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

Quality Network for Forensic Mental Health Services

Editors: Megan Georgiou, Matthew Oultram and Dr Quazi Haque
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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:

Lion, AM, Guild Lodge, Lancashire Care NHS Foundation Trust.

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Foreword

We remain a successful network with strong engagement from those using and working within forensic services.

Our peer review programme highlights the challenges of delivering high quality care but also recognises the achievements and expertise across our forensic services.

Successful care relies on people within our services and across the system working together. We are therefore very pleased that this set of standards has benefited from the expertise of clinicians, managers, commissioners, regulators, patients and carers across the forensic system.

These standards continue to recognise the importance of the therapeutic use of security whilst also promoting important principles around evidence-based care, patient and carer involvement, parity of physical healthcare, public health priorities, and good governance. We also wish to recognise excellence, and reflect this within new standards addressing quality improvement, co-production and research.

I want to thank the team at the forensic quality network for leading on the development of these standards, and their tireless commitment toward working with services to support better care. Finally, I want to recognise the many patients and carers who have contributed to this work - we could not present a credible framework for high quality care without their participation.

Dr Quazi Haque, Consultant Forensic Psychiatrist,
Chair of the Quality Network for Forensic Mental Health Services

Introduction

These standards have been developed in consultation with the member services of the Quality Network for Forensic Mental Health Services (QNFMHS), patients, family and friends, and other key stakeholders.

The standards were developed in five stages:

1. **Standards consultation roadshow:** We hosted three events in the autumn of 2018 in London, Middlesbrough and Bristol to consult on the standards. The events were attended by a range of professionals, patients, family and friends, and other key stakeholders.

2. **Expert consultation group:** Further meetings were arranged to focus on priority areas with members of the advisory group, QNFMHS patient and family and friends representatives, and other experts in December 2018.

3. **Collaboration with NHS England's Clinical Reference Group for Adult Secure Services:** Members of this group were heavily involved in developing the new standards. The standards are referred to within the published adult medium and low secure specifications (published March 2018):

   > *The service must deliver services, within the guidance contained in Royal College of Psychiatrists Quality Network Standards for Forensic Care CCQI. Providers must be members of the Quality Network and participate in the peer review process.*

4. **Electronic consultation:** A revised draft of the standards was circulated to all QNFMHS contacts, including: individuals working in member services, QNFMHS patient and family and friends representatives, advisory group members and representatives from relevant agencies.

5. **Final review by the QNFMHS advisory group:** Members of the QNFMHS advisory group reviewed the final draft and agreed the final version.

Categorisation and themes

Each standard has been rated to define whether it is essential, expected or desirable in relation to patient care.

All criteria are rated as Type 1, 2 or 3

> **Type 1:** Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law.

Type 2: Expected standards that all services should meet.

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

To support the identification of key themes between the standards, a key has been devised. Throughout the document, the following icons will denote where a standard represents one of these themes.

Theme	Icon
Patient/carer information	
Care planning	
Medication	
Safety	
Wellbeing	
Healthy lifestyle	
General environment	
Patient and carer involvement	
Training and competencies	
Service development	
Policies and procedures	

Involving family, friends and carers

The following standards uphold the principle that we wish to ensure positive engagement, support and collaboration from all those who are part of a patient's life, whether family, friends, or carers in the pathway of care.

These standards do not supersede the patient's right to privacy. The sharing of confidential information and/or contact with family, friends or carers must uphold the patient's wishes and occur only with their informed consent.

This does not reduce the responsibility of services to support carers where required, ensure access to statutory carer assessment and provide general information regarding the service. The need to uphold public safety is not affected.

Standards for Forensic Mental Health Services

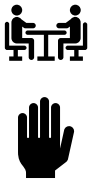
Admission and Assessment			
No.	**Standard**	**Type**	**Key**
1	Patients will receive a multidisciplinary pre-admission assessment of need that ensures admissions to the service are appropriate and the needs of patients are clearly identified. *Guidance: The pre-admission assessment includes:* • *Assessment of mental health needs;* • *Security risks and needs;* • *Problem areas and risk factors;* • *Physical health needs;* • *Safeguarding needs;* • *Cultural/spiritual needs (including language and translation needs);* • *Personal needs;* • *Strengths, protective factors and goals;* • *A clinical formulation.*	2	
2	The multi-disciplinary team 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. *Guidance: Decisions to accept or refuse patients are recorded.*	2	
3	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 and on admission.*	2	 
4	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.*	2	 

5	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 in 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 nicotine replacement options; • Resources to meet spiritual, cultural and gender needs. *Guidance: Patients are offered a verbal explanation of the information contained in the welcome pack.*	2	
6	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.	2	
7	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.	2	 
Physical Healthcare			
8	All records held by the service are integrated into one patient record. *Guidance: External clinicians, such as GPs, are encouraged to use hospital recording systems.*	2	
9	Patients are offered a staff member of the same gender as them, and/or a chaperone of the same gender, for physical examinations.	2	

10	Patients have their physical healthcare needs assessed within 72 hours of 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. A monitoring plan is in place for patients who decline an initial assessment, until an assessment can be completed.*	1	
11	Care plans consider physical health outcomes and interventions in the following areas: • Health awareness; • Weight management; • Smoking; • Diet and nutrition; • Exercise; • Dental and optical needs; • 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.*	2	
12	Patients are informed of and supported to access screening programmes available in line with those available to the general population with the aim of ensuring early diagnosis and prevention of further ill health. *Guidance: Patients are informed of the higher physical health risks for patients in secure mental health, such as diabetes, dyslipidaemia, hypertension, epilepsy, asthma etc. and gender-specific needs.*	2	
13	Emergency medical resuscitation equipment (crash bag) is available within three minutes. The crash bag is maintained and checked weekly, and after each use.	1	

Treatment and Recovery			
14	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; • Reducing risk and risk of reoffending; • Specific safety and security arrangements; • Medication management; • Management of physical health conditions.	1	
15	The multi-disciplinary team develops the care plan collaboratively with the patient, and their carer.	2	
16	The multi-disciplinary team reviews and updates care plans at least monthly, or more frequently according to clinical need.	2	
17	The patient and their carer are involved in discussions about the patient's care and treatment planning and they are offered a copy of the care plan and the opportunity to review this.	2	
18	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.	2	
19	Patients are offered evidence based pharmacological interventions and any exceptions are documented in the case notes.	2	
20	Patients are offered evidence based psychological interventions to promote mental health recovery and offending/risk behaviour, and any exceptions are documented in the case notes. *Guidance: This is likely to include interventions to address mental health recovery, insight, drug and alcohol, offending/risk behaviour, and family relations. The number, type and frequency of psychological interventions offered are informed by the evidence base.*	2	

21	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.*	2	
22	Patients have a personalised plan of therapeutic and skill-developing activity that is directly correlated to their outcomes plan. Activities and therapy are planned over seven days and not limited to conventional working hours. Patients can see the connection between activities they are undertaking and the achievement of their recovery goals.	2	
23	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 and the patient's views are clearly documented.*	1	
24	The team provides information, signposting and encouragement to patients where relevant to access local organisations for peer support, social engagement and meaningful occupation such as: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	2	
25	The team develops a leave plan jointly with the patient that includes: • The aim and purpose of section 17 leave; • Conditions of the leave and the therapeutic purpose; • 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; • Expectations on return from leave e.g. searching; • MAPPA requirements and victim issues, where relevant.	2	

26	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:* • *Housing support;* • *Support with finances, benefits and debt management;* • *Advice and support on disclosure;* • *Medication and access to primary healthcare services;* • *Clothing;* • *Transfer of personal items;* • *Personal care;* • *Use of electronic devices, such as mobile phones.*	2	
27	Patients and their carer are invited to a discharge meeting and are involved in decisions about discharge plans.	2	
28	The service works proactively with the home area care coordinator and next point of care (including other inpatient services, forensic outreach teams, community mental health teams or prison) to develop robust discharge/transfer arrangements and minimise delay in accessing crisis support. *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.*	2	
29	There is a system in place for all permanent and agency nursing staff to be assessed as competent to administer medications.	1	
30	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. *Guidance: Patients are helped to understand the functions, expected outcomes, limitations and side effects of their medications and to self-manage as far as possible.*	2	

31	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)	2	
32	The safe use of psychotropic medication is audited and reviewed, at least annually and at a service level. *Guidance: This includes medications such as lithium, valproate, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines.*	2	
33	Evidence-based clinical and patient reported outcome measurement data is collected post-admission and routinely reviewed by the team and patient at clinical reviews.	2	
Patient Experience			
34	Individual staff members are easily identifiable. *Guidance: For example, by wearing or displaying appropriate photo identification.*	2	
35	Patients and their carers are offered written and verbal information about the patient's mental illness and any physical health conditions.	2	
36	Confidentiality and its limits are explained to the patient and their carers on admission, both verbally and in writing. *Guidance: For carers, this includes confidentiality in relation to third party information.*	2	
37	The patient's consent to the sharing of clinical information outside the clinical team is recorded and there is a system for review. If this is not obtained the reasons for this are recorded.	2	

38	The advocate is independent, known by name to the patient group, and where requested raises issues on behalf of the patients and feeds back any actions or outcomes.	2	
39	Patients are treated with compassion, dignity and respect. *Guidance: This includes respect of a patient's race, age, expressed social gender, marital status, sexual orientation, maternity, disability, social and cultural background.*	2	
40	Patients feel listened to and understood by staff members.	2	
41	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.	2	
42	Patients' preferences/views are taken into account when allocating staff members undertaking overnight observations in bedroom areas.	2	
43	There is a clear and well understood route for patient communication to the organisation's board, and from the board back to patients on the wards. Patients are given the opportunity to communicate their feedback and experiences of using the service in a variety of forms, including feedback surveys, focus groups, community meetings and patient representatives.	2	

44	There is a minimum of two community meetings a month on each ward that are attended by patients and staff members. • The meeting is chaired or co-chaired by a patient; • Discussions are recorded with written minutes; • There is a clear process for the discussions from this meeting to be fed through management and governance routes to the board, and a clear process through which the board feeds back to patients at the ward-based community meeting.	2	
45	The service has a user involvement and co-production strategy covering all aspects of service delivery. *Guidance: The strategy defines patient and carer involvement as an equal partnership between people who design and deliver services, people who use the services and people in the community.*	2	
46	There is a designated lead for patient and carer involvement. *Guidance: This individual is part of the executive management team and attends each ward-based community meeting a minimum of once a year.*	2	
47	The service facilitates access to a peer support service.	3	
48	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	
49	The service enables patients to make healthy diet choices at meal and non-meal times. *Guidance: Policies and practices around access to non-hospital food and drink, including patient shop items, take-aways and use of patient leave are in place. The provision of information and support for carers regarding appropriate choices around food and drink they may bring to the unit and provide on home visits is documented.*	2	

50	Education is offered to patients on the importance of maintaining a healthy lifestyle and the service encourages patients to remain active. *Guidance: Patients have access to a range of physical activities and appropriate physical health monitoring measures are in place.*	2	
Family, Friends and Visitors			
51	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.*	2	
52	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.*	2	
53	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.*	2	
54	Carers are supported to engage in meetings, events and service initiatives. *Guidance: This includes organising transport and facilitating Skype calls.*	2	
55	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	2	

56	When a patient withdraws consent, general information about the hospital, its service provision, as well as education about mental ill-health and recovery is still available to carers.	2	
57	The service has a strategy for carer engagement developed through use of the 'Carer support and involvement in secure mental health services toolkit' (NHS England, 2018). The strategy describes measures taken to proactively support: • A carer's own needs around information and support; • How they can be involved in the care of their loved one; • Opportunities to be involved in service developments, training and improvements.	2	
58	Visitors are made to feel welcome and the service provides a positive first impression.	2	
59	There is a designated visitors' room within the secure perimeter. The space must meet the following requirements: • Suitable to maintain privacy and confidentiality; • Provide a homely environment; • Observations are not overly intrusive; • Accessible by patients and visitors.	2	
60	The service can 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.*	2	

61	The pathway of care considers victim issues and is developed in liaison with relevant supervisory agencies e.g. the responsible local authority, offender manager and/or MAPPA.	2	
Ward Environment			
62	Call button/personal alarms are available to all staff, patients and visitors within the secure perimeter.	1	
63	Lockable facilities are provided for: • Patients for their personal possessions (with staff override feature) with maintained records of access; • Staff away from the patient area for the storage of any items not allowed within patient areas (which are locally determined); • Visitors away from patient areas to store prohibited or restricted items whilst they are in the service.	2	
64	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.*	1	
65	The environment meets the needs of individuals with physical disabilities. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	1	
66	Patients can adjust or request changes to the environment to maintain thermal comfort. *Guidance: This includes adjustments to heating, ventilation through the use of windows and support to add/remove clothing.*	2	
67	Patients can personalise the ward environment and their bedroom spaces, in conjunction with staff members and where appropriate.	2	

68	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.*	1	
69	Furnishings minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points.	1	
70	Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking. Bedrooms have patient operated privacy locks that staff can override from the outside.	1	
71	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.	1	
72	The service has designated and fit for purpose facilities for patients within the secure perimeter for: • Education; • Therapies; • Tribunals; • Quiet space; • Physical exercise; • Primary health provision; • Self-catering/cooking; • Dining; • Shop/café; • Video-conferencing; • Laundry.	2	
73	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.*	2	
74	There is a secure treatment and dispensary room.	2	

75	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.*	2	
76	Patients can wash and use the toilet in private.	2	  
77	Patients can access safe outdoor space when requested, at least daily and when it is safe to do so. *Guidance: Unless individual risk assessments dictate otherwise. Any exceptions should be documented in case notes.*	2	 
78	Patients can make and receive calls in private.	2	 
79	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.*	2	 
80	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).*	2	 
81	There is a dedicated de-escalation space that is furnished for the purpose of de-escalation.	2	 

82	Any designated seclusion room 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;* • *Has access to toilet and washing facilities.*	2	
Physical Security			
83	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.*	2	

84	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).*	1	
85	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	
86	In outside areas within the secure perimeter, permanent furniture, fixtures and equipment are fixed and are prevented from use as a climb aid.	2	
87	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.	1	
88	There are controlled systems in place to manage access and egress through all doors and gates that form part of the secure perimeter.	1	
89	Where CCTV is in use, there should be passive recording of the perimeter, reception frontage and access from the secure area to reception.	2	

90	Access to the secure service for visitors, staff and patients is via an airlock. *Guidance: An airlock is a physical access security system comprising a space with two or more doors/gates, one of which must be closed before another can be opened. All access through the secure perimeter is managed by such an airlock system, either procedural or electronic, whereby the integrity of the secure perimeter is maintained by at least one of the two doors/gates being locked at all times.*	1	
91	The reception/control room is: • Within or forms part of the secure external perimeter; • Staffed 24 hours per day 7 days a week or can be made fully operational in the case of an emergency. *Guidance: The operation of the reception/control room is documented within the operational procedure.*	2	
92	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	
93	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.	2	
94	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.	1	

95	Prohibited, restricted and patient accessible items are individually risk assessed, controlled and monitored. *Guidance: Policies and procedures on the management of prohibited items are formalised.*	1	
96	There is a designated security lead with responsibility for security within the service. *Guidance: The designated individual has relevant experience and training.*	2	
Procedural Security			
For standards 97-105, there are formalised policies, procedures and guidance, which have been co-produced where possible, on:			
97	Anti-bullying. *Guidance: Policies and procedures include information for staff and patients, for those who are bullying, and those who are being bullied.*	2	
98	Conducting searches of patients and their personal property, staff members, visitors and the environment.	2	
99	Effective liaison with local police on incidents of criminal activity/harassment/violence and other criminal justice agencies, where relevant. *Guidance: A memorandum of understanding is in place with local police on reporting crime.*	2	
100	Supporting patients' use of electronic equipment and safe access to the internet, including specific advice around the appropriate use of social networking sites, confidentiality and risk.	2	
101	Managing situations where patients are absent without leave.	2	

102	Patient observation.	2	
103	Prevention of suicide and management of self-harm.	2	
104	Minimising restrictive practices. *Guidance: Policies and procedures include a formalised strategy for minimising restrictive practices that is proportionate to the possible risks identified. A process for reviewing restrictive practices is documented with specified timescales. Individual care plans focus on minimisation and restrictive practices.*	2	
105	Visiting, including procedures for children and unwanted visitors (i.e. those who pose a threat to patients, or to staff members).	2	
106	A contingency plan addresses: • The chain of operational control; • Communications; • Patient and staff safety and security; • Maintaining continuity in treatment; • Accommodation; • Testing by live and desktop exercises, including a collective response to rehearsing alarm calls at least six-monthly.	1	
107	The service's policies and procedures are developed, implemented and reviewed 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.	2	
108	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.	2	

109	Policies, procedures and guidelines are formatted, disseminated and stored in ways that staff, patients and carers find accessible and easy to use.	2	
110	There are systems in place to assess staff knowledge of policies critical to their role.	2	
Relational Security			
111	There is a relational security component to the induction programme for all staff that is informed by See Think Act and as a minimum covers: • The context of risk and consequence in secure care; • An explanation of the definition of relational security; • An explanation of the relational security model; • How to manage boundaries effectively.	2	
112	There is a structure in place for direct care staff that supports ongoing skill development in the eight areas of relational security.	2	
113	There are clear and effective systems for communication and handover within and between staff teams. *Guidance: Relevant issues are identified using the relational security explorer wheel, are noted in handovers, and audited.*	2	
Safeguarding			
114	Inter-agency protocols for the safeguarding of adults and children are easily accessible on the ward. This includes local safeguarding responsibilities and functions, and escalating concerns if an inadequate response is received to a safeguarding alert or referral. *Guidance: 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.*	1	
115	There is a local designated safeguarding lead who can give advice and ensure that all safeguarding issues are raised and resolved, in line with local policy and external requirements of the Safeguarding Adults and Children Board.	1	

116	There is a system in place to respond to themes and trends in safeguarding alerts/referrals and there are mechanisms to share learning. *Guidance: An action plan is in place to address any issues raised, including where training needs are identified.*	2	
117	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.*	1	
Workforce			
118	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, registered psychologists, allied healthcare professionals, social workers and educational professionals.*	2	
119	The service has a mechanism for responding to safer staffing, including: • A method for the team to report concerns about staffing; • 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.	2	
120	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.*	2	

121	All clinical staff members receive individual 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.*	2	
122	All staff members receive individual monthly line management supervision. *Guidance: Supervisors should be appropriately trained to deliver supervision.*	2	
123	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	2	
124	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. It can also be used to discuss concerns and issues of relational security. Reflection is a conscious effort to think about an activity or incident that allows the individual and/or group to consider what was positive or challenging, and if appropriate, plan how it might be enhanced, improved or done differently in the future.*	2	

125	There are processes and initiatives in place to support staff health and well-being. *Guidance: This includes:* • *Providing access to support services;* • *Monitoring staff sickness and burnout;* • *Encouraging staff to take scheduled breaks;* • *Assessing and improving morale;* • *Providing wellbeing programmes;* • *Monitoring turnover;* • *Reviewing feedback from exit reports and taking action where needed.*	2	
126	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 and weekly supervision until core competencies have been assessed as met.*	1	
127	Staff members receive training consistent with their role and in line with their professional body. This 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;	1	
128	Staff members receive training on: • Recognising and communicating with patients, 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.	2	

129	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.	2	
130	The team effectively manages violence and aggression in the service. *Guidance:* • *Staff are appropriately trained and confident in managing violence and aggression;* • *Education is offered to patients on least restrictive practices;* • *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.*	1	
131	Patients and carers are involved in the design and delivery of face-to-face training.	2	

Governance			
132	Service quality improvement is supported by a formal programme of involvement: • There is a co-produced local quality improvement strategy linked to the needs of patients and the workforce; • Models of care within the service are routinely subject to evaluation and review; • There is a mechanism in place for staff and patients to influence and contribute to quality improvement projects.	3	
133	The service supports research and the implementation of evidence-based interventions: • There is a local research strategy linked to the needs of patients and workforce; • Research includes projects co-produced with patients and carers and collaboratively engages with other services and stakeholders; • Assessment and treatment models of care within the service are routinely subject to evaluation; • There is a mechanism in place for staff and patients to influence and contribute to research projects; • The service shares the outcomes of their research with patients, carers, staff and other stakeholders by means such as plain language summaries, research papers, posters and presentations.	3	
134	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.	2	
135	The ward/unit has a strategic managerial meeting, at least annually, with all stakeholders to consider topics such as referrals, the clinical model, service developments, issues of concern and to re-affirm good practice. *Guidance: Stakeholders should include staff member representatives from across the care pathway, as well as patient and carer representatives.*	2	

136	There is a widely accessible complaints procedure, for staff, patients and visitors, that clearly sets out the ways in which a complaint can be made, the process for investigation and how communication is managed throughout.	2	
137	Complaints are reviewed on a quarterly basis to identify themes, trends and learning.	2	
138	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.*	2	
139	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this. Staff members are provided with feedback following the reporting of an incident.	2	
140	Staff members share information about any serious incidents involving a patient with the patient themselves and their carer, in line with the Statutory Duty of Candour (or equivalent).	2	
141	Staff members, patients and carers who are affected by a serious or distressing incident are offered post incident support.	2	
142	Findings from investigations, recommendations, and implementation reports are routinely shared between the team and the board, and vice versa, so that lessons can be learned.	2	
143	An audit of environmental risk is conducted annually and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*	2	

References

Care Quality Commission (2015) How the CQC regulates: Specialist mental health services: Appendices to the provider handbook. Available at: https://www.cqc.org.uk/sites/default/files/20150327_mental_health_provider_handbook_appendices_march_15_update.pdf

Care Quality Commission (2018) The state of care in mental health services 2014 to 2017. Findings from CQC's programme of comprehensive inspections of specialist mental health services. Available at: https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

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

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

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

Department of Health (2012) Low Secure Services: Good Practice Commissioning Guide, Consultation Draft.

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

GOV.UK (2018) Modernising the Mental Health Act – final report from the independent review. Available at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

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

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

National Collaborating Centre for Mental Health (2019) Evidence and tools to enable co-production in mental health commissioning. Available at:

https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/working-well-together/working-well-together-evidence-and-tools-to-enable-coproduction-in-mental-health-commissioning.pdf

NHS England (2018) Adult Medium Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services (FOLS). Available at: https://www.england.nhs.uk/wp-content/uploads/2018/03/adult-medium-secure-service-specification-v3.pdf

NHS England (2018) Carer support and involvement in secure mental health services: A Toolkit. Available online at: https://www.england.nhs.uk/wp-content/uploads/2018/05/secure-carers-toolkit-v2.pdf

NHS England (2019) Adult Low Secure Services including Access: Assessment Service and Forensic Outreach and Liaison Services (FOLS). Available at: https://www.england.nhs.uk/wp-content/uploads/2018/03/adult-low-secure-service-specification-v3.pdf

Public Health England (2017) Working together to address obesity in adult mental health secure units: A systematic review of the evidence and a summary of the implications for practice. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/591875/obesity_in_mental_health_secure_units.pdf

QNFMHS (2018) Expert Consultation Group Meetings, September and October 2018.

QNFMHS (2018) Standards Consultation Group: Patient and Family and Friends Representatives, December 2018.

QNFMHS (2018) Standards Expert Group, December 2018.

QNFMHS (2019) Standards E-Consultation, March 2019.

Royal College of Psychiatrists (2010) Standards and Criteria for Women in Medium Secure Care.

Royal College of Psychiatrists (2015) See, Think, Act: Your Guide to Relational Security (2nd Edition), CCQI. Available online at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-forensic/forensic-see-think-act-qnfmhs/sta_hndbk_2nded_web.pdf?sfvrsn=90e1fc26_4

Royal College of Psychiatrists (2017) Standards for Forensic Mental Health Services: Low and Medium Secure Care – Second Edition, CCQI. Available online at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-forensic/forensic-standards-qnfmhs/qnfmhs-standards-for-forensic-mental-health-services-2nd-edition-2017.pdf?sfvrsn=3b7e16ba_2

Royal College of Psychiatrists (2017) Standards for Inpatient Mental Health Services (Second Edition). Available online at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-

resources/ccqi-resources-core-standards-inpatient-mental-health-services.pdf?sfvrsn=d503ffca_2

Royal College of Speech and Language Therapists (2013) Five Good Communication Standards: Reasonable Adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings. Available at: https://www.rcslt.org/-/media/Project/RCSLT/good-comm-standards.pdf

Royal College of Speech and Language Therapists (2017) Justice Evidence Base. Available at: https://www.rcslt.org/-/media/Project/RCSLT/justice-evidence-base2017-1.pdf

Should you require further information about a source for a standard, please contact the Quality Network.

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Project Contact Details and Information

Megan Georgiou, Programme Manager
Megan.Georgiou@rcpsych.ac.uk
0203 701 2701

Matthew Oultram, Deputy Programme Manager
Matthew.Oultram@rcpsych.ac.uk
0203 701 2763

Address

Quality Network for Forensic Mental Health Services
Royal College of Psychiatrists
2nd Floor
21 Prescot Street
London
E1 8BB

Website

www.qnfmhs.co.uk

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

www.rcpsych.ac.uk

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