PICU CCQI
QUALITY NETWORK FOR PSYCHIATRIC INTENSIVE CARE UNITS

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ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Psychiatric Intensive Care Units

Quality Network for Psychiatric Intensive Care Units

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Foreword

Welcome to the first edition of standards for psychiatric intensive care units from the newly formed Quality Network for Psychiatric Intensive Care Units (QNPICU), organised by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).

These new standards replace the set developed by the Accreditation for Psychiatric Intensive Care Units (AIMS PICU) in 2014 and they act as a framework by which to assess the quality of psychiatric intensive care units via a process of accreditation, incorporating elements of self and peer-review. They have been created through a series of consultations with expert stakeholders, member services, and patient and carer representatives, to ensure that services are assessed against a set of quality standards and to recognise good practice within the field.

The new standards mark a period of change that aims to provide members with a more meaningful and useful approach to quality improvement. We are excited to share with you our plans to bring member services together to learn and share good practice through a number of mediums, including events and regular communications. We know that the best way for individuals and services to progress is to provide those valuable networking opportunities and to improve communications on a national level.

We hope you find the new QNPICU standards useful. It is important to acknowledge that the contributions from individuals working in member services is invaluable to this process and we would like to thank those that have been a part of our work at the CCQI. We look forward to working more closely with you and to expanding the programme of work to benefit those using our services.

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Introduction

These standards have been developed in consultation with individuals from member services of the Quality Network for Psychiatric Intensive Care Units (QNPICU) programme (previously AIMS PICU), patient and carer representatives and other experts (please see appendix 2 for a full list of acknowledgements).

1. Mapping exercise

The first stage of this process was to review the existing AIMS PICU Standards for Psychiatric Intensive Care Units - 3rd Edition (2014)[1] to identify gaps, to remove repetition and to identify those standards which could be phrased in a more measurable way. The second stage involved mapping these standards against the Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2015). The purpose of this stage was to identify published inpatient standards that were applicable to PICU services.

2. Literature review

A literature review and review of key documents was carried out (see reference list).

3. Standards consultation event

AIMS PICU hosted a standards consultation event on 21 February 2017 for key stakeholders to comment on a draft of the revised standards. The event was attended by around 40 stakeholders including senior managers, multidisciplinary team staff, frontline staff and patients. Following a brief introductory presentation on the process of developing the standards, delegates worked in small groups making verbal and written comments on the standards before feeding back at the end of the day. The delegates were asked to remove the standards no longer required, add further standards and edit existing standards.

4. Electronic consultation

In April 2017, a draft of the standards was sent electronically to AIMS PICU member services and the AIMS PICU advisory group.

5. Categorisation of standards

All criteria are rated as Type 1 or 2.

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

[1] http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/picus/ourstandards.aspx

standards also include the fundamentals of care, including the provision of evidence based care and treatment.

Type 2: Expected standards that all services should meet.

Standards for Psychiatric Intensive Care Units
First Edition
October 2017

Admission and Assessment		
No.	**Standard**	**Type**
1	Following assessment, PICU clinical staff members (ward manager/nurse in charge) make decisions about patient admission or transfer, taking into account safety and/or therapeutic activity on the ward. If admission is not thought to be appropriate, PICU staff offer advice and guidance on the management of the patient. *Guidance: The aims of admission are agreed among the referring team, the ward team, the patient and carer(s).*	1
2	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation and documented in the patients' notes. When patients do not have capacity, best interest processes involving professionals and family (where appropriate) are followed. These assessments should be undertaken: On admission; At regular intervals as required by the relevant legal requirement; If the patient's capacity changes; If the treatment plan changes; If the patient, family or professionals request it.	1
3	Information on previous care planning and interventions are sourced by the ward staff/team within 24 hours of admission.	2
4	There are systems in place to ensure that the ward takes account of any advance decisions or statements that the patient has made. *Guidance: These are accessible and staff know where to find them.*	1
5	Staff members explain the purpose of the admission to the patient as soon as is practically possible.	1
6	The patient's carer/next of kin is contacted by a staff member (with patient consent) to notify them of the admission and to give them the ward contact details.	1
7	Where a patient is being admitted directly from the community, the admitting nurse checks that the referring agency gives clear details on and management plans for the following (this is also discussed with the patient): The security of the patient's home; Arrangements for dependents (children, people they are caring for); Arrangements for pets/essential maintenance of home.	1
8	Patients have a comprehensive initial assessment which is started immediately and completed within 1 week. This involves the multi-disciplinary team and includes patients': Mental health and medication; Psychosocial needs; Strengths and areas for development. *Guidance: The assessment acknowledges predefined and agreed goals as set out in the referral for admission between the referring MDT, the PICU and where possible the patient themselves.*	1

Patients have a comprehensive physical health review. This is started immediately following admission. The assessment is completed within 1 week, or prior to discharge. The following processes are in place (standards 9-11):		
9	First 4 hours: Details of past medical 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.	1
10	First 24 hours: Physical examination; Height, weight; Blood tests (Can use recent blood tests if appropriate); ECG.	1
11	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.	1
12	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.*	1
13	Clear information is made available, in paper and/or electronic formats, to patients, carers and healthcare practitioners on: A simple description of the ward and its purpose; Admission criteria; Clinical pathways describing access and discharge; Main interventions and treatments available; Contact details for the ward and hospital.	1
14	Detained patients are given verbal and written information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes.	1
15	There is a written mutual code of conduct or similar for ward behaviour of which patients are advised, and adherence to this is monitored.	1
Care Planning and Treatment		
16	All patients have a documented diagnosis and a clinical formulation which is jointly constructed by the patient. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. It also includes planning for transfer/discharge/return from the PICU. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.*	1
17	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.	1

18	Every patient has a written care/intervention 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 and social needs;* *Measurable goals and outcomes;* *Strategies for self-management;* *Crisis and contingency plans;* *Review dates and discharge framework.*	1
19	The patient (and their carer, with the patient's consent) are offered a copy of the care plan and the opportunity to review this.	1
20	Patients' preferences for sharing information with their carer are established, respected and reviewed throughout their care. *Guidance: The team follows a protocol for responding to carers when the patient does not consent to their involvement.*	1
21	All patients receive an in-depth multidisciplinary review at least once a week, involving the whole MDT and external professionals involved in the care of the patient (when required), which incorporates the views of carers. All patients are offered a face to face review with a consultant once a week.	1
22	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and are supported in self-management.	1
23	Patients have a documented risk assessment and associated 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 of neglect; Risk from others. *Guidance: Risk management plans include risk to carers and incorporate carers' views.*	1
24	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.	2
25	Ward managers and senior managers promote positive risk-taking to encourage patient recovery and personal development. Staff members are supported to enable this.	2
26	The team and patient jointly develop a leave 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 on leave; Conditions of the leave; Contact details of the ward and crisis numbers. *Guidance: This standard is not applicable for patients in high security care.*	1

27	When patients are absent without leave, 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; Completes an incident form.	1
28	Patients are told about the level of observation that they are under, how it is instigated and the review process. *Guidance: If a patient is observed within eyesight or within arm's length for more than 72 hours, this is reviewed by the MDT.*	1
29	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for review is set and patient consent is recorded.	1
30	Patients (and their carers, with patient consent) are helped to understand the purpose, expected outcomes, and side effects of their medications and to enable them to make informed choices and to self-manage as far as possible.	1
31	Patients have their medications reviewed at least weekly by the MDT. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. *Guidance: When patients experience side effects from their medication, there is a care plan, which has been developed with the patient, for managing this. Side effect monitoring tools can be used to support reviews.*	1
32	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.	1
33	Patients with drug and alcohol problems have access to specialist help e.g. substance misuse interventions.	1
34	Each patient is offered a pre-arranged up to 1-hour session at least three times a week with their named nurse to discuss progress, care plans and concerns. These sessions are documented.	1
35	A range of accessible recreational activities, including engaging in creative work, hobbies and special and social interests, are provided 7 days a week including evenings and bank holidays. *Guidance: Activities which are provided during working hours, Monday- Friday, are timetabled. The delivery of activities across the 7 day period, including evenings, is audited.*	1
36	Every patient has a personalised timetable of activities and interventions to promote social inclusion, which the team supports and enables them to engage with. *Guidance: This is co-produced with the patient and could include activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*	1
37	Patients have access to a range of art/creative therapies.	1

38	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.	2
39	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.	2
40	The team supports patients to access organisations, with whom they have joint working protocols, which offer: Housing support; Support with finances, benefits and debt management. *Guidance: Housing advice and/or support is given to patients prior to discharge.*	1
41	The ward/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
Referral, Discharge and Transfer		
42	Discharge planning from the ward is initiated at the first multi-disciplinary team review and a provisional discharge date is set with the patient.	2
43	The inpatient team invites a community team representative to participate and contribute to MDT reviews and discharge planning. *Guidance: If the representative is unable to attend in person, teleconferencing facilities may be used. For patients within a high secure environment, a representative from an identified onward pathway is invited.*	2
44	A clear discharge/transfer plan is sent to all relevant parties before or on the day of discharge. The plan includes details of: Aftercare arrangements/care in the community; 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.	1
45	When patients are transferred between wards/units there is a handover which ensures that the new team have an up to date care plan and risk assessment.	1
46	There is a formal process to prevent and expedite delayed discharges.	2

47	Teams provide specific transition support to patients when their care is being transferred to another ward/unit, to a community mental health team, or back home under the care of their GP. *Guidance: The team provides transition mentors; transition support packs; or training for patients on how to manage transitions.*	2
48	The team ensures that patients who are discharged have arrangements in place to be followed up within 2 to 3 days of discharge. The patient is aware of the arrangements for follow-up.	1
Patient and Carer Experience		
49	On admission to the ward, 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.*	1
50	Staff members wear their Trust ID when working on the ward and this is easily visible.	1
51	Patients know who is co-ordinating their care and how to contact them if they have any questions.	1
52	Patients are informed of the person who is their designated key worker 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.	1
53	Staff carrying out physical examinations are either of the same gender, a same-sex chaperone is present, or the patient is able to choose the gender of the staff member. This is provided if feasible and if not the reasons for this are documented.	1
54	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.*	1
55	Patients feel listened to and understood by staff members.	1
56	Patients are consulted about changes to the ward environment.	2
57	There is a minuted 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 and to review the quality and provision of activities with staff members.*	2
58	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.	1
59	Staff members respect the patient's personal space, e.g. by knocking and waiting before entering their bedroom.	1
60	Patients can wash and use the toilet in private, unless risk assessment deems they require constant observation.	1
61	When talking to patients and carers, health professionals communicate clearly and in a way that they understand.	1

62	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.	1
63	The patient is given a 'welcome pack' or introductory information that contains the following: A clear description of the aims of the ward; The current programme and modes of treatment; The ward team membership; Personal safety on the ward; The code of conduct on the ward; Ward facilities and the layout of the ward; What practical items can and cannot be brought in; Clear guidance on the smoking policy; Resources to meet spiritual, cultural and gender needs. *Guidance: The information pack is co-designed with patients.*	2
64	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).*	1
65	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 psycho-education group. Written information could include leaflets or websites.*	1
66	All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates) for those detained. *Guidance: This is clearly displayed in an information area on the wall.*	1
67	The ward 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 (e.g. emergency situations where it is not possible to get an interpreter at short notice).	1
68	The team provides each carer with carer's information. This includes: The names and contact details of key staff members on the ward and who to contact in an emergency; Other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities. *Guidance: Information is provided verbally and in writing (e.g. carer's pack).*	1
69	Carers feel supported by the ward staff members. *Guidance: This could be through the provision/sign-posting to carer support networks or groups. It could be through the provision of a designated staff member dedicated to carer support.*	1
70	Carers (with patient consent) are involved in discussions about the patient's care, treatment and discharge planning.	1

71	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.	1
72	Carers are offered individual time with staff members, within 72 hours of the patient's admission to discuss concerns, family history and their own needs.	2
73	There is a policy on the use of devices with the capacity to communicate and/or record (including mobile phones), which is communicated to staff, patients and visitors, e.g. by means of a poster or leaflet.	1
74	Patients are able to leave the ward to access safe outdoor space on a daily basis, subject to risk assessment.	1
75	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.	1
76	Patients are supported to access relevant faith-specific support, 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. *Guidance: Where possible, faith-specific support is sought through someone with an understanding of mental health issues.*	1
77	All patients can access a range of current culturally-specific resources for entertainment, which reflect the ward's population. *Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.*	1
78	Patients can make and receive telephone calls in private, subject to risk assessment. *Guidance: Cordless and mobile phones (without smart features) might be considered.*	1
Workforce		
79	The multi-disciplinary team consists of or has access to professionals in the following disciplines within the context of core team skills: Medical (e.g. a dedicated consultant psychiatrist and a trainee psychiatric doctor); Nursing (e.g. a team of specialist inpatient nurses, both qualified nurses, healthcare support workers and assistant practitioners); Management (e.g. a manager and deputy with relevant clinical expertise); Occupational therapy (a specialist in psychiatric inpatient care); Psychology (a specialist clinical psychologist); Pharmacy (a specialist pharmacist with experience in acute psychiatric inpatient settings); Social care (e.g. access to a social worker or equivalent to address holistic care needs).	1
80	There is access to dedicated sessional or part-sessional administrative support that meets the needs of the ward.	2

81	The ward 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 (e.g. incident reporting, Datix, or equivalent); Access to additional staff members; An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	1
82	The ward is staffed by permanent staff, and bank and agency staff are used only in exceptional circumstances e.g. in response to additional clinical need. *Guidance: Where bank and agency staff are used, the ward attempts to use the same staff to maintain continuity of care.*	1
83	The sessional input from psychologists and accredited psychological therapists is sufficient: (1) to provide assessment and formulation of patients' psychological needs;(2) to ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway; (3) is sufficient to 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.	2
84	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.*	2
85	In the event of an emergency, there is an identified duty doctor available at all times to attend the ward within 30 minutes, including out of hours. *Guidance: An 'emergency' is defined as an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.*	1
86	There is an identified duty doctor available at all times to attend the ward within 1 hour during normal working hours and within 4 hours when out of hours.	1
87	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.*	1
88	A clinician trained to use resuscitation equipment is immediately available to attend an emergency at all times.	1
89	Staff members in training and newly qualified staff members receive weekly line management supervision.	2
90	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. The uptake of supervision is audited on an annual basis.*	1

91	All staff members receive line management supervision at least monthly. *Guidance: The uptake of supervision is audited on an annual basis.*	2
92	Staff members are able to access reflective practice groups at least every 4 weeks where teams can meet together to think about team dynamics and develop their clinical practice.	2
93	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.	1
94	The ward actively supports staff health and well-being. *Guidance: For example, providing access to support services (e.g. enabling staff to self-refer to occupational health 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.*	1
95	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.*	1
96	Ward-based staff members have access to a dedicated staff room.	1
97	The ward uses a shared (MDT) information system.	1
98	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans, including vulnerability, suicide risk, violence and aggression and general progress.	1
99	All staff complete a security induction programme before being issued with secure keys, pass cards or fobs.	1
100	New staff members, including bank staff, receive a ward-based induction programme 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. Where additional training is identified this should be delivered.*	1
101	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines.	1
Staff members receive training in the areas outlined in criteria 102-109:		
102	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	1
103	Physical health assessment. *Guidance: This could include training in understanding physical health problems, undertaking physical observations and when to refer the patient for specialist input.*	1
104	The Care Programme Approach including transfer/discharge planning.	1

105	Risk assessment, risk management and positive risk taking. *Guidance: This could include: Safeguarding vulnerable adults and children; Assessing and managing suicide risk and self-harm; Prevention of aggression and violence; PREVENT training; Recognising and responding to the signs of abuse, exploitation or neglect.*	1
106	Recognising and communicating with patients with cognitive impairment or learning disabilities.	1
107	Management of violence and aggression.	1
108	Statutory and mandatory training. *Guidance: Includes equality and diversity, information governance, basic life support, infection control.*	1
109	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	1
110	Staff members can access leadership and management training appropriate to their role and specialty.	2
111	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.	1
112	The team effectively manages violence and aggression on the ward. *Guidance:* *1) Staff members do not deliberately restrain patients in a way that affects their airway, breathing or circulation;* *2) Restrictive intervention always represents the least restrictive option to meet the immediate need;* *3) Individualised support plans, incorporating behaviour support plans, are implemented for all patients who are known to be at risk of being exposed to restrictive interventions;* *4) The team does not use seclusion or segregation other than for patients detained under the Mental Health Act (or equivalent) or unless in an emergency as a last resort;** *5) The multi-disciplinary team works to reduce the number of restrictive interventions used;* *6) Providers report on the use of restrictive interventions to service commissioners, who monitor and act in the event of concerns.* *7) Patients' vital signs are monitored and any deterioration is responded to.* **If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately.*	1
113	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.	1
114	Staff members follow an agreed protocol when conducting searches of patients and their personal property.	1

115	Staff members feel safe when escorting patients on leave. *Guidance: There is an established procedure and agreed means of communication for the clinical team in clinical work outside the ward environment. For example, the use of mobile phones or two-way radios.*	1
Environment and Facilities		
116	In reception: • a single main entry point is controlled by an airlock; • the airlock entrance is access-controlled from within a main staff area and can be operated by specifically-designated electronic fobs and manually; • the entrance has an emergency override allowing both doors to open at the same time. This is to enable people to enter/exit the ward through the airlock in an emergency.	1
117	There is a key management system in place which accounts for all secure keys/passes including spare/replacement keys which should be held under the control of a senior manager.	1
118	Windows that form part of the external secure perimeter do not open more than 100mm and are designed to prevent the passage of contraband.	1
119	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.	1
120	Staff members, patients and visitors are able to raise alarms using assistance buttons, strip alarms, or personal alarms. *Guidance: There is a clearly documented and tested procedure for the use of alarms which includes guidance for patients on how to call for help using the alarm.*	1
121	Furniture is arranged so that alarms can be reached and doors are not obstructed.	1
122	Fixtures, fittings and installations in outdoor spaces (e.g. garden areas or courtyards) are protected or designed to prevent climbing and tampering.	1
123	All doors (with the exception of those in bedrooms, bathrooms and toilets) are fitted with a robust clear observation panel.	2
124	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.*	1
125	Emergency medical resuscitation equipment, as required by Trust/organisation guidelines, is available immediately (available for use within the first minutes of a cardiorespiratory arrest) and is maintained and checked weekly, and after each use.	1
126	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery.	1
127	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day, subject to risk assessment.	2
128	All rooms are kept clean.	1

129	Staff members and patients can control heating, ventilation and light. *Guidance: For example, patients are able to ventilate their rooms through the use of windows, they have access to light switches and they can request adjustments to control heating.*	2
130	All patients have single bedrooms	2
131	Every patient has an en-suite bathroom. *Guidance: Where is this is not possible, the ward has at least one bathroom/shower room for every three patients.*	2
132	Male and female patients have separate bedrooms, toilets and washing facilities.	1
133	Bathrooms, toilets and bedrooms are lockable from the inside with external staff override.	1
134	Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking.	1
135	Patients are able to personalise their bedroom spaces. *Guidance: For example patients by putting up photos and pictures.*	2
136	Patients have access to lockable storage facilities within patient bedrooms. *Guidance: Patients within high security care have access to lockable storage facilities on the ward.*	1
137	Patients have access (subject to risk assessment) to: Activities room (containing board games, art and stereo equipment); Internet and social media (with appropriate safeguards in place); Day room (with a television and DVD player, or equivalent); A room with physical exercise equipment. *Guidance: Patients within high security care would not have access to the internet and social media.*	1
138	The ward has a designated room which is suitably designed and equipped for physical examination and minor medical procedures.	2
139	There is a separable gender-specific space which can be used as required.	1
140	The ward has at least one quiet room other than patient bedrooms.	2
141	There is a designated area or room (de-escalation space) specifically for the purpose of reducing arousal and/or agitation.	2
142	In wards 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.	1

143	Wards that do not have seclusion facilities ensure that local policies fully describe alternatives to seclusion and define how patients' safety, dignity, privacy, and health and well-being needs will be met.	1
144	The ward enables safety, privacy and dignity during visits, and has guidance on children visiting, if they are permitted.	1
145	A family visiting room, which is warm, clean and well equipped, is available outside the main body of the ward.	1
Governance		
146	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	1
147	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	1
148	The team makes sure that other patients on the ward who are distressed by events are offered support and time to discuss their experiences.	1
149	There are agreed protocols in place with local police to ensure effective and sensitive liaison regarding incidents of criminal activity, harassment or violence.	2
150	In the case of criminal justice engagement, there are policies covering: • victim issues; • change of risk in the community; • contact with the police; • communication with MAPPA; • communication with PREVENT; • communication with the Ministry of Justice.	1
151	All patient information is stored 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.*	1
152	An audit of environmental risk is conducted annually and a risk management strategy is agreed and acted on. *Guidance: This includes a ligature risk assessment.*	1
153	The multi-disciplinary team collects data on the use of restrictive interventions and uses it to actively reduce its use year on year. *Guidance: Data are used to compare the service to national benchmarks where possible.*	1
154	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.	1
155	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	1

156	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.	2
157	Lessons learned from incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of the lessons learnt.	1
158	Staff members share information about any serious untoward incidents involving a patient with the patient themselves and their carer, in line with the Duty of Candour agreement, or equivalent.	1

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Appendix 1: British Standards Institution Development of Core Standards for Inpatient Services

The following text was taken from the introductory section of the Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2015).

Description and scope of the standards

The core standards for inpatient mental health services have been developed by the Royal College of Psychiatrists' College Centre for Quality Improvement (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.

Within the core standards some minimum standards have been included. This is to ensure that wards/units/services which are members of quality improvement programmes hosted by the CCQI are safe, comply with the law, respect patients' rights and provide the fundamentals of care.

How the standards were developed

The CCQI and BSI undertook a review of 17 sets of its existing standards to identify which standards were 'core' to all mental health services. These core standards then underwent an extensive review process. A steering group and a reference group made up of clinical, patient and family and friends experts enabled representation from each of the different specialties whose standards were used in this project. Feedback was also sought from other sources including CCQI staff, the chair persons of the different CCQI advisory groups and representatives from the College's faculties and divisions.

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.

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