertaking physical observations, using early warning scores (e.g. NEWS2), identification and management of the medically deteriorating patient and basic life support.*
147	1	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*
148	1	Risk assessment and management.

		Guidance: This includes assessing and managing suicide risk and self-harm, and the prevention and management of challenging behaviour.
149	2	Person-centred behavioural and neuro-behavioural approaches (e.g. PBS, tailored neuropsychiatric behavioural support) designed to enhance quality of life, reduce behaviours that challenge and promote meaningful engagement.
150	1	Cognitive impairment, learning disability and autism, including awareness of neurodiversity and how to interact appropriately with autistic people and people who have a learning disability.
151	2	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care. *Guidance: Training should address all nine protected characteristics and their relevance to delivering equitable mental health care.*
152	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.
153	1	Common physical conditions such as diabetes, epilepsy, brain injury awareness, and managing behaviours that challenge including hypersexuality/sexual disinhibition.
154	1	Staff are trained in human rights-based approaches to working with people at risk of restrictive practices and in trauma-informed principles.
155	2	Patient and/or carer representatives are involved in delivering and developing staff training.

Staff wellbeing and support

No.	Type	Standard
156	1	The ward/unit actively supports staff health and well-being. *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, promoting sleep hygiene and known health inequalities facing night staff, and reviewing feedback from exit reports and taking action where needed.*
157	1	Patients and staff members feel safe on the ward. *Guidance: Staff and patient experience is systematically captured, reviewed and acted upon.*
158	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day, if they work more than six hours a*

		day. Adequate cover is provided to ensure staff members can take their breaks.
159	1	Staff members, patients and carers who are affected by a serious incident including control and restraint and rapid tranquilisation are offered post-incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection.*
160	2	There is regular reflective practice available of sufficient frequency to ensure that all staff can access this at least every six weeks. *Guidance: Reflective practice should be facilitated by someone with experience in managing a group process.*
161	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.
162	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.
163	1	Those in ward leadership roles are visible and present on the ward and actively role model and promote an open learning culture. They are confident and competent in both listening and following up in line with Freedom to Speak Up principles. *Guidance: Staff know that incident reporting, learning from incidents and responsiveness to feedback are leadership priorities. If staff raise concerns, they are confident their leadership will address them.*
164	3	The service has a system for reviewing culture in the ward and takes action on findings. *Guidance: This may include review of incident and restrictive practice data, patient and carer feedback, staffing and employee relations data and/or use of a validated staff survey, culture of care or safety culture tool/survey.*

Section 8: Governance

No.	Type	Standard
165	1	The unit reviews demographic data at least annually about people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment. *Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.*
166	2	The unit reviews demographic data at least annually about people who are referred. Data are compared and action is taken to address any inequalities in admission.

167	1	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this.
168	1	The multi-disciplinary team collects audit data on the use of restrictive interventions, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and or quality improvement methodology. *Guidance: Audit data are used to compare the service to national benchmarks where possible*.
169	2	The multi-disciplinary team collects patient ethnicity data on the use of restrictive interventions and actively works to reduce inequalities year on year through use of audit and/or other quality improvement methodology. *Guidance: Audit data are used to compare the service to national benchmarks where available*.
170	1	When serious mistakes are made in care, this is discussed with the patient and their carer, an apology given and actions taken as appropriate to mitigate the outcome of the mistake and/or prevent its recurrence. Any safeguarding concerns that have arisen through the incident are raised and processed in line with policy.
171	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.
172	3	The ward reviews its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services. Progress against the plan is reviewed at regular time points throughout the year and refreshed annually. *Guidance: Good practice includes adopting practices in line with recommendations in RCPsych Net Zero Guidance. This may include, for example, assigning a Sustainability Champion role and staff undertaking training in sustainable practice*.
173	2	The team actively involved in QI activity.
174	2	The team actively encourages patients and carers to be involved in QI initiatives.

References

1. College Centre for Quality Improvement. (2022). *Standards for inpatient mental health services*. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/ccqi-core-standards-in-2022.pdf?sfvrsn=ae828418_8*

2. NHS Commissioning Board. (2013). *NHS standard contract for specialised rehabilitation for patients with highly complex needs (all ages). Service specifications*. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf

3. Department of Health. (2005). *The National Service Framework for Long-term Conditions.* Available at: https://assets.publishing.service.gov.uk/media/5a756bede5274a1baf95e73b/National_Service_Framework_for_Long_Term_Conditions.pdf

4. National Neurosciences Advisory Group. (2023). *Optimal clinical pathway for adults: Traumatic Brain Injury.* Available at: https://static1.squarespace.com/static/5f1021faf6248b39f4c64f5d/t/64fe266fa42f975f1623d5c2/1694377587517/02+NNAG+Traumatic+Brain+Injury+Pathway+Final+03.pdf

5. National Neurosciences Advisory Group. (2023). *Optimal clinical pathway for adults: Functional Neurological Disorder.* Available at: https://static1.squarespace.com/static/5f1021faf6248b39f4c64f5d/t/641c2ef543a1e6271d142c90/1679568632459/01+NNAG+FND+Pathway+Final+Feb+2023.pdf

6. Sugavanam T, Mead G, Bulley C, Donaghy M, van Wijck F. (2013). *The effects and experiences of goal setting in stroke rehabilitation - a systematic review.* Disabil Rehabil. 2013 Feb;35(3):177-90. doi: 10.3109/09638288.2012.690501. Epub 2012 Jun 7. PMID: 22671934.

7. Jennie L. Ponsford, Amelia J. Hicks, Kate R. Gould, Marina G. Downing, Malcolm Hopwood, Tim J. Feeney. (2022). *Positive behaviour support for adults with acquired brain injury and challenging behaviour: A randomised controlled trial.* Annals of Physical and Rehabilitation Medicine, Volume 65, Issue 2, 2022, 101604, ISSN 1877-0657.

8. British Society of Physical & Rehabilitation Medicine. (2023). *BSPRM Specialised Neurorehabilitation Service Standards*. Available at: https://www.bsprm.org.uk/resources/guideline-documents/

9. British Society of Physical & Rehabilitation Medicine. (2008). *BSPRM and Long-term Neurological Conditions: Management at the Interface of Neurology, Rehabilitation and Palliative Care*. Available at: https://www.bsprm.org.uk/joint-publications-with-other-organisations/

10. Royal College of Psychiatrists. (2024). *Outcome measures in psychiatry.* Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-

policy/college-reports/college-report-cr240-outcome-measures-in-psychiatry.pdf?sfvrsn=3d5adc4e_5

11. Headway for Brain Injury Association. *Standards for evaluation.* Available at: https://www.headway.org.uk/about-brain-injury/professionals/approved-provider-scheme/summary-of-standards-to-be-assessed/

12. Care Quality Commission. (2020). *Brief guide: Sexual safety on mental health wards.* Available at: https://www.cqc.org.uk/sites/default/files/Brief_Guide_Sexual_Safety_in_Mental_Health_wards_v1.pdf

**A full list of references from CCQI Core Standards that were used for this set of standards can be found within the CCQI publication.*

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NEURO
QUALITY NETWORK
FOR NEUROPSYCHIATRY
SERVICES

QN-NEURO

The Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CCQI
COLLEGE CENTRE
FOR QUALITY
IMPROVEMENT