Do the right thing: how to judge a good ward

Ten standards for adult in-patient mental healthcare

June 2011
Do the right thing: how to judge a good ward

Ten standards for adult in-patient mental healthcare

Occasional Paper OP79
June 2011

Royal College of Psychiatrists
London
This document was written by Masood Khan and Rowena Daw, with advice and assistance from Dr Michele Hampson and members of the General and Community Psychiatry Faculty of the Royal College of Psychiatrists, together with the AIMS (Accreditation for In-patient Mental Health Services) team at the College’s Centre for Quality Improvement (CCQI).
Contents

Executive summary 4
Introduction 7
The evidence: a summary 9
Ten standards of adult in-patient mental healthcare: a detailed case 10
Appendix
  The ten key standards checklist 17
References 18
Executive summary

The following standards for working-age adult in-patient wards have been distilled from agreed existing standards for in-patient care (see Introduction, p. 7). These standards can be used by trusts and health boards as a check on the quality of the service they provide.

1. **Bed occupancy rates of 85% or less**
   Bed occupancy rates are a main driver of in-patient care standards. A bed occupancy rate of 85% is seen as optimal.¹ This enables individuals to be admitted in a timely fashion to a local bed, thereby retaining links with their social support network, and allows them to take leave without the risk of losing a place in the same ward should that be needed. Delays in admission, which result from higher rates of bed occupancy, may cause a person’s illness to worsen and may be detrimental to their long-term health.

2. **Ward size maximum of 18 beds**
   General adult wards should not have more than 18 beds on any one ward. Larger wards can seem institutional and can contribute to patients feeling less safe.
   
   Integral to effective treatment and recovery is a good relationship between the patient and the staff, coupled with a tailored approach to the individual's needs and careful planning of their care pathway. This can be more difficult to build and sustain with greater numbers of patients on wards. Smaller wards also permit a more personal and comfortable environment.

3. **A physical environment that is fit for purpose**
   The layout, design, decoration and ambience provided by the physical surroundings all play a role in fostering a therapeutic environment for both patients and staff. Access to fresh air is vital, as are quiet and private spaces on the ward and in outdoor areas. A good ward should also have appropriate spaces for community in-reach activities. Separate toilets and sleeping accommodation for men and women is also an important standard and a government policy. Guidelines on interior and exterior design could provide a model for how a ward should look. Periodic reviews of the ward environment would be useful, as the ward is not a static place. A dedicated team to address the appearance of the ward would be beneficial.
4. The Ward as a Therapeutic Space

The ward needs to be a therapeutic space that can help a patient gain control over their general recovery. It should provide a structured therapeutic system of activities on weekdays and weekends alike. The range of activities should include occupational therapies such as art and craft, yoga and quizzes, as well as ordinary simple indoor and outdoor activities such as preparing food, reading in the library, and gardening.

Active measures should be taken to enhance patients’ physical health including encouraging a healthy diet and exercise, assisting with smoking cessation and addressing substance misuse.

5. Proportionate and Respectful Approach to Risk and Safety

Therapeutic interventions that result in lower risk as a person’s illness diminishes contribute to patients, staff and carers feeling safe. Safety also results from good relationships and interactions and the trust that is built up between these individuals. Keeping people safe needs well-trained, well-supported staff who communicate effectively and treat people with respect and dignity.

Formal procedures and requirements exist to address patient and staff safety. Safety standards cover: security (property, environment, layout, design, alarm processes), risk management, violence prevention and management, and policies to deal with substance misuse. Nevertheless, a balance is required: the ward culture should not be unduly risk averse as recovery requires a careful level of risk-taking.

6. Information-Sharing and Involvement in Care-Planning

Patients and their carers wish to be listened to and supported. They need the relevant information provided and explained. They need, to the extent feasible, to be directly involved in decisions about their care and in care planning. Even for those who are very unwell this aids autonomy and instils belief in recovery. For detained individuals this includes seeking consent to treatment, and recording that fact, or, when the person lacks capacity, ensuring that they are actively involved in decisions about treatment.

7. A Recovery-Based Approach: Links with the Community and Other Agencies

A recovery-based approach underscores most aspects of in-patient care. Inpatients are part of the wider community and links with the community are essential both as out-reach and in-reach activities. The engagement with local councils and other agencies relating to housing, employment, education and financial services speeds up transitional phases for patients. Those
experiencing day-to-day ward life need to have appropriate, community-related activities integrated into care plans.

8. ACCESS TO PSYCHOLOGICAL INTERVENTIONS

Psychological therapies are an integral part of the recovery process. Wards should provide access to the range of psychological interventions that National Institute for Health and Clinical Excellence (NICE) guidelines stipulate for the acute illness phase of psychosis and other diagnoses. All relevant guidelines recommend at least one psychological intervention per week for in-patients. Psychological therapies need to be provided by staff who have the appropriate skills and experience.

9. PERSONALISED CARE: STAFFING AND DAILY ONE-ON-ONE CONTACTS

Adequate staffing with people of the right skill level and skills mix is necessary for wards to function well. One-on-one interaction on a daily basis is key to reviewing patients’ health at its broadest level and to providing the listening time that patients value so highly. Disturbed and erratic behaviour can also be minimised with regular one-on-one sessions. Understanding, being aware of, and securing regular updates on a patient’s progress, first-hand, can also inform most of the ten standards discussed in this document. This provision should be detailed in the care plan.

10. PROVIDING SOCIAILLY AND CULTURALLY SENSITIVE CARE

People from Black and minority ethnic backgrounds have been found to be disadvantaged with regard to access to information, one-on-one contact and access to therapists, and they continue to be disproportionately represented among those individuals who are detained under mental health law. In addition, certain groups, owing to their ethnic and cultural background, require specific measures so that appropriate and necessary provisions can be in place on their admission and throughout their time in hospital.

Delivering culturally appropriate care means going beyond such obvious but central matters as diverse religious practices, English language requirements, dietary requirements and cultural observances. It should also include staff training to address attitudes and beliefs that cause misunderstanding between groups and result in unequal treatment.

THE CURRENT SITUATION

Although data are not collected on all these standards, sufficient evidence exists to conclude that there is much room for improvement. Bed occupancy rates, daily one-on-one contact with staff, information provision, patient involvement in care planning and patient safety stand out as areas where practice falls particularly short.
Introduction

In 2008, the Royal College of Psychiatrists’ Fair Deal campaign manifesto recorded the evidence that mental health services have lagged behind physical health services. In-patient care in some hospitals did not meet acceptable standards. Although we acknowledge the considerable investment in the National Health Service (NHS) infrastructure over the past decade, we considered that in-patient services needed continued investment to make patient experience healthier, safer and more conducive to proper clinical recovery and rehabilitation.

At the end of the 3-year Fair Deal campaign it is now time to re-examine the issue and reassess the evidence in the new political and economic climate, and to identify essential areas for improvement.

In the new commissioning framework, general practice commissioners will need guidance in assessing quality of in-patient care. The following standards for working-age adult in-patient wards have been distilled from agreed existing standards for in-patient care, including those adopted by the Care Quality Commission (CQC), the Acute Care Declaration, Star Wards (www.starwards.org.uk), NHS Mental Health Minimum Dataset (www.mhmdsonline.ic.nhs.uk) and the latest data from the Royal College of Psychiatrists’ Quality Improvement Network, AIMS. Those are standards that working psychiatrists believe to be vital to the effective operation of wards and delivery of high-quality care, and those that most directly affect outcomes.

The evidence we draw on in this paper comes primarily from the most recent reviews of in-patient care (cited above). From these sources we conclude that there are still major concerns in relation to standards of care.

The purpose of this occasional paper is: (a) to offer a useful minimum checklist of standards for managers and commissioners of services to apply in strategic planning and in assessing for themselves the quality of their wards; and (b) to provide elaboration of the ten standards drawing on the evidence of current practice as found by the reviewing bodies.

In a time of financial austerity the costly area of hospital care is bound to be earmarked for extra efficiencies. Although the Royal College of Psychiatrists welcomes work to promote crisis care outside hospital, quality in-patient care is as vital as ever. In-patient care is particularly relevant for the increasing number of individuals with mental disorder who are detained under the mental health law. For such people especially, as they are unable to make the choice to leave, the ward is their home, however temporarily.

---

a. Accreditation for In-patient Mental Health Services (AIMS) is a standards-based accreditation programme designed to improve the quality of care in in-patient mental health wards. Through a comprehensive process of review, AIMS identifies and acknowledges high standards of organisation and patient care and other support to achieve these. Registering with AIMS is voluntary.
Given the continued reduction in bed numbers and increased community care over the past decade, in-patient units have become places for crisis stabilisation and are likely to admit only those individuals who are the most disturbed, distressed or unwell; up to half of those individuals will have problems arising from substance misuse. All this needs to be taken into account in the design, management and delivery of in-patient care (Box 1).

**Box 1  Acute in-patient services**

Acute in-patient services need support to fulfil a clearly defined role and function, to have staff with appropriate and relevant skills and to achieve the aspirations for mental health services:

- to be service-user centred: providing individualised, tailored support
- to be recovery-focused: facilitating people to recover or rebuild their lives
- to support social inclusion: assisting with other aspects of people’s lives such as employment, housing, education, as well as their mental health issues.

Sainsbury Centre for Mental Health (p. 9).7
The evidence: a summary

The evidence we draw on comes primarily from the most recent AIMS peer reviews, two reports by the CQC and the most recent Mental Welfare Commission report, supplemented with material from the Mental Health Minimum Dataset.

The CQC Patient Survey Report 2009, the first of its kind, collected responses from over 7500 people. The AIMS data give a more incomplete picture because only approximately 25% of wards participate in the AIMS programme. Nonetheless, this is an accurate snapshot of how wards are performing in relation to the ten standards we have selected. Unsurprisingly, there is much variation in performance between different hospitals. However, there are still major concerns in relation to standards of care. The extent of improvements in some areas cannot be quantified, as there are no available data. However, the data show that:

- average bed occupancy rates in English in-patient units are much higher than the 85% standard
- there is insufficient attention to information provision for patients and carers and too little patient and carer involvement in care planning
- access to psychological therapies falls far short of acceptable standards recommended by NICE and other health bodies
- daily one-on-one contact with nursing staff is at a lower rate than what is accepted as being conducive to recovery
- outreach links into the community are insufficient in two-thirds of the wards inspected by the Royal College of Psychiatrists’ Centre for Quality Improvement (CCQI)
- in many worse-performing trusts, around half of patients report feeling unsafe and the majority of these were women
- therapeutic activities and advice for mental and physical therapies are below the levels patients feel they need; therapeutic provision generally falls short of acceptable standards
- with admission rates not falling for individuals from Black and minority ethnic backgrounds and patients from this group being several times more likely to be admitted for in-patient care, further in-patient staff training for ethnic awareness, sensitivity and identification of culturally sensitive issues cannot be overestimated.
Ten standards of adult in-patient mental healthcare: a detailed case

1. **Bed occupancy rates of 85% or less**

Very high bed occupancy militates against quality and safety of in-patient care. Bed utilisation is at its most efficient when bed occupancy is at 85%.

This means that patients can be admitted in a timely fashion to a local bed, retain the connections with their social support network and take leave without the risk that they cannot return to their ward should they need a longer period of in-patient care. It allows functioning space to accommodate those newly admitted and to provide proper treatments to current patients. Delays in admission to hospital can result in patients becoming more distressed and unwell, and likely to need more long-term care.

The Healthcare Commission (CQC since 2009) reported progress in bed occupancy rates, whereas AIMS data from 2009 have shown that more than half of adult general wards were running at over 100% occupancy rates and only 16% met the required target. In 2010, the CQC reported that only 21% of all acute wards they visited met the Royal College of Psychiatrists’ target of 85%. They added that this has been the case for many years and that it may now represent the normal working conditions of in-patient services. Apart from necessary admissions being refused due to a lack of beds, current treatments can also end prematurely with readmissions for a return to care being refused.

The Mental Health Welfare Commission in Scotland reported that occupancy rates in 2009 to 2010 have fluctuated between 80.2 and 84.4% with patient discharges remaining constant for this period. This may exemplify how an 85% occupancy rate can instil healthy rates of admissions and discharges.

The bed occupancy rate is interrelated with other kinds of crisis care. The CQC endorses the College’s recommendation that: ‘Different models of in-patient care, including assessment wards, the integration of crisis teams with wards and crisis houses, and other alternatives to admission or facilitation of discharge must be evaluated thoroughly’ (p. 12). Such measures can help manage bed availability and fluctuating admission demands.

2. **Ward size maximum of 18 beds**

The College recommends that the number of beds on a general adult ward should not exceed 18. Larger wards can be more institutional and contribute
to patients feeling less safe. The larger numbers make the environment noisier, more disturbed and scarier for vulnerable patients.

Rapport between patients and staff is integral to effective treatment. The trust the patient feels can be more difficult to build with greater numbers of patients on the ward; monitoring activities and behaviour can become more demanding. The tailored approach to an individual patient’s needs can be compromised and careful planning of the care pathway can become more challenging. As ward size figures are not collected, the current situation cannot be assessed.

3. A PHYSICAL ENVIRONMENT THAT IS FIT FOR PURPOSE

Delivering a relaxed, comfortable, safe and predictable environment is essential to patient recovery and can be fostered through physical surroundings. Access to quiet and private spaces on the ward and in outdoor areas can greatly nurture patient well-being. Many women and some men value having separate spaces.12 A good ward should also have appropriate spaces for community in-reach activities. An AIMS report shows that 82% of wards reviewed have a variety of private, comfortable rooms and 94% offered a range of semi-private and public spaces.2

Segregated gender accommodation with separate sleeping and toilet facilities has been government policy for a decade and is essential for vulnerable patients, mostly women. Its achievement remains an intractable problem, with tangible improvements hard to measure. According to AIMS data, 85% of wards have separate sleeping accommodation for men and women and 59% have gender-segregated lounges.8 The CQC reported that 92% of patients had gender-segregated sleeping areas.9 The Mental Health Welfare Commission in Scotland reported improvements in the numbers of female-only sitting rooms and in providing private spaces for patients to meet visitors.10

Guidelines on interior and exterior design could provide a model for how a ward should look. In addition, as the ward is not a static place, a dedicated team to address the appearance of the ward periodically would be beneficial (Box 2).

A ward’s physical environment should be considered as part of patient treatment and should be factored into the early designs of wards. This timely consideration and planning would help to avoid the problems of inappropriate personal space for patients.

Box 2 IMPROVEMENT IN WARD ORGANISATION AND PHYSICAL ENVIRONMENT

- Development of patient information area on ward
- Development of motivational posters inspiring hope
- Development of a decoration team to address the appearance of the ward, for example displaying flowers and potted plants in communal areas, posters on the walls of the corridors and day area, new furniture in staff office.

In-patient ESTEEM Project, North East London Foundation Trust.
4. THE WARD AS A THERAPEUTIC SPACE

The value of structured, therapeutic activities on in-patient wards cannot be overestimated. A lack of regular activities can lead to boredom, frustration and inactivity, which not only impede recovery but also can instigate unsafe, violent and erratic behaviour. In-patients may be experiencing paranoia, be easily over-stimulated and sometimes frightened and disoriented. The ward activities should be organised by keeping the day as predictable as possible using meaningful, enjoyable, age-appropriate occupations with regular rest periods built in.

The range of activities might include occupational therapies (e.g. art and craft, yoga, quizzes) as well as ordinary indoor activities such as food preparation, interior decorating work, as well as outdoor activities such as gardening. The CQC has shown concern that ward activities have declined with the loss of occupational therapy staff, but at the same time they point out that all staff should share in the responsibility to keep patients engaged, instead of relying solely on occupational therapists.\(^4\) It should be considered a core role of ward-based staff and as important a function as administering medication.

The latest AIMS reviews revealed that although regular activities are being carried out on weekdays, evening and weekend engagements are much less frequent. Specifically, 96% of ward staff said there were activities in the day on weekdays, 61% reported activities in the evenings and 63% for weekends.\(^6\) The CQC patient survey reported that 35% of patients complained of too little to do during weekdays, and this rose to 54% when asked about evenings and weekends.\(^8\)

Promoting a lifestyle of good general health is particularly important, as people with severe mental illness are more at risk of physical ill health. Active measures to protect and promote physical well-being include encouraging a healthy diet, exercise, assisting with smoking cessation and strategies to address substance misuse. Of patients reporting to the CQC, 86% said they had physical health checks, but only 44% felt they had received enough care for their physical health.\(^9\)

As both the AIMS and the CQC highlighted insufficient therapeutic provision on wards, fresh initiatives and strategies need instilling to ensure essential therapy is not lacking for in-patients. A more structured approach to incorporating more frequent, regular activities throughout the week assists the overall recovery of patients as well as helping to reduce risk.

5. PROPORTIONATE AND RESPECTFUL APPROACH TO RISK AND SAFETY

The level of safety in a ward is determined primarily by how effectively patients are being treated and thus what therapeutic interventions are available. Safety also results from a positive ward culture that nurtures good relationships and interactions between patients, carers and staff and the trust that is built up between them. Staff should be trained in communication that is simple, unambiguous and easy to understand and they need to have an interpersonal style that is warm, supportive and reassuring.

There are also essential formal procedures and requirements to cover patient and staff safety. For instance, AIMS sets out standards for security,
risk management, violence prevention and management, medicines, and confidentiality. Important safety measures can be compromised by the presence of illegal drugs and alcohol on wards. Therefore, effective policies and staff training to manage these issues are vital.

The CQC patient survey highlighted that in the worst performing 20% of trusts, only 50-60% of patients said they felt safe, and overall less than 45% always felt safe. In Scotland, although the majority of patients felt safe, two-thirds of those who said they did not feel safe were female; they added that their concerns were often not taken seriously by staff or there was no time to discuss the issue further with them.

The CQC has found that unnecessary and excessive restrictions and security measures are sometimes imposed on detained patients. Excessive restrictions on clothing, access to food and drink, visiting rights and leisure activities have been reported. Undue restrictions on a patient's autonomy compromise their personal dignity and rights as an individual. Such excessive restrictions are upsetting for the patient and can delay recovery. Safety and risk policies are in place to aid patient recovery. Unnecessary bureaucracy and rules can not only hamper a patient's recovery, but possibly exacerbate their mental illness. Whether a person is detained or voluntarily admitted to hospital, general ethical standards that are adhered to in the community should, wherever possible, apply on the ward.

6. INFORMATION-SHARING AND INVOLVEMENT IN CARE-PLANNING

Patients and carers wish to be listened to and supported and they need the relevant information provided and explained. Carers need to be identified, provided with information and encouraged to be involved.

Patients need to be directly involved in decisions about their care and care planning to whatever extent is feasible. At the most basic level, patients' views need to be recorded on care plans and copies made available to them. Involving patients and carers in care planning aids autonomy and instills belief in recovery. For detained patients this includes seeking consent to treatment or, for those who lack capacity, ensuring that the patient is actively involved in decisions about treatment.

As AIMS data showed, 40% of patients did not feel involved in all the decisions made about their care. Only half of carers had been consulted and felt that they could have active participation in a care plan. Thirty per cent of patients felt that they were unable to involve all the people they rely on for support in their assessments. A further 38% were not involved in negotiating their therapy programme. This may in part be because less than half of ward staff had received training in procedures for assessing carers' needs.

Making detained individuals aware of their legal status should be routine. Services registered with the AIMS reported a 100% compliance with this requirement, yet only 67% of the informal/voluntary patients stated that their legal status had been explained to them.

In Scotland, many patients reported that they were not given sufficient information about their care and treatment and 66% of respondents did not feel involved in their care plan.

Communication between patient, staff and carers is vital and should be integrated into the entire care pathway so that appropriate and essential
knowledge is shared (Box 3). Apart from assisting effective treatment this can also help minimise the trauma of unexpected issues arising.

**Box 3  Mind: Care in Crisis 2011**

**4.6 Continuity of care and access to care plans/records**

People wanted continuity and not to have to deal with a lot of different staff over a short period, especially when this meant re-telling their story and/or staff not understanding their needs and circumstances. Staff in particular commented on the hazards of not being able to access information about a person out of hours.

---

**7. A RECOVERY-BASED APPROACH: LINKS WITH THE COMMUNITY AND OTHER AGENCIES**

It is important for hospital staff to remember that in-patients have lives outside hospital, with their families and in places of work, education and leisure. They can face homelessness, unemployment and debt as a result of their illness and in-patient stay. Improved links with local councils and other agencies that manage re-housing can speed up the transitional phases. This also helps bed management by minimising ‘bed blocking’.

Where appropriate, pre-admission community-related positive activities of in-patients should be allowed to continue or be freshly integrated into care plans if not already there. Visits to employment organisations, faith representatives, voluntary bodies, specialist therapists and advisory supporters in the community would help encourage the sense that in-patients are not segregated from the outside world. Conversely, in-reach to the acute unit should be facilitated for local agencies that offer employment, training, housing and social support.

The adult ward AIMS report revealed that 93% of staff said that patients were encouraged to access a broad range of activities facilitated by external agencies and multidisciplinary health professionals. However, only 63% of patients said that they had weekly community outreach visits.

It is impossible to consider in-patients without the community. This is because it is hoped that the patient will return there in better health and with better links in their community. Assimilating healthier patients back into the community should be factored into care plans. Stronger links with community agencies would encourage recovery as well as more fluid and efficient ward management and patients’ social inclusion.

---

**8. ACCESS TO PSYCHOLOGICAL INTERVENTIONS**

In their updated guidance, NICE recommends psychological therapies for schizophrenia and other disorders in the acute illness phase and beyond. Wards should provide access to the full range of psychological interventions
that NICE guidelines stipulate. All relevant guidelines recommend at least one psychological intervention per week for in-patients.\textsuperscript{b}

Psychological therapies need to be provided by staff of the appropriate skills and experience. There should be provision for quality assurance and patient feedback.

The AIMS reports\textsuperscript{8} that despite the majority of wards providing training in basic psychological therapies, only 38% of patients had been offered supportive counselling and only 65% of ward managers said that patients had access to specialist practitioners of psychological therapies of up to one session per week. Despite healthy figures from staff feedback, patient feedback highlighted by the CQC showed only 29% being offered talking therapies; nearly a quarter of all respondents asked for such therapy but did not receive it.\textsuperscript{14}

Psychological therapies are an additional provision that can supplement treatment on wards. Varying the form of treatment and offering the patient a choice will ensure greater support to patients with therapy that is accepted to be conducive to recovery. Psychological therapies should be available at least once a week to all patients.

9. PERSONALISED CARE: STAFFING AND DAILY ONE-ON-ONE CONTACTS

It is essential that wards are staffed with people with the right skill level and skills mix. Adequate staff time and appropriate multidisciplinary staff mix (including occupational therapists and dedicated psychology staff) are important. However, the way staff are used may be as significant as overall numbers and staff time needs to be apportioned as accurately as possible to improve patient outcomes.\textsuperscript{11} In particular, daily one-on-one interaction, preferably with the primary nurse, is key to providing listening time for patients and monitoring their experience. Understanding, being aware of and securing regular updates on a patient’s progress, first-hand, can also inform most of the standards discussed in this document.

Only 52% of patients said in the AIMS survey that they had supportive one-on-one meetings with staff for at least 15 minutes every day.\textsuperscript{8} Care Quality Commission data revealed that in 20% of the worst performing trusts as little as 50% of patients felt they were given enough time with a psychiatrist and even fewer (40%) said they were given enough time with a nurse.\textsuperscript{9} In the Mental Health Welfare Commission in Scotland report many patients felt they did not meet with their named nurse often enough and many did not know who their named nurse was. Figures were better for regular consultant contact as three-quarters of respondents said they saw their psychiatrist often enough.\textsuperscript{10}

Staffing structures should be arranged so that every patient has a one-on-one session with a relevant staff member once a day.

\textsuperscript{b} Star Wards details a quality tiered approach to the integration of psychological therapies and self-management (see p. 7).
10. PROVIDING SOCIALLY AND CULTURALLY SENSITIVE CARE

Certain groups, based on race and cultural background, require special consideration so that appropriate and necessary provisions can be in place on their admission. It is vital to know the cultural mix of patients and staff and aim to ensure cultural alignment, including everyone’s ability to understand the spoken language.

The Count Me In census\textsuperscript{15} shows that admission rates for individuals from Black and minority ethnic communities are not falling and that some groups are over three times more likely than average to be admitted for in-patient care. It is important to note independent research that indicates higher rates of mental illness in some Black and minority ethnic groups.\textsuperscript{16}

Sociocultural issues of patients from Black and minority ethnic communities have been documented in a Royal College of Psychiatrists report in 2010.\textsuperscript{17} As the report has shown that those groups are more likely to be admitted to psychiatric wards, problems of health beliefs, mistrust of services, lack of culturally competent practices in services and denial of mental disorders need to be addressed. A starting point is not to aggregate all ethnic divisions into one group as it is identifying and making distinctions within, and establishing provisions for, minorities that will deliver effective care. This will also help services to be adequately equipped when treating patients who express themselves in varied ways.

Being aware and understanding the needs of a diverse society can help provide the appropriate and effective treatment to an often socially and culturally diverse ward population. Failing to make the distinction among individuals from varied social and ethnic backgrounds can lead to inappropriate treatments being prescribed and this could further harm recovery. Knowledge and training on cultural differences within communities should be available to all staff on in-patient wards. Specific links with relevant community leads and agencies can support this work.
Appendix
The ten key standards checklist

1. **Bed occupancy of 85% or less**
2. **Ward size: 18 maximum**
3. **Environment offers gender specific bedrooms and toilet facilities, and direct access to external space and a quiet room**
4. **Daily therapeutic activities**
5. **Positive risk management policy**
6. **Information sharing on diagnosis and treatment to inform the care pathway**
7. **Linking with external community for housing, faith communities, employment, voluntary services, etc.**
8. **Access to at least one psychological intervention a week**
9. **Daily one-on-one contact**
10. **Cultural sensitivity: staff trained in cultural awareness with access to interpreters**
References


Do the right thing:
how to judge a good ward

Ten standards for adult in-patient mental healthcare

June 2011