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ROYAL COLLEGE OF PSYCHIATRISTS

NEURO
QUALITY NETWORK FOR NEUROPSYCHIATRY SERVICES

# Quality Standards for Neuropsychiatry Services

1st Edition

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# Introduction

**What is the Quality Network for Neuropsychiatry Services (QN-Neuro)?**
QN-Neuro is a quality improvement programme for services in the UK working with people experiencing neurological disorders and associated psychiatric symptoms and/or acquired or traumatic brain injury with psychiatric complications.

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

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

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

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

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

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

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

**Standard types:**

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

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

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

# Quality Standards for Neuro Services

## Section 1: Admission and assessment

### Prior to admission

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

| No. | Type | Standard |
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| 9 | 1 | Assessments of patients' capacity to consent to care and treatment in hospital are performed prior to admission and regularly reviewed in accordance with relevant legislation. |

## On admission

| No. | Type | Standard |
| --- | --- | --- |
| 10 | 1 | On admission to the ward/unit, patients feel welcomed by staff members who explain why they are in hospital.<br><br>*Guidance: Staff members show patients around and introduce themselves and other patients, offer them refreshments and address them using the name and pronouns they prefer. Staff should enquire as relevant how they would like to be supported in regard to their gender.* |
| 11 | 1 | The patient's carer is contacted as soon as possible by a staff member (where appropriate and with patient consent) to notify them of the admission and to give them the ward/unit contact details. |
| 12 | 1 | Patients are given accessible written information which staff members talk through with them as soon as practically possible. The information includes:<br>- Their rights regarding admission and consent to treatment;<br>- Their rights under relevant mental health legislation<br>- How to access advocacy services;<br>- How to access a second opinion;<br>- How to access interpreting services;<br>- How to view their health records;<br>- How to raise concerns, complaints and give compliments. |
| 13 | 1 | Patients have a comprehensive mental health assessment which is started within four hours of admission. This involves the multi-disciplinary team and includes consideration of the patient's:<br>- Mental health and medication;<br>- Psychosocial and psychological needs;<br>- Cognitive and neurodisability needs;<br>- Behaviour that challenges;<br>- Strengths and areas for development. |
| 14 | 1 | Patients have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. If all or part of the examination is declined, then the reason is recorded and repeated attempts are made. |
| 15 | 1 | Patients have a risk assessment and safety plan which is co-produced (where the patient is able to participate), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality).<br><br>*Guidance: This assessment includes physical health-related risk, and considers risk to self, risk to others and risk from others.* |
| 16 | 1 | People admitted to the ward outside the area in which they live have a review of their placement at least every three months. |

# Section 2: Care and treatment

## Reviews and care planning

| No. | Type | Standard |
|---|---|---|
| 17 | 1 | Patients know who the key people are in their team and how to contact them if they have any questions. |
| 18 | 1 | There is a documented formalised review of care or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this with advanced preparation and feedback. |
| 19 | 1 | Multidisciplinary formulation of the patient's function, needs and risks is established across their neurological, physical, neurobehavioural, neurocognitive, communication and psychosocial domains. |
| 20 | 1 | Every patient has a written, formulation-based care plan, reflecting their individual goals and biopsychosocial needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy.<br><br>*Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.* |
| 21 | 2 | Patient-centred and value-based goals are agreed with the patient at the start of treatment wherever possible. Where not possible, goals are agreed initially by the MDT. Progress is reviewed collaboratively with the patient during clinical review meetings and at discharge.<br><br>*Guidance: Goals are determined with consideration of carers' and family members' input, legal representation, and advanced directives where relevant.* |
| 22 | 2 | Patients are supported to develop a positive behaviour support plan, which is overseen by a qualified psychologist. |
| 23 | 1 | Each patient is offered protected time at least once a week with a nominated member of their care team to discuss progress, care plans and concerns. |
| 24 | 1 | Clinical outcome measurement is collected at two time points (at assessment and discharge).<br><br>*Guidance: This includes patient-reported outcome measurements where possible.* |

## Therapies and activities

| No. | Type | Standard |
|---|---|---|
| 25 | 1 | Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to their individual needs. |
| 26 | 2 | Every patient has a seven-day personalised therapeutic/recreational timetable, which the team encourages them to engage with.<br><br>*Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.* |

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| 27 | 2 | Patients receive psychoeducation on topics such as activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management. |
| 28 | 1 | Patients (and carers, with patient consent) are offered written and verbal information about the patient's formulation and treatment. |
| 29 | 2 | There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group.<br><br>*Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.* |
| 30 | 2 | Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues. |
| 31 | 1 | Patients have access to safe outdoor space every day. |

## Medication

| No. | Type | Standard |
|---|---|---|
| 32 | 1 | Where clinically appropriate, patients have a staged, programmed, self-medication care plan in place. |
| 33 | 1 | When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded. |
| 34 | 1 | Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.<br><br>*Guidance: Side effect monitoring tools can be used to support reviews.* |
| 35 | 1 | Every patient's PRN medication is reviewed weekly: frequency, dose and indication. |
| 36 | 1 | All staff members who administer medications have been assessed as competent to do so. The assessment is completed at least once every three years using a competency-based tool. |
| 37 | 2 | Patients and carers and prescribers are able to meet with a pharmacist to discuss medications. |

## Physical healthcare

| No. | Type | Standard |
|---|---|---|
| 38 | 1 | Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission. There are local pathways and shared care agreements for physical health care in place which are easily accessed.<br><br>*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.* |

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| 39 | 1 | Patients who are prescribed mood stabilisers, anticonvulsants or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon. |
| 40 | 1 | Multidisciplinary care plans are in place for the management of dysphagia, pressure sores, wound care, and PEG/RIG/catheter care. |
| 41 | 1 | Staff are able to provide physical health monitoring, record this accurately, and appropriately escalate can when early warning sign thresholds are met. |
| 42 | 1 | The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. |
| 43 | 1 | Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan. |

## Accessing the community

| No. | Type | Standard |
|---|---|---|
| 44 | 1 | The team and patient jointly develop a community access plan, which is shared with the patient, that includes:<br>- A risk assessment and risk management plan that includes an explanation of what to do if problems arise in the community;<br>- Conditions of the community access plan;<br>- Contact details of the ward/unit and crisis numbers and ability to access bed on return.<br><br>*Guidance: The plan should include reference to any physical safety considerations.* |
| 45 | 1 | Staff agree community access plans with the patient's carer where appropriate, allowing carers sufficient time to prepare. |
| 46 | 3 | Patients, according to risk assessment, have access to regular 'green' walking sessions.<br><br>*Guidance: Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rain wear.* |
| 47 | 2 | The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to:<br>- Voluntary organisations;<br>- Community centres;<br>- Local religious/cultural groups;<br>- Peer support networks;<br>- Recovery colleges. |
| 48 | 1 | When patients are unexpectedly absent from the ward, the team (in accordance with local policy):<br>- Activates a risk management plan;<br>- Makes efforts to locate the patient; |

| | | - Alerts carers, people at risk and the relevant authorities;<br>- Escalates as appropriate. |
|---|---|---|

### Interface with other services

| No. | Type | Standard |
|---|---|---|
| 49 | 3 | The team supports patients to attend an appointment with their community GP or hospital specialist if they need to whilst an inpatient, if they are admitted in the local area. |
| 50 | 1 | The team supports patients to access support with finances, benefits, debt management and housing needs. |
| 51 | 1 | The ward/ unit/ organisation has a care pathway for patients who are pregnant or in the post-partum period.<br><br>*Guidance: Women who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there are exceptional circumstances.* |
| 52 | 1 | All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates). |

## Section 3: Discharge planning and transfer of care

| No. | Type | Standard |
|---|---|---|
| 53 | 1 | Mental health practitioners carry out a thorough assessment of the person's personal, social, safety and practical needs to reduce the risk at the point of discharge.<br><br>*Guidance: Where possible, this should be completed in partnership with carers.* |
| 54 | 1 | The team sends a copy of the patient's care plan or interim discharge summary to everyone identified in the plan as involved in their ongoing care (including carers, with patient consent) within 24 hours of discharge.<br><br>*Guidance: The plan includes details of:*<br>*- Care in the community/aftercare arrangements;*<br>*- Crisis and contingency arrangements including details of who to contact;*<br>*- Medication including monitoring arrangements;*<br>*- Positive behavioural support plan;*<br>*- Details of when, where and who will follow up with the patient.* |
| 55 | 2 | A discharge summary is sent, within a week, to the patient's GP and others concerned (with the patient's consent), The summary includes why the patient was admitted and how their condition has changed, and their diagnosis, medication and formulation. |
| 56 | 2 | The team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 72 hours of discharge. |

| 57 | 3 | Teams provide support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP.<br><br>*Guidance: The team provides transition mentors; transition support packs; or training for patients on how to manage transitions.* |
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| 58 | 1 | When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, taking their wishes into account as far as possible. |

## Section 4: Risk and safeguarding

| No. | Type | Standard |
|---|---|---|
| 59 | 1 | Staff know how to prevent and respond to sexual exploitation and disinhibition, coercion, intimidation and abuse. |
| 60 | 1 | Patients are involved (wherever possible) in decisions about their level of therapeutic observations by staff.<br><br>*Guidance: Patients are also supported to understand how the level can be reduced. Where restrictions are applied and there is a lack of capacity to consent, the appropriate legal framework is also considered.* |
| 61 | 2 | Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them. |
| 62 | 2 | Staff collect data on patients' behaviour frequency, triggers and consequences of behaviour and this data is used to inform positive behaviour support plans. |
| 63 | 1 | When restraint is used staff members restrain in adherence with accredited restraint techniques. |
| 64 | 1 | Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long-term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018. |
| 65 | 1 | In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions. |
| 66 | 1 | The team uses seclusion only as a last resort and for brief periods only. |
| 67 | 1 | In units where long-term segregation is used, the area used conforms to standards as prescribed by the Mental Health Act and Mental Capacity Act Codes of Practice.<br><br>*Guidance: This includes patients having access to meaningful and therapeutic activity and outdoor space.* |

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| 68 | 1 | Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs, including respiratory rate, monitored by staff members and any deterioration is responded to. |
| 69 | 1 | When a young person under the age of 18 is admitted:<br>- There is a named CAMHS clinician who is available for consultation and advice;<br>- The local authority or local equivalent is informed of the admission;<br>- The CQC or local equivalent is informed if the patient is detained;<br>- A single room is used. |

# Section 5: Patient and carer engagement

## Patient involvement

| No. | Type | Standard |
|---|---|---|
| 70 | 1 | The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. |
| 71 | 2 | Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics. |
| 72 | 2 | Services are developed in partnership with patients and carers and have an active role in decision making.<br><br>*Guidance: Patients and carers should have lived experience relevant to a neuro setting.* |

## Treatment with dignity and respect

| No. | Type | Standard |
|---|---|---|
| 73 | 1 | Staff members treat all patients and carers with compassion, dignity and respect. |
| 74 | 1 | Patients feel listened to and understood by staff members. |
| 75 | 1 | Staff members respect patients' personal space, e.g. by knocking and waiting before entering their bedroom unless there is an emergency. |

## Carer engagement and support

| No. | Type | Standard |
|---|---|---|
| 76 | 1 | Carers are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents. |
| 77 | 1 | Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. |
| 78 | 2 | Carers are offered individual time with staff members, within 48 hours of the patient’s admission to discuss concerns and their own needs. |

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| 79 | 2 | The team provides each carer with accessible carer's information.<br>*Guidance: Information is provided verbally and in writing (e.g. in a carers' pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.* |
| 80 | 2 | Carers are provided with feedback, information and support at least once a week and have a designated point of contact within the service. |
| 81 | 2 | Carers feel supported by the ward staff members. |

### Provisions of information to patient and carers

| No. | Type | Standard |
|---|---|---|
| 82 | 1 | Information is provided in a variety of formats to ensure it is accessible for people with neuropsychiatric conditions. |
| 83 | 1 | Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties, including their family or carers, are respected and reviewed regularly. |
| 84 | 1 | The team knows how to respond to carers when the patient does not consent to their involvement.<br><br>*Guidance: The ward may receive information from the carer in confidence.* |
| 85 | 2 | The ward/unit works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. |

## Section 6: Service environment

| No. | Type | Standard |
|---|---|---|
| 86 | 1 | Male and female patients have separate bedrooms, toilets and washing facilities. Room allocation should accommodate a spectrum of gender and patient gender self-identification should be supported wherever possible.<br><br>*Guidance: Self-identification as male or female should be accepted, and allocation to a gendered room done with patients' agreement. Where this allocation could present risks to the patient or to vulnerable others, this is risk assessed and all practical steps taken to accommodate patient preference. If patient preference cannot be safely accommodated, this is discussed between the patient and clinical team and agreement made on the most appropriate environment for care.* |
| 87 | 2 | All patients have single bedrooms. |

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| 88 | 3 | Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment. |
| 89 | 2 | Patients are able to personalise their bedroom spaces.<br><br>*Guidance; For example, by putting up photos and pictures.* |
| 90 | 2 | The ward/unit has at least one bathroom/shower room for every three patients. |
| 91 | 3 | Every patient has an en-suite bathroom.<br><br>*Guidance: Where ensuite bathrooms are available, these are prioritised for people whose clinical need requires access.* |
| 92 | 1 | Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room, or access to groups. |
| 93 | 2 | All patients can access a range of current culturally-specific resources for entertainment, which reflect the ward/unit's population.<br><br>*Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.* |
| 94 | 3 | All patients can access a charge point for electronic devices such as mobile phones. |
| 95 | 1 | The environment complies with current legislation on disabled access.<br><br>*Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.* |
| 96 | 1 | Where needed to support disability management or rehabilitation, environmental adaptations can be put in place in the unit environment.<br><br>*Guidance: For example, fall mats.* |
| 97 | 1 | When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives. |
| 98 | 1 | Patients use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy.<br><br>*Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.* |
| 99 | 1 | A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management. |

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| 100 | 1 | Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety.<br><br>*Guidance: This includes avoiding the use of blanket rules and assessing risk on an individual basis.* |
| 101 | 1 | Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms. There is an agreed response when the alarm is raised. |
| 102 | 2 | Staff members and patients can control heating, ventilation and light on the ward/unit.<br><br>*Guidance: For example, patients are able ventilate their rooms through the use of windows, they have access to light switches and they can request adjustments to control heating.* |
| 103 | 1 | Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use. |
| 104 | 2 | The ward/unit has a designated room for physical examination and minor medical procedures. |
| 105 | 1 | In wards/units where seclusion is used, there is a designated room that meets the following requirements:<br>- It allows clear observation;<br>- It is well insulated and ventilated;<br>- It has adequate lighting, including a window(s) that provides natural light;<br>- It has direct access to toilet/washing facilities;<br>- It has limited furnishings (which includes a bed, pillow, mattress and blanket or covering);<br>- It is safe and secure, and does not contain anything that could be potentially harmful;<br>- It includes a means of two-way communication with the team;<br>- It has a clock that patients can see. |
| 106 | 1 | There is a separable gender-specific space which can be used as required. |
| 107 | 2 | The ward/unit has at least one therapy room where staff can see patients in a private space other than the patient's bedroom. |
| 108 | 2 | There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day.<br><br>*Guidance: Hot drinks may be available on a risk-assessed basis.* |
| 109 | 1 | Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements, feeding guidelines and which are also sufficient in quantity. Meals are varied and reflect the individual’s neurodisability, cultural and religious needs. |
| 110 | 2 | Ward/unit-based staff members have access to a dedicated staff room. |

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| 111 | 1 | All patient information is kept in accordance with current legislation.<br><br>*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.* |
| 112 | 2 | Patients are consulted about changes to the ward/unit environment. |
| 113 | 2 | The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms. |

# Section 7: Staffing

## The multidisciplinary team complement

| No. | Type | Standard |
|---|---|---|
| The unit is appropriately staffed in line with the BSPRM (British Society of Physical Rehabilitation Medicine) Minimum Staffing Provision for Specialist Inpatient Rehabilitation Services. The team includes: | | |
| 114 | 1 | A consultant accredited in rehabilitation medicine and/or psychiatry.<br><br>*Guidance: If a psychiatrist, the consultant has knowledge and skills relevant to the specialism.* |
| 115 | 1 | Non-consultant medical input. |
| 116 | 1 | Nurse(s), including RGNs and RMNs in neurobehavioural settings. |
| 117 | 1 | Physiotherapist(s). |
| 118 | 1 | Clinical psychologist(s) who contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions.<br><br>*Guidance: Clinical psychologists should have completed, or be working towards the requirements of the British Psychological Society Specialist Register of Clinical Neuropsychologists.* |
| 119 | 1 | Occupational therapist(s) who work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence based occupational interventions. |
| 120 | 1 | Speech and language therapist(s). |
| 121 | 1 | Social worker(s)/discharge coordinator(s). |
| 122 | 1 | Dietician(s). |
| 123 | 1 | Clerical staff. |

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| 124 | 1 | Trained therapy assistant(s). |
| 125 | 2 | The team has access to rehab engineers and other professions as appropriate to their caseload. |
| 126 | 1 | The team has access to a neurologist for patients requiring regular review. |
| 127 | 3 | There is dedicated sessional input from arts or creative therapists. |

## Staffing levels

| No. | Type | Standard |
|---|---|---|
| 128 | 1 | The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:<br>- A method for the team to report concerns about staffing levels;<br>- Access to additional staff members;<br>- An agreed contingency plan, such as the minor and temporary reduction of non-essential services.<br><br>*Guidance: Staffing levels should comply with the British Society of Physical and Rehabilitation Medicine (BSPRM) guidelines.* |
| 129 | 2 | The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need or short-term absence of permanent staff. |
| 130 | 1 | There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency. |

## Recruitment, induction and supervision

| No. | Type | Standard |
|---|---|---|
| 131 | 2 | Patient or carer representatives are involved in the interview process for recruiting potential staff members.<br><br>*Guidance: The representatives should have experiences relevant to a neuro setting.* |
| 132 | 1 | New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as met. |
| 133 | 1 | All staff undergo specific training in therapeutic observation when they are inducted into a Trust or changing wards. This includes:<br>- Principles around positive engagement with patients,<br>- When to increase or decrease observation levels and the necessary |

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|---|---|---|
| | | multi-disciplinary team discussions that should occur relating to this;<br>- Actions to take if the patent absconds. |
| 134 | 1 | All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.<br><br>*Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.* |
| 135 | 2 | All staff members receive individual line management supervision at least monthly. |

## Staff training and development

| No. | Type | Standard |
|---|---|---|
| Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: | | |
| 136 | 1 | The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent). |
| 137 | 1 | Physical health assessment and management.<br><br>*Guidance: This could include training in understanding physical health problems, undertaking physical observations, basic life support, and Early Warning Signs.* |
| 138 | 1 | Safeguarding vulnerable adults and children.<br><br>*Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.* |
| 139 | 1 | Risk assessment and management.<br><br>*Guidance: This includes assessing and managing suicide risk and self-harm, and the prevention and management of challenging behaviour.* |
| 140 | 2 | Positive behaviour support (PBS) techniques. |
| 141 | 1 | Recognising and communicating with patients with cognitive and communication impairment and learning disabilities. |
| 142 | 1 | Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care. |
| 143 | 2 | Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality. |
| 144 | 1 | Common physical conditions such as diabetes, epilepsy, brain injury awareness, and managing behaviours that challenge including hypersexuality/sexual disinhibition. |

| | | |
|---|---|---|
| 145 | 1 | All staff members who deliver therapies and activities are appropriately trained and supervised. |
| 146 | 2 | Patient and/or carer representatives are involved in delivering and developing staff training. |

## Staff wellbeing and support

| No. | Type | Standard |
|---|---|---|
| 147 | 1 | The ward/unit actively supports staff health and well-being.<br><br>*Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.* |
| 148 | 1 | Patients and staff members feel safe on the ward. |
| 149 | 1 | Staff members are able to take breaks during their shift that comply with the European Working Time Directive.<br><br>*Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.* |
| 150 | 1 | Staff members, patients and carers who are affected by a serious incident including control and restraint and rapid tranquilisation are offered post-incident support.<br><br>*Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection.* |
| 151 | 3 | Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice. |
| 152 | 1 | Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing. |
| 153 | 1 | When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans. |

# Section 8: Governance

| No. | Type | Standard |
|---|---|---|
| 154 | 1 | The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment. |

| | | |
|---|---|---|
| | | *Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.* |
| 155 | 1 | Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this. |
| 156 | 1 | The multi-disciplinary team collects audit data on the use of restrictive interventions, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and or quality improvement methodology.<br><br>*Guidance: Audit data are used to compare the service to national benchmarks where possible.* |
| 157 | 1 | When serious mistakes are made in care, this is discussed with the patient themself and their carer, in line with the Duty of Candour agreement. |
| 158 | 1 | Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons. |
| 159 | 3 | The ward reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team. |
| 160 | 2 | The team actively involved in QI activity. |
| 161 | 2 | The team actively encourages patients and carers to be involved in QI initiatives. |

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

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