FORENSIC CCQI
QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Forensic Mental Health Services: Low and Medium Secure Care – Second Edition

Quality Network for Forensic Mental Health Services

Editors: Megan Georgiou and Sam Holder
Publication Number: CCQI264

Date: June 2017

This publication is available at: www.qnfmhs.co.uk

Any enquiries relating to this publication should be sent to us at:
megan.georgiou@rcpsych.ac.uk

Artwork displayed on the front cover of the report:

Untitled 1, Tamarind Centre, Birmingham and Solihull Mental Health NHS Foundation Trust.

Contents

Introduction

The first edition of these standards[1] was published in 2016 following an extensive process of consultation with member services, patients, family and friends, and other key stakeholders. They are based on the Standards for Medium Secure Services (2014) and the Standards for Low Secure Services (2012), along with the Royal College of Psychiatrists Standards for Inpatient Mental Health Services (2015). This new edition has been produced in order to acknowledge feedback collated from member services and peer-review teams following the first year of implementation as part of the Network's review process. The revised draft was presented to the QNFMHS Advisory Group for feedback before finalisation.

[1] RCPsych (2016) Standards for Forensic Mental Health Services: Low and Medium Secure Care, London: CCQI. Available online at: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/forensicmentalhealth/publications.aspx

Standards for Forensic Mental Health Services: Low and Medium Secure Care

Second Edition – 2017

No	Standard	Source document
Patient Safety		
Physical Security		
1	A physical security document (PSD) describes the physical security in place at the service. *Guidance: The PSD describes:* • *how the building and security elements work;* • *the inner and outer security of the building and how they relate;* • *the security process in controlling the environment;* • *the security systems in place to a level that it can be used as a training aid.*	1
2	The secure perimeter is in line with the planning specification for the level of security offered, is protected against climbing, and is easily observable. *Guidance: The secure external perimeter:* • *is formed by buildings;* • *is formed by buildings connected with fencing (5.2 m high for MSU and 3m high for LSU);* • *joins the reception and surrounds the remainder of the unit;* • *surrounds the whole unit.* *Where fencing is used it must be weld mesh (3mm diameter and 13mm centres vertically and 75mm centres horizontally).*	3
3	There is a daily recorded inspection of the perimeter and programme of maintenance specifically for the perimeter, with evidence of immediate action taken when problems are identified.	2, 4
4	In outside areas within the secure perimeter, permanent furniture, fixtures and equipment are fixed and are prevented from use as a climb aid.	3, 8
5	Windows that form part of the external secure perimeter are set within the building masonry, do not open more than 125mm and are designed to prevent the passage of contraband.	3, 8
6	There are controlled systems in place to manage access and egress through all doors and gates that form part of the secure perimeter.	3
7	Where CCTV is in use, there should be passive recording of the perimeter, reception frontage and access from the secure area to reception.	8
8	Access to the secure service for visitors, staff and patients is via an airlock.	6, 7
9	The reception/control room: • is within or forms part of the secure external perimeter; • is manned 24 hours per day 7 days week or can be made fully operational in the case of an emergency.	3, 8
10	There is a key management system in place which accounts for all secure keys/passes, including spare/replacement keys which are held under the control of a senior manager.	2, 8

No	Standard	Source document
11	Secure pass keys are: • on a sealed ring; • secured to staff at all times within the secure perimeter; • prevented from being removed from the secure perimeter.	3, 8
12	There is a process to ensure that: • keys are not issued until a security induction has been completed; • keys are only issued upon the presentation of valid ID; • a list of approved key holders is updated monthly identifying new starters who have completed their induction training and any leavers from the service.	3, 8
13	Prohibited, restricted and patient accessible items are risk assessed, controlled and monitored.	3, 7
14	There is a designated security lead with responsibility for security within the service.	7
Procedural Security		
There are formalised policies, procedures and guidance on:		7, 8, 10
15	Anti-bullying (for those who are bullying and those who are being bullied)	
16	Conducting searches of patients and their personal property	
17	Effective liaison with local police on incidents of criminal activity/harassment/violence	
18	Managing patients' use of electronic equipment and access to the internet, including specific advice around the appropriate use of social networking sites, confidentiality and risk	
19	Managing situations where patients are absent without leave	
20	Patient observation	
21	Prevention of suicide and management of self-harm	
22	Prohibited items	
23	Restrictive practices	
24	Visiting, including procedures for children and unwanted visitors (i.e. those who pose a threat to patients, or to staff members)	
25	The service's policies and procedures are developed and implemented in consultation with patients, their carers and staff members. There is a process in place to enable patients and their representatives to view policies critical to their care.	7, 8, 10
26	Policies, procedures and guidelines are formatted, disseminated and stored in ways that staff members find accessible and easy to use.	10, 13
27	There are systems in place to assess staff knowledge of policies critical to their role.	8

No	Standard	Source document
28	Policies, procedures and contingency plans are reviewed, and updated where required, at the point of material change to the service, in the event of an incident, and every three years as a minimum.	4, 7
29	A contingency plan addresses: • the chain of operational control; • communications; • patient and staff safety and security; • maintaining continuity in treatment; • accommodation.	2, 4, 7, 8
Relational Security		
30	There is an induction and annual training programme for all staff that specifically addresses issues of relational security and is supported by the use of See, Think, Act (2nd Edition).	2, 8, 9
31	There are clear and effective systems for communication and handover within and between staff teams.	2, 8, 9
32	There is a process in place to monitor how the service is performing against items relevant to relational security and an action plan is in place to address any issues raised. *Guidance: Relevant issues are identified using the relational security explorer wheel, are noted in handovers and audited.*	8, 9
Safeguarding		
33	Staff members follow inter-agency protocols for the safeguarding of adults and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.	10
34	There is a designated safeguarding lead who is able to give advice and ensure that all safeguarding issues are raised and resolved, in line with local policy.	2, 8
35	There is a system in place to respond to themes and trends in safeguarding referrals and shared learning.	8
36	On admission, a record is made for each patient of any children known to be in their social network, their relationship to those children and any known risks whether or not reflected in convictions. *Guidance: In the case of emergency admissions this should be conducted as soon as possible.*	8

No	Standard	Source document

Patient Experience		
Patient Focus		
37	On admission to the service, staff members introduce themselves, other patients and show them around. *Guidance: This may also include the use of a 'buddy system' prior to admission.*	10
38	Individual staff members are easily identifiable. *Guidance: For example, by wearing appropriate photo identification.*	10
39	All information is provided in a format which is easily understood by patients. *Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example, audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is culturally relevant.*	10
40	Patients are given a 'welcome pack', or introductory information, at the first appropriate opportunity that contains, at a minimum, the following: • A clear description of the aims of the service; • The current programme and modes of treatment; • The service team membership; • Personal safety on the service; • The code of conduct on the service; • Service facilities and the layout of the service; • What practical items can and cannot be brought in; • Clear guidance on the smoking policy in smoke-free hospitals and how to access smoking breaks off the hospital grounds; • Resources to meet spiritual, cultural and gender needs.	10
41	Clear information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on: • Admission criteria; • Clinical pathways describing access and discharge; • How the service involves patients and their carers; • Contact details for the service.	10
42	Patients are given verbal and written information on: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.	10
43	Patients (and their carers with consent) are offered written and verbal information about the patient's mental illness.	10

No	Standard	Source document
44	Confidentiality and its limits are explained to the patient (and their carers with consent) on admission, both verbally and in writing. *Guidance: For carers this includes confidentiality in relation to third party information.*	10
45	The patient's consent to the sharing of clinical information outside the clinical team is recorded. If this is not obtained the reasons for this are recorded.	10
46	Patients and their carers are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service. *Guidance: This might include surveys or focus groups.*	10
47	There is a minimum of one minuted community meeting per month that is attended by patients and staff members. *Guidance: This is an opportunity for patients to share experiences, to highlight service issues and to review the quality and provision of activities with staff members.*	10
48	Patients are consulted about changes to the service environment.	10
49	Patients are treated with compassion, dignity and respect. *Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.*	10
50	Patients feel listened to and understood by staff members.	10
51	The advocate is known by name to the patient group, and where requested raises issues on behalf of the patients and feeds back any actions or outcomes.	8
52	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.	10
53	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.	10
54	All overnight observations in bedroom areas are undertaken by staff members of the same gender as the patient.	12
	Family and Friends	
55	The team provides each carer with a carers' information pack. *Guidance: This includes the names and contact details of key staff members at the service. It also includes other local sources of advice and support such as local carers' groups, carers' workshops, advocacy services and relevant charities.*	10
56	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This is an opportunity for carers to discuss what support or services they need, including physical, mental and emotional needs. Arrangements should be made through the carer's local council.*	10

No	Standard	Source document
57	Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network. *Guidance: This could be a group/network which meets face-to-face or communicates electronically.*	10
58	The team follows a protocol for responding to carers when the patient does not consent to their involvement. *Guidance: There should be a written process in place, which may be embedded within existing policies or procedures.*	10
59	With patient consent, carers are involved in discussions about the patient's care and treatment planning.	10
60	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	10
61	Patients go on section 17 leave into the care of carers, only with carer agreement and timely contact with them beforehand.	10
	Environment and Facilities	
62	The main entrance where visitors are expected to wait is welcoming, has comfortable seating and provides a positive first impression.	8
63	There is a dedicated visitors' room within the secure perimeter.	4, 7
64	The service is able to safely facilitate child visits and is equipped with a range of child-appropriate facilities such as toys, games and books. *Guidance: The children should only visit if they are the offspring of or have a close relationship with the patient and it is in the child's best interest to visit. Sufficient staff should be made available to enable children to visit during evenings and weekends.*	10
65	Call button/personal alarms are available to all staff, patients and visitors within the secure perimeter.	10
66	There are lockers for visitors away from patient areas to store prohibited or restricted items whilst they are in the service.	4, 7
67	Lockers are provided for staff away from the patient area for the storage of any items not allowed within patient areas (which are locally determined).	4, 7
68	Patients have access to lockable facilities (with staff override feature) for personal possessions with maintained records of access.	4, 7
69	The patient and staff environment is homely, light, clean and bright.	7, 10
70	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. *Guidance: Measures may include staff placement, the use of mirrors or CCTV.*	10
71	Furnishings minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points.	4, 7

No	Standard	Source document
72	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.*	10
73	Bedrooms have patient operated privacy locks that staff can override from the outside.	8
74	Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking.	4, 7
75	Doors in rooms used by patients have observation panels with integrated blinds/obscuring mechanisms. These can be operated by patients with an external override feature for staff.	4, 7
76	Patients are able to ventilate their rooms through the use of windows, have access to light switches and can request adjustments to control heating.	10
77	Patients are able to personalise their bedroom spaces.	10
78	The service has at least one bathroom/shower room for every three patients. *Guidance: Services built after 2011 should provide en-suite facilities as specified in the Environmental Design Guide. Older buildings should have an established maintenance programme working towards this.*	10
79	Patients can wash and use the toilet in private.	10
80	The service has designated facilities for patients within the secure perimeter for: • Education; • Occupational and psychological therapy; • Tribunals; • Physical exercise; • Primary health provision; • Self-catering/cooking; • Dining; • Shop/café; • Laundry.	8
81	There is a designated multi-faith room within the secure perimeter which provides patients with access to faith-specific materials and facilities that are associated with cultural or spiritual practices. *Guidance: This space should be private and quiet.*	10
82	There is a secure treatment and dispensary room.	8
83	The service has at least one quiet room. *Guidance: The quiet room is in addition to a patient's bedrooms.*	10
84	Patients are able to access safe outdoor space for recreational purposes at least daily. *Guidance: This includes court yards, secure gardens or utilising leave.*	10
85	Patients can make and receive telephone calls in private.	10
86	There is a facility for patients to video-conference.	8

No	Standard	Source document
87	All patients have access to facilities to make their own hot and cold drinks and snacks. *Guidance: Facilities are accessible at all times unless individual risk assessments dictate otherwise.*	10
88	All patients can access a range of current resources for entertainment, which reflect the service's population. *Guidance: This may include recent magazines, daily newspapers, books, board games, a TV and DVD player with DVDs, computers and internet access (where risk assessment allows).*	10
89	There is a dedicated de-escalation space that the team may consider using, with the patient's agreement, specifically for the purpose of reducing arousal and/or agitation. *Guidance: This space is furnished for the use of de-escalation.*	10
90	In services where seclusion is used, there is a designated room that meets the requirements of the Mental Health Act Code of Practice. *Guidance: The room:* • *allows for communication with the patient when the patient is in the room and the door is locked, e.g. via an intercom;* • *includes limited furnishings which should include a bed, pillow, mattress and blanket or covering;* • *has no apparent safety hazards;* • *has robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside);* • *has externally controlled lighting, including a main light and subdued lighting for night time;* • *has robust door(s) which open outwards;* • *has externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature;* • *does not have blind spots, and alternate viewing panels are available where required;* • *has a clock visible to the patient from within the room; and* • *has access to toilet and washing facilities.*	5, 10
91	Staff members ensure that no confidential data is visible or accessible beyond the team. *Guidance: This might be by locking cabinets and offices, using swipe cards and having password protected computer access, and ensuring computer screens are not visible through reflection or direct sight.*	10

No	Standard	Source document
Clinical Effectiveness		
Patient Pathways and Outcomes: Admission		
92	There is a clinical model that describes the purpose of the service and details the clinical approach in relation to key therapeutic outcome areas.	8
93	Patients will receive a multidisciplinary pre-admission assessment of need that ensures admissions to the service are appropriate and the needs of patients are clearly identified. *Guidance:* The pre-admission a*ssessment includes:* • *Assessment of mental health needs;* • *Problem areas and risk factors;* • *Physical health needs;* • *Security risks and needs;* • *Safeguarding needs;* • *Cultural/spiritual needs (including language and translation needs);* • *Personal needs;* • *Strengths, protective factors and goals.*	7, 8, 10
94	The multi-disciplinary team (MDT) make decisions about patient admission or transfer. They can refuse to accept patients if they anticipate that the patient mix will compromise safety and/or therapeutic activity.	10
Patient Pathways and Outcomes: Treatment and Recovery		
95	Every patient has a written care plan reflecting their individual needs, including: • Any agreed treatment for physical and mental health; • Positive behavioural support plans; • Advance directives; • Specific personal care arrangements; • Specific safety and security arrangements; • Medication management; • Management of physical health conditions.	8, 10
96	The multi-disciplinary team (MDT) develops the care plan collaboratively with the patient, and their carer (with patient consent).	10
97	The multi-disciplinary team (MDT) reviews and updates care plans according to clinical need or at least once a month.	10
98	The patient and their carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.	10
99	Patients have a pathway of care planned that is realistic and takes account of their aspirations. The plan identifies services the patient is likely to need through their pathway to the community or to the last realistic point of care.	8
100	Patients are offered evidence based pharmacological and psychological interventions and any exceptions are documented in the case notes. *Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base.*	10

No	Standard	Source document
101	Patients have clear personalised outcomes identified in key recovery areas (if relevant) and understand which outcomes are pathway critical i.e. what they must achieve to progress to the next level of care. *Guidance: Recovery areas may include:* • *Mental health recovery;* • *Insight;* • *Problem behaviours and risk;* • *Drugs and alcohol;* • *Independent living skills;* • *Physical health.*	8
102	Patients have a personalised plan of therapeutic and skill-developing activity that is directly correlated to their outcomes plan. Patients can see the connection between activities they are undertaking and the achievement of their recovery goals. *Guidance: Activities and therapy are planned over seven days and not limited to conventional working hours.*	2, 8, 10
103	The team provides information, signposting and encouragement to patients where relevant to access local organisations for peer support and social engagement such as: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	10
104	Patients have a Care Programme Approach (CPA) meeting (or equivalent) within the first three months and as a minimum every six months thereafter to review ongoing outcomes work and progress. *Guidance: There is evidence that patients are encouraged and supported to play a key participating role in their CPA meeting.*	2, 8
105	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	10
106	Clinical outcome monitoring includes reviewing patient progress against patient-defined goals in collaboration with the patient.	10
	Patient Pathways and Outcomes: Medication	
107	All staff members who administer medications have been assessed as competent to do so. Assessment is repeated on a yearly basis using a competency-based tool.	10
108	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded.	10

No	Standard	Source document
109	Patients (and their carers with consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications and to self-manage as far as possible. *Guidance: When patients experience side effects from their medication, this is engaged with and there is a clear care plan in place for managing this.*	10
110	Patients prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the patient: • A personal/family history (at baseline and annual review) • Lifestyle review (at every review) • Weight (every week for the first 6 weeks) • Waist circumference (at baseline and annual review) • Blood pressure (at every review) • Fasting plasma glucose/ HbA1c (glycated haemoglobin) (at every review) • Lipid profile (at every review)	10
111	The safe use of high risk medication is audited and reviewed, at least annually and at a service level. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines.*	10
Patient Pathways and Outcomes: Leave and Discharge		
112	The team develops a leave plan jointly with the patient that includes: • The aim and purpose of section 17 leave; • Conditions of the leave; • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Contact details of the service.	10
113	The team supports patients to access organisations which offer: • Housing support; • Support with finances, benefits and debt management.	10
114	The service identifies and addresses the immediate needs and concerns of the patient in relation to transitions to other services or to the community. *Guidance: This is likely to include practical issues such as:* • *Access to money;* • *Medication;* • *Clothing;* • *Transfer of personal items;* • *Personal care.*	13

No	Standard	Source document
115	Patients and their carer (with patient consent) are invited to a discharge meeting and are involved in decisions about discharge plans.	10
116	The service works proactively with the home area care coordinator and next point of care (including other in-patient services, forensic outreach teams, community mental health teams or prison) to develop robust discharge/transfer arrangements and minimise delay. *Guidance: Patient discharge plans feature triggers and arrangements for 'recall' to the service if the patient relapses. When patients are transferred between services there is a handover which ensures that the new team have an up to date care plan and risk assessment.*	8, 10
Physical Healthcare		
117	All records held by the organisation are integrated into one patient record.	13
118	Patients are offered a staff member of the same gender as them, and/or a chaperone of the same gender, for physical examinations.	10
119	Patients have their physical healthcare needs assessed on admission and reviewed every six months or more frequently if required. Patients are informed of the outcome of their physical health assessment and this is recorded in their notes. *Guidance: This includes past medical history and family medical history, current medication, physical observations, physical examination, blood tests, physical symptoms, lifestyle factors and lifestyle advice.*	8, 10
120	Care plans consider physical health outcomes and interventions in the following areas: • Health awareness; • Weight management; • Smoking; • Diet and nutrition; • Exercise; • Any patient specific items. *Guidance: For patients who have not successfully reached their physical health targets after 3 months of following lifestyle advice, the team discusses further intervention.*	8, 10
121	The team gives targeted lifestyle advice and provides health promotion activities for patients. This includes: • Smoking cessation advice; • Healthy eating advice; • Physical exercise advice and opportunities to exercise.	10

No	Standard	Source document
122	Screening programmes are available in line with those available to the general population with the aim of ensuring early diagnosis and prevention of further ill health. *Guidance: The screening programme recognises the higher physical health risks for patients in secure mental health, such as diabetes, dyslipidaemia, hypertension, epilepsy, asthma etc.*	2
123	There are joint working protocols/care pathways in place to support patients in accessing the following services: • Primary health care; • Accident and emergency; • Social services; • Local and specialist mental health services; • Secondary physical healthcare. *Guidance: This includes the team informing the patient's GP of any significant changes in the patient's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP. In an acute physical health emergency, guidance about when to call 999 and when to contact the duty doctor is provided.*	10
124	Emergency medical resuscitation equipment (crash bag) is available within three minutes. The crash bag is maintained and checked weekly, and after each use.	10
	Workforce	
125	The multi-disciplinary team consists of or has access to staff from a number of different professional backgrounds that enables them to deliver a full range of treatments/therapies appropriate to the patient population. *Guidance: The team includes psychiatrists, nurses (including primary care), healthcare assistants, psychologists, occupational therapists, social workers and educational professionals.*	2, 7
126	The service has a mechanism for responding to low staffing 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; • An overdependence on bank and agency staff members results in action being taken.	10
127	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service.	10

No	Standard	Source document
128	There is a medical on-call arrangement in place which enables the service to: • Respond within 30 minutes to psychiatric emergencies; • Fulfil the requirements of the Mental Health Act Code of Practice. *Guidance: An identified doctor should be available at all times to attend the service, including out of hours. They should be able to attend the ward within 1 hour during normal working hours and within 4 hours outside of this.*	8, 10
	Supervision and Support	
129	Staff members in training and newly qualified staff members are offered weekly supervision.	10
130	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.*	10
131	All staff members receive monthly line management supervision.	10
132	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	10
133	All staff members have access to monthly formal reflective practice sessions. *Guidance: This forum provides staff members with the opportunity to reflect on their own actions and the actions of others. This forum can also be used to discuss concerns and issues of relational security.*	10
134	Staff members and patients feel confident to contribute to and safely challenge decisions. *Guidance: This includes decisions about care, treatment and how the service operates.*	10
135	Staff members feel able to raise any concerns they may have about standards of care. *Guidance: There is an active system in place for whistleblowing and raising concerns regarding standards of care.*	10
136	The service actively supports staff health and well-being. *Guidance: This includes:* • *providing access to support services;* • *monitoring staff sickness and burnout;* • *assessing and improving morale;* • *monitoring turnover;* • *reviewing feedback from exit reports and taking action where needed.*	10

No	Standard	Source document
	Training	
137	New staff members, including bank and agency staff, receive an induction based on an agreed list of core competencies. *Guidance: This includes 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.*	10
138	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: • Statutory and mandatory training; • The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent); • Physical health assessment; • Drug and illicit substance awareness; • Immediate Life Support; • Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities; • Recovery and outcomes approaches; • A patient's perspective; • Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	8, 10
139	The team receives training on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence.	10
140	The team effectively manages violence and aggression in the service. *Guidance:* • *Staff members do not deliberately restrain patients in a way that affects their airway, breathing or circulation;* • *Restrictive intervention always represents the least restrictive option to meet the immediate need;* • *The team works to reduce the amount of restrictive practice used;* • *Providers report on the use of restrictive interventions to service commissioners, who monitor and act in the event of concerns.*	10
141	Patients and carers are involved in delivering face-to-face training.	10

No	Standard	Source document
Governance		
142	The ward/unit has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. *Guidance: Stakeholders could include staff member representatives from across the care pathway, as well as patient and carer representatives.*	10
143	There is a widely accessible complaints procedure that clearly sets out the ways in which a complaint can be made, the process for investigation and how communication is managed throughout.	2, 8
144	Complaints are reviewed on a quarterly basis to identify themes, trends and learning.	2, 8
145	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	10
146	Staff members share information about any serious untoward incidents involving a patient with the patient themselves and their carer (with patient consent), in line with the Statutory Duty of Candour (or equivalent).	10, 11
147	Staff members, patients and carers who are affected by a serious or distressing incident are offered post incident support.	10
148	Contingency plans are tested by live and desktop exercises.	2, 4, 7, 8
149	A collective response to alarm calls is rehearsed at least 6 monthly.	10
150	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*	10
151	When staff members undertake audits they: • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle. *Guidance: Audits may include topics such as the use of control and restraint, or restrictive practice.*	10
152	Findings from investigations, measures and reports are routinely shared between the team and the board, and vice versa, so that lessons can be learned.	8

References

1 Department of Health (2002) *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*. Available online at: http://napicu.org.uk/wp-content/uploads/2013/04/2002-NMS.pdf

2 Department of Health (2006) *Standards for Better Health.* Available online at: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4132991.pdf

3 Department of Health (2011) *Environmental Design Guide: Adult Medium Secure Services*. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215623/dh_126177.pdf

4 Department of Health (2012) *Low Secure Services: Good Practice Commissioning Guide, Consultation Draft.* Available online at: http://apps.bps.org.uk/_publicationfiles/consultation-responses/Low%20Secure%20Services%20&%20Psych%20Intensive%20Care%20-%20cons%20paper%201.pdf

5 Department of Health (2015) *Mental Health Act 1983: Code of Practice.* Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

6 NAPICU (2014) *National Minimum Standards for Psychiatric Intensive Care in General Adult Services.* Available online at: http://napicu.org.uk/wp-content/uploads/2014/12/NMS-2014-final.pdf

7 Royal College of Psychiatrists (2012) *Standards for Low Secure Services*, CCQI. Available online at: http://www.rcpsych.ac.uk/pdf/QNFMHSStandardsLowSecureServices.pdf

8 Royal College of Psychiatrists (2014) *Standards for Medium Secure Services*, CCQI. Available online at: http://www.rcpsych.ac.uk/pdf/QNFMHS%20Standards%20for%20Medium%20Secure%20Services%20%202014%20Amended.pdf

9 Royal College of Psychiatrists (2015) *See, Think, Act: Your Guide to Relational Security (2nd Edition)*, CCQI. Available online at: http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf

10 Royal College of Psychiatrists (2015) *Standards for Inpatient Mental Health Services*, CCQI. Available online at: http://www.rcpsych.ac.uk/pdf/RCPsych_Standards_In_2016.pdf

11 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Available online at: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/pdfs/ukdsi_9780111117613_en.pdf

12 Royal College of Psychiatrists (2010) *Standards and Criteria for Women in Medium Secure Care.* Available online at: http://www.rcpsych.ac.uk/pdf/Implementation%20Criteria%20with%20Standards%20for%20Women%20Final_NEW%20COVER.pdf

13 QNFMHS (2016) Expert Consultation Group Meeting, 17 March 2016.

Royal College of Psychiatrists Centre for Quality Improvement
21 Prescot Street • London • E1 8BB

www.rcpsych.ac.uk

COLLEGE CENTRE FOR
QUALITY IMPROVEMENT