QNIC

Quality Network for In-patient CAMHS

Service Standards 2005/2006

Editors:
Emma Hartwell
Ottilie Dugmore
Lucy Palmer
Helen Thurley

[RCN Logo here]

Edition 3a October 2005
CRU032

CONTENTS

Page:

Foreword 1

Introduction 3

SECTION 1: ENVIRONMENT AND FACILITIES 8

SECTION 2: STAFFING & TRAINING 14

SECTION 3: ACCESS, ADMISSION AND DISCHARGE 26

SECTION 4: CARE AND TREATMENT 32

SECTION 5: INFORMATION, CONSENT & CONFIDENTIALITY 40

SECTION 6: RIGHTS, SAFEGUARDS AND CHILD PROTECTION 48

SECTION 7: AUDIT AND POLICY 56

SECTION 8: LOCATION WITHIN A PUBLIC HEALTH CONTEXT 62

Bibliography Year 1 66

Bibliography Year 2 71

Bibliography Year 3 72

Appendix A – Acknowledgements 74

Appendix B – QNIC Executive Committee 76

Appendix C – QNIC Standards Feedback Form 78

Appendix D – QNIC Standards Order Form 80

Foreword

I welcome these standards with great pleasure. I am proud of nurses' enthusiastic contribution to this work and I expect that we will continue to play an essential part of QNIC as it becomes a members' association. This reflects the key role of nurses in the management and therapeutic work of these highly specialised services.

The inclusion of the Royal College of Nursing in this edition of the QNIC Service Standards confirms QNIC's commitment to multi-professional working. It is encouraging to see the collaboration between disciplines that is an integral part of the QNIC process.

In this 3rd edition of the standards, it is clear that once again the latest policy and evidence-base for best practice has been used to inform and improve the content. The standards continue to cover, as comprehensively as is possible, all areas of in-patient CAMHS care. They are impressive in that throughout they are person-centred - whether this relates to the young service users, their parents/carers, or to staff. Additionally, there is a focus on the culture of the unit where care is delivered, as it is experienced by all of the above groups; the standards are underpinned by values that endorse a positive and effective unit culture. The standards also recognise the importance of staff working cohesively together and valuing their partners in care. This in turn impacts on the ability of units to identify and meet the needs of the young people they serve.

Many of the standards are developmental in their expression, with a clear attempt to shape multi-professional practice. These are not just intended for centres of excellence; they will challenge all teams across the country to develop their service. The structures and processes they engender will improve units' ability to self-regulate and lead the way in developing practice and transforming care.

All the professions involved in the review and development of the standards should be justly proud of what they have achieved. Service users, the general public and commissioners of these units can be reassured that QNIC members critically evaluate their service against the standards and are committed to continuous quality improvement.

Sue Hinchliff
Head of Accreditation
Royal College of Nursing of the United Kingdom
London, July 2004.

Introduction

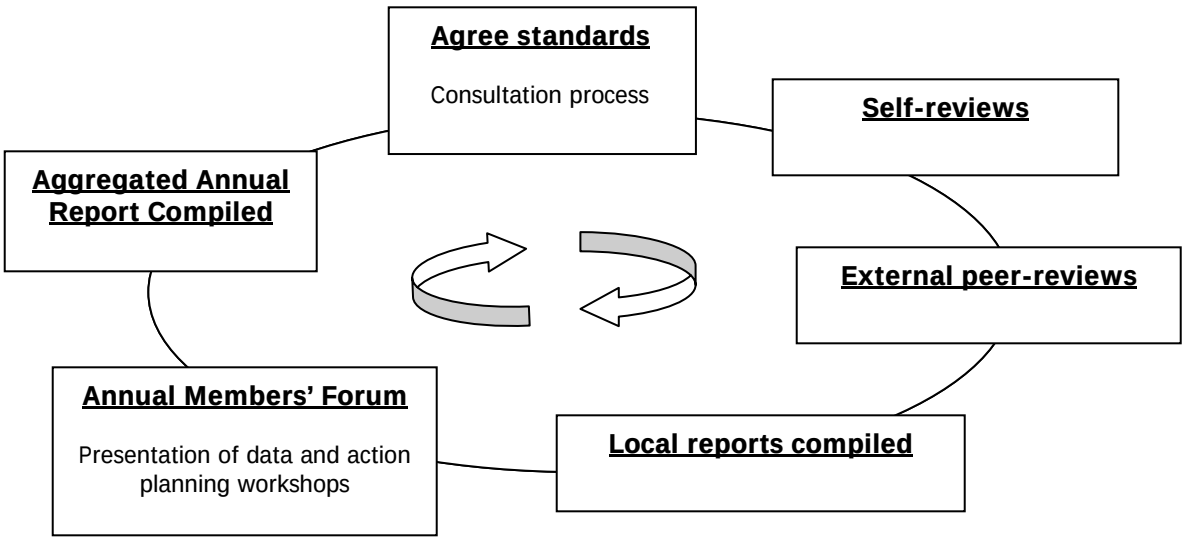
Background

The QNIC standards evolved from a set developed to evaluate services as part of the National In-patient Child and Adolescent Psychiatry Study (NICAPS) (Ref 96, O'Herlihy et al., 2001). The NICAPS standards were based on the findings of a literature review and information from an expert panel. The first QNIC standards were developed in 2001, and these were first revised in 2002. This new edition represents the second revision of these standards.

The QNIC review process

The standards represent just one part of the QNIC cycle; the real benefit for CAMHS in-patient units is in taking part in the process of QNIC reviews. These reviews aim to gradually improve services using the principles of the clinical audit cycle (see figure below). The fifth annual cycle of reviews will run from May 2005 to April 2004. For the fourth cycle, 75 in-patient CAMHS units across the UK and the Republic of Ireland took part in the QNIC process. If you are interested in joining QNIC please contact Peter Thompson on 020 7977 6693 or pthompson@cru.rcpsych.ac.uk

The annual cycle of reviews



In response to feedback obtained after the first year, QNIC now allows units to receive either a comprehensive or focused review, and this can be alternated each year. Comprehensive reviews cover most of the service standards, whereas focused review are based on fewer, more specific areas for improvement.

Updating the QNIC Standards

Edition 3a of the QNIC standards maps the standards against The Healthcare Commission's Standards for Better Health. For reference purposes, the document used for mapping the standards is entitled 'Criteria for assessing core standards: Information for mental health services and learning disability services' (The Healthcare Commission, April 2005). The Standards for Better Health represent a level of service that all patients and service users should be able to expect. Subsequently there is an additional column (SFBH) to be found in these QNIC standards, which lists the specific sections of the Standard for Better Health which correspond to the QNIC standards. This should enable a unit to gauge their own compliance with these new standards.

Aside from this mapping exercise, the QNIC standards remain the same as those contained in the third edition. The process used to update these standards is described below.

The third version of the QNIC standards was informed by a new literature review. In addition, a standards workshop was held, to which all QNIC members were invited. Once additions and changes had been proposed there was a wider consultation with all QNIC members and with the QNIC executive committee.

For the literature search, a table of sources of information, and a table of search terms were devised. An extensive number of sources were consulted, including websites, professional bodies, regulators, policy documents, other quality networks, and experts. All relevant literature was reviewed and used to inform the standards. New documents reviewed include, for example, Getting the right start: National Service Framework for Children Emerging Findings (2004) and Standards for Better Health: Health Care Standards for Services under the NHS (2004). These and others are listed in the bibliography under Year 3.

QNIC members were invited to attend a one-day workshop on 21/01/2004 to discuss and review the 2002/2003 standards. A good range of units was represented at the workshop, including general psychiatric units, secure and forensic units, learning disability units, children's units and adolescent units, from both NHS and independently funded sectors. A wide range of disciplines was also represented. Small groups discussed 2 sections of the standards each; groups were asked to "brainstorm" items and consider what is critical to the quality of care provided. They then worked through each standard and criterion, noting comments and amendments.

A consultation document was sent out to over 150 members via the QNIC email discussion group, and to the executive committee. The document listed suggested criteria additions, changes and removals. We accepted criteria where there was clear consensus; otherwise a decision was negotiated within the project team.

Please note that for this edition of the standards we have made some changes to terminology to make the criteria clearer and more consistent. "Young people" will be used to describe children, adolescents, patients or clients. "Parents" will be used to mean parents, carers and those with parental responsibility. "Unit" will be used in the place of ward. "Trust" will be used to also refer to employing or parent organisation; the latter is more relevant in independently funded services.

As criteria are compared across the cycles, we have kept the same numbering for the existing criteria. New standards, or new criteria within an existing standard, have been allocated the next available number. This means that the numbering does not always flow logically from one criterion or standard to the next, but ensures that we can measure units' performance consistently over many cycles.

As with the previous edition of the standards, all the criteria have been allocated a rating of either "E" for essential/ legal requirements or "D" for desirable.

Important Note

Data collection tools adapted from these standards will be provided with guidance notes to QNIC members before reviews take place. This document is provided for reference and not for data collection.

These are best practice statements and consequently we would not expect services to meet every standard. While there are some statements that are based upon legal requirements, this document is not intended to act as a legal guide in any way. This is not intended to be a guide to any reviews conducted by regulatory bodies.

If you have any questions about these standards please contact Peter Thompson on 020 7977 6693 or email pthompson@cru.rcpsych.ac.uk

SECTION 1: ENVIRONMENT AND FACILITIES

Standard: **SFBH**

1 The in-patient unit is well designed and has the necessary facilities and resources to meet service needs

Criteria:
Rating: E= Essential; D= Desirable

- ***Ref 105:*** *Annex C, "Services should be accommodated in buildings fit for supporting all the expected functions".*

1.1	The unit is comfortable and has a warm, welcoming atmosphere	E	**C21**

- ***Ref 73:*** *pg.51, Recommendation 24 -"Higher standards of décor are needed than previously accepted."*

1.2	There is indoor and outdoor space for recreation	E	**C21**

- ***Ref 73:*** *pg.22, Recommendation 10 - "Units should have an associated landscaped area for exercise."*
- ***Ref 5:*** *pg.16, S15 "Adequate inside space and outdoor facilities are important and will be used in a pro-active way to extend the learning process."*
- ***Ref 97:*** *A number of respondents "highlighted the need for physical space and privacy."*

1.3	There is a designated dining area	E	**C21**

- ***Ref 73:*** *pg.25, " ...a ward dining room large enough for all patients to have their meals at the same time is required."*

1.4	The unit contains large and small rooms for individual and family interviews	E	**C21**

- ***Ref 73:*** *pg.29, "At least one room <u>per ward</u> is needed for interviewing individual patients and relatives."*
- ***Ref 87:*** *item 36, "Adequate spaces are provided for more private or confidential interactions i.e. conversations; phone calls; meeting visitors; interviews with staff."*

1.5	Waiting rooms/areas are provided, and contain age-appropriate play and reading material	E	**C21**
1.6	If seclusion is used as part of an agreed therapeutic plan, there is a designated seclusion facility available, which is designed to minimise risk of injury and where the young person is continually monitored.	E	**C21**

- ***Ref 73:*** *pg.51, Recommendation 27 - "Seclusion facilities should be available in every unit."*

1.8	Age-appropriate play/leisure materials are provided for recreational purposes and can also be used as diagnostic and therapeutic tools	E	**C21**

- ***Ref 18:*** *pg.17, "You can expect your child to have full opportunity to play and meet other children throughout a stay in hospital."*

Section 1: Environment and Facilities

Criteria continued:

1.9	All confidential case material, e.g. notes, are kept in locked cabinets or locked offices	E	**C20b)**
1.10	Drugs are kept in a secure place with the dispensary book	E	
	• ***Ref 89:*** *pg.20, Standard 13.9 -"Prescribed and 'household' medication, other than that kept by individual children keeping their own medication, is kept securely (e.g. in a locked cabinet whose key is not accessible to children), and there is a policy with written guidance, implemented in practice, for storing and administering medicine."*		
1.11	One computer is provided for every two pupils	D	
	• ***Ref 78:*** *pg.16, "A standard for pupil:computer ratio of perhaps 2:1 could also be usefully considered."*		
1.12	There is sufficient space for educational activities	E	**C21**
	• ***Ref 89:*** *pg.21, Standard 14.5 -"Children are provided with facilities that are conducive to study and do homework and are actively encouraged and supported in doing so - this may include provision of books, computers and library membership. Children are given help with homework if they wish."*		
1.13	The service entrance and key clinical areas are clearly signposted	D	**C21**
	• ***Ref 87:*** *item 78 under Staff and Staff Management, CHI ward-based Clinical Team Self-assessment tool updated May 2002*		
1.14	There is sufficient car parking space for staff and visitors	D	**C21**
	• ***Ref 87:*** *item 77 under Staff and Staff Management, CHI ward-based Clinical Team Self-assessment tool updated May 2002*		
1.15	The unit is maintained at a high level of cleanliness	E	**C21**
	• ***Ref 18****: pg.17, "You can expect the hospital to be safe and clean and appropriately furnished for the needs of children and young people of all ages."*		
	• ***Ref 97:*** *A number of respondents "Emphasised the need for units, especially washing areas/bathrooms, to be clean."*		
	• ***Ref 104:*** *pg.18, "Health care services are provided in environments which promote effective care and optimise health outcomes, by being well maintained and kept at acceptable national levels of cleanliness."*		
1.16	Heating and ventilation in the unit is adequately regulated	E	**C21**
1.17	There are agreed standards in place covering maintenance response times	D	**C20a) C21**
	• ***Ref 114:*** *"Agreed written standards in place covering maintenance response times"*		
1.18	There are sufficient IT resources to support high quality care and the monitoring and evaluation of the service	D	**C21**
	• ***Ref 105:*** *point 7.14, "The infrastructure to support the delivery of high quality services includes the provision of … networked IT". Annex C "IT resources and equipment to support high quality care and the monitoring and evaluation of services should be available in all appropriate settings."*		

Section 1: Environment and Facilities

Standard:

2 Children's units and adolescent units are separate from adult units

Criteria:
Rating: E= Essential; D= Desirable

2.1	When a children's or adolescent unit is on the same site as an adult unit there are policies and procedures to prevent unwanted visitors to the child or adolescent unit	E	**C20b)**

- ***Ref 18:*** *pg.16, "You can expect your child to be looked after in a children's ward."*
- ***Ref 73:*** *pg.50, Recommendation 12 -"Units are currently best sited on the campus of a DGH with their own entrance and building."*
- ***Ref 73:*** *pg.51, Recommendation 20 -"Psychiatric units should have only one point of public entry or exit."*
- ***Ref 95:*** *pg.133 Recommendation 8,- "We recommend that the goal of separate adolescent provision from children and adults should be explored by policy makers and considered actively by management in all hospitals." (para 13.9)*

Standard:

3 Premises are designed and managed so that young people's rights, privacy and dignity are respected

Criteria:
Rating: E= Essential; D= Desirable

3.1	All young people have the option of having a single bedroom	D	

- ***Ref 73:*** *pg.51, Recommendation 22 -"Issues of privacy and the security of female (and/or male) patients are better addressed by the provision of single rooms."*
- ***Ref 89:*** *pg.37, Standard 24.5 - "Each child has a single bedroom or their own area in a double bedroom, of a suitable size, with a suitable bed and bedding, seating, storage for clothes, lockable or otherwise safe storage for personal possessions, a window with curtains (or other window covering), lighting sufficient to read by, carpet or other appropriate floor covering, and heating."*
- ***Ref 90:*** *pg.119, M38.2 "All children are admitted to a single room unless there is a specific request or clinical reason to share on a companion basis."*

3.2a	All young people may sleep in privacy and in areas separate from the opposite sex	E	**C13a)** **C20b)**
3.2b	All young people may bathe and wash in privacy and in areas separate from the opposite sex	E	**C13a)** **C20b)**

- ***Ref 89:*** *pg.39, standard 25.4 -"Bathrooms, showers and toilets are sited and designed to take account of the children's needs for privacy, dignity and safety, and are readily accessible from sleeping and recreational areas of the home. Showers which are not in individual rooms are provided in individual cubicles or fully individually curtained for privacy."*
- ***Ref 90:*** *pg.119, M38.4 "Consideration is given to the management of mixed sex groups."*

Section 1: Environment and Facilities

Criteria continued:

- ***Ref 97:*** *A number of respondents reported that "single sex bathrooms were thought to be desirable."*

3.3 There is a specific room for physical examination and minor medical procedures — E — **C20b)**

- ***Ref 73:*** *pg.29, "The ward will require treatment room facilities to enable blood samples to be taken, medical examinations to be carried out and minor first aid or other procedures performed."*

3.4 There are suitably located quiet room(s) available, other than young people's bedrooms, for reading, reflection etc. — D

- ***Ref 89:*** *pg.38, Standard 24.15, "There are rooms in which children can meet privately with visitors and space for private activities, play and recreation which do not affect other children's routine activities."*

3.5 There are private rooms for meeting relatives and friends — D — **C13a)**

- *As above for 3.4*
- ***Ref 97:*** *A number of respondents reported that they "require units to provide designated space for time/meetings with parents".*

3.6 Young people have access to a telephone in a private area — D

- ***Ref 89:*** *pg.8, Standard 4.2, "...Contact by visits, telephone and letters are all facilitated where there are no such restrictions."*
- ***Ref 89:*** *Pg.37, Standard 24.11, "One or more telephones are provided for the exclusive use of children in the home in private. These offer acceptable levels of privacy for personal calls, and are maintained in working order, any damage or breakdown being promptly repaired. Disabled children are enabled to use the telephone in private as far as is possible."*

3.7 There are arrangements for the safe-keeping of young people's property — D — **C20a)**

- ***Ref 89:*** *pg.37, Standard 24.5, "...each child has...lockable or otherwise safe storage for personal possessions."*
- ***Ref 97:*** *A number of respondents reported that there should be " a reasonable amount of lockable cupboard space for storing personal possessions."*

3.8 There are arrangements for the safe-keeping of staff's property — D — **C20a)**

Standard:

4 The unit provides a safe environment for staff and young people

Criteria:

Rating: E= Essential; D= Desirable.

- ***Ref 89:*** *pg.40, Standard 26.4, "The registered provider has planned responses to a range of foreseeable crises...."*
- ***Ref 53:*** *Health & Safety Executive (1992)*

Section 1: Environment and Facilities

Criteria continued:

- ***Ref 73:*** *pg. 51, Recommendation 17 -"Buildings and operational policies should be designed to deal with a greater range of cases than generally anticipated, bearing particularly the needs of the more disturbed in-patient population in mind."*

4.1	There are areas with clear lines of sight to enable staff to monitor young people who need closer observation	E	

- ***Ref 73:*** *pg.51, Recommendation 23 - "Floor plans, room access, physical structure, furnishings and fittings must be designed with specific security and observation issues in mind."*

4.2	There is appropriate security within the unit, e.g. certain doors may be locked if needed	E	**C20a)**
4.4	Entrances and exits are designed to enable staff to see who is entering or leaving	D	**C20a)**

- ***Ref 87:*** *item 9 under Clinical Risk Management, CHI Clinical Team Self-assessment tool updated May 2002*

Standard:

5 Young people are consulted about the unit environment and have choice when this is appropriate

Criteria:
Rating: E= Essential; D= Desirable.

5.1	Young people are consulted on noise levels, security, décor and furniture	D	

- ***Ref 89:*** *pg.38, Standard 24.14, "Children are given opportunities to have a say in the general décor, furnishings and upkeep of the home if they wish."*

5.2	Young people are encouraged to personalise their bedroom spaces	D	

- ***Ref 47:*** *Standard 24.8 "Children are able and encouraged to personalise their bedrooms."*
- ***Ref 18:*** *pg.17, "You can expect your child to wear his or her own clothes (rather than those of the hospital) and have some of his or her own things in hospital."*

Standard:

6 There is equipment and there are procedures for dealing with emergencies in the unit

Criteria:
Rating: E= Essential; D= Desirable.

6.1	There is a procedure for evacuation in case of fire which is rehearsed at regular intervals	E	**C24**

- ***Ref 89:*** *pg.40, Standard 26.7, "Children and staff know the emergency evacuation procedures for the home, including those for at night, in case of fire."*

Section 1: Environment and Facilities

Criteria continued:

6.2	The procedure for resuscitation of young people is clearly documented, resuscitation equipment is available and its location is clearly identified • ***Ref 96***	E	
6.3	There is an alarm/communication system in place, e.g. there are panic buttons and/or walkie-talkies for the staff	E	**C20a)**
6.3a	There is a way for young people to raise an alarm in an emergency • ***Ref 73:*** *pg.43, "An alarm system to summon help should be built into all areas except patient bedrooms…The issue of personal 'rape' alarms to individual staff members and to vulnerable patients may be considered as a supplementary measure"* • ***Ref 87:*** *item 8, CHI, Clinical Team Self-Assessment tool Updated May 2002*	D	**C20a)**
6.4	The unit is managed in line with Health and Safety legislation and guidance • ***Ref 53***	E	**C20a)**
6.5	There is an identified duty doctor available at all times to attend the unit • ***Ref 96***	E	
6.6	An audit of environmental risk has been conducted, e.g. possible ligature points have been identified and dealt with • ***Ref : 87:*** *item 9, CHI, Clinical Team Self-Assessment tool Updated May 2002*	E	**C7c)** **C20a)**

SECTION 2: STAFFING & TRAINING

Standard:

7 The number of nursing staff on the unit is sufficient to safely meet the needs of the young people at all times

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 73:*** *pg.52, Recommendation 29, - "Appropriate levels and training of staff are essential. An inadequate ratio of trained to untrained staff seriously threatens security."*
- ***Ref 89:*** *pg.45, "Staff are sufficient in number, experience and qualification to meet the needs of the children."*
- ***Ref 90:*** *pg. 95, M5.1 " The number and skills of clinicians and support staff assigned to each unit reflect the number and the needs of patients on each unit."*
- ***Ref 78:*** *criteria 7.1 – 7.13*

WARD STAFF/PATIENT SHIFT RATIOS

Nature of shift	'Low' case dependency	'High' case dependency
Night-time	2 staff (plus additional on-call for emergency)	1:3
Basic observation and maintenance of safety	1:3/1:4	1:2/1:3
Active therapeutic programming times	1:3	1:2
Emergency / intensive care	1:2	1:1

Adapted from Furlong S and Ward M. Assessing patient dependency and staff skill mix. Nursing Standard 1997;11:33-38

Low
Simple instruction is needed to avoid danger or may need to be moved away from danger. Communicates mostly age-appropriately.

High
Needs to be repeatedly moved away or needs to be physically contained to avoid danger. Communicates age-inappropriately or does not develop relationships.

7.1 To maintain basic observation and maintenance of safety there is at least one member of staff on duty for every three young people with "low" case dependency — E

7.2 To maintain basic observation and maintenance of safety there is at least one member of staff on duty for every two young people with "high" case dependency — D

7.3 When low intensity occupational activities are offered there is at least one member of staff on duty for every three young people with "low" case dependency — D

Section 2: Staffing

Criteria continued:

7.4	When low intensity occupational activities are offered there is at least one member of staff on duty for every two young people with "high" case dependency	D
7.5	When active therapeutic programming is offered there is at least one member of staff on duty for every three young people with "low" case dependency	D
7.6	When active therapeutic programming is offered there is at least one member of staff on duty for every two young people with "high" case dependency	D
7.7	When emergency or intensive care is offered there is at least one member of staff on duty for every two young people with "low" case dependency	D
7.8	When emergency or intensive care is offered there is at least one member of staff on duty for every one young people with "high" case dependency	D
7.9	At night-time in a typical unit with "low" case dependency there are two staff on duty	E
7.10	At night-time there is at least one member of staff on duty for every three young people with "high" case dependency	D
7.11	There are sufficient staff to ensure that when young people's liberty is restricted it is with the minimum force and risk of injury and in line with Trust policy	E
7.12	Extra nursing cover is available when needed, e.g. there is access to additional on-call staff in emergency	E
7.13	There is sufficient flexibility in staffing numbers to accommodate young people's changing dependency needs	E
7.14	The unit is staffed by permanent staff and agency staff are used only in exceptional circumstances	D

- ***Ref 94: IHA consultation 2002*** *(Document held by QNIC)*
- ***Ref 97:*** *"All of the young people consulted highlighted the need to have staff on the unit who they knew, felt comfortable with and who knew them. It was generally felt that bank and agency staff often did not know the young people they were caring for and indeed, often relied on the young people to tell them about the unit routines and rules."*

7.15	Staff receive support from surrounding hospital-based services, e.g. in the event of certain untoward incidents or if staff are needed to escort a young person to an accident and emergency department	D

Section 2: Staffing

Standard:

8 There are nurses with a specialist qualification in the unit at all times

Criteria:
Rating: E= Essential; D= Desirable.

8.1 There is at least one nurse holding the RMN qualification on duty at all times — E

- ***Ref 78***

8.2 At least two staff hold the RMN, RSCN or Project 2000 child branch qualification on duty per shift and one at night-time (Grade E-H) — E

- ***Ref 78****: pg.11, "Minimum skill mix should be two trained members of staff (Grade E, F, G OR H) per shift (one on nights)."*

Standard:

9 The in-patient unit comprises a core multi-professional team

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 105:*** *Annex C, "The professional mix within specialist services and teams should be balanced to ensure availability of an appropriate representation of skills, in particular professional and team isolation should be avoided in all services"*

9.1a A typical unit with 10-12 places includes at least one WTE consultant child and adolescent psychiatrist — E

9.1b A typical unit with 10-12 places includes at least one WTE SpR — E

9.1c A typical unit with 10-12 places includes at least one level two SHO — E

- ***Ref 78:*** *pg.5, "One whole-time equivalent (WTE) consultant / 10-12 bed unit."*
- ***Ref 94:*** *pg.10, IHA consultation 2002 (Document held by QNIC)*

9.2 A typical unit with 10-12 places includes one WTE clinical psychologist — E

- ***Ref 78:*** *pg.5, "One WTE clinical psychologist for adolescent units and 0.8 WTE for children's units. At least one session input is needed for specialist activities such as psychometric testing or specific therapeutic interventions."*

9.3 A typical unit with 10-12 places includes provision of 0.5 WTE social work input — E

- ***Ref 78:*** *pg.6, "Minimum of one session social work input /unit. Further social work input up to 0.5 WTE/unit is recommended to carry out a more complete role."*
- ***Ref 94:*** *pg.11, IHA consultation 2002 (Document held by QNIC)*

9.4 All units have access to psychotherapeutic interventions, e.g. arts therapies, family therapy and occupational therapy — E

Section 2: Staffing

Criteria continued:

- ***Ref 78:*** *pg. 6 "Access to psychotherapeutic sessions for all units. Up to 0.5 WTE for more complete case work and supervision roles. Access to family therapy sessions for all units. Up to 0.5 WTE family therapist time for case work and supervision. Access to sessions for both adolescents and children's units."*

9.5 There is a minimum of one teacher to 4 students per lesson, according to the needs of the pupils — E

- ***Ref 58:*** *pg.142, c. "All children in hospital should receive appropriate education" (see joint DH/DFEE guidance- The Education of Sick Children, DFEE Circular number 12/94, DH circulars LAC (94) 10 HSG (94) 24,May 1994).*
- ***Ref 78:*** *pg 6 "All units must have a dedicated educational provision. Minimum staffing level is one teacher to four students/lesson – including the head teacher or teacher in charge. Up to a ratio of 1:1 can be necessary for specific individual programmes or patient groups."*

9.6 The unit has access to a range of education professionals which include primary level teachers, specialist subject teachers, a special educational needs co-ordinator, an educational psychologist, an education welfare officer, a classroom or welfare assistant or a pupil assessment officer and career guidance or access to Connexions — D

Standard:

10 Unit staff work effectively as a multi-disciplinary team

Criteria:
Rating: E= Essential; D= Desirable.

10.1 There is a line management structure with clear lines of accountability within the unit — E

- ***Ref 5:*** *Standard 20.3 "Managers ensure that each staff member has clear accountabilities which are known, understood and regularly appraised."*
- ***Ref 3:*** *pg.79, point 131 "There must be clear and agreed lines of clinical responsibility for all professional staff."*

10.2 There are regular multi-disciplinary team meetings for clinical matters and administration, and the team is consulted on relevant management decisions such as developing and reviewing operational policy — E

- ***Ref 87:*** *item 92, CHI Ward-based Clinical Team Self-Assessment tool updated May 2002.*
- ***Ref 73:*** *pg.50, Recommendation 4 "Operational policies should be drawn up jointly by all relevant groups involving clinicians (particularly nursing staff), ideally before the design planning gets underway. There is then an iterative process involving changes in the policies and design"*

10.3 Good staff morale is recognised as important and efforts to improve morale are made when necessary, e.g. the levels of vacancies and sick leave are monitored and investigated — E

- ***Ref 5:*** *Standard 18 "It is essential... that staff feel safe, and, that in helping children or young people to access and release their emotions, they themselves are not overwhelmed or burnt out". Also Standard 20 "All staff are valued, given appropriate supervision, support and ongoing relevant training, for their individual needs and the corporate needs."*

Section 2: Staffing

Criteria continued:

10.4	There are clear procedures for managing complaints from staff	E	
	• ***Ref 11:*** *pg.194, Recommendation 54 "Employers should have published procedures that make it clear to staff how complaints will be taken up and investigated, by whom and within what timescale."*		
	• ***Ref 11:*** *pg.194, Recommendation 53 " Employers should accept that staff in residential homes for children should be able to raise significant concerns outside their normal line management when they consider the line manager has been unresponsive or is the source of concern."*		
10.5	There is a forum where staff are able to express their concerns about the management of young people within the unit and these concerns are taken seriously	E	**C8a)**
10.7	Staff are aware of the procedures in place for reporting concerns about poor performance and for whistle-blowing	E	**C7b)** **C8a)**
	• ***Ref 90:*** *pg.137, Standard M35.5, " There is a written policy for handling serious / untoward incidents and the circumstances under which reports need to be made."*		
	• ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002. item 100,101 & 102 (100 - There is a clear policy in relation to disciplinary action and grievance procedures. Staff are aware and understand the processes; 101 - The Trust has a policy allowing for the sensitive and confidential handling of staff needing to "blow the whistle" on poor practice. Staff are aware and understand the process; 102 - The Trust has a policy allowing for the sensitive and confidential handling of staff needing to report incidents of harassment, bullying or discrimination. Staff are aware and understand the process.)*		
10.8	The team has integrated health and social care records used by all staff	E	**C6**
10.9	The roles and responsibilities of unit staff are clearly defined, e.g. in up-to-date job descriptions and in operational policy	E	
	• ***Ref 11:*** *point 3.18 "These job descriptions should set out the main duties, responsibilities and accountabilities of each job."*		
10.10	There is time scheduled in staff rotas to allow handover sessions between shifts	E	
	• ***Ref 89:*** *point 48.6 "Staff rotas have time scheduled to ensure that handover sessions, spending time with individual children, completion of records, planning and carrying out of care programmes occur without compromising overall care of children."*		
	• ***Ref 114:*** *"Time is allocated on the rota for effective handover between shifts"*		
10.11	There are sufficient administrative and secretarial staff to support effective running of the unit	D	
	• ***Ref 107:*** *point 7.14 "An infrastructure should be in place to support the delivery of high quality CAMHS provision. This should include sufficient administration and secretarial support."*		
10.12	The unit has a designated clinical risk management lead	D	**C7c)**

Section 2: Staffing

Standard:

11 There is a budget for training relating to child and adolescent mental health

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 105:*** *Annex C, "The necessary resources to support the training and development requirements of the CAMHS workforce should be available"*

11.2	There are arrangements for staff cover to allow staff to attend training	D	

Standard:

12 The training needs of in-patient unit staff have been formally assessed

Criteria:
Rating: E= Essential; D= Desirable.

12.1	Training needs are informed through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems - all have been assessed in the last year	E	**C5c) C8b)**

- ***Ref 3:*** *point 7.17 "In our view the Personal Development Contract should be regarded as a means by which staff and their managers consider the training requirements of staff; plan how those training needs will be met over the next year, including who will meet them; and agree a written plan for the training that is signed by all parties. The Contract should be linked to the statement of purpose and objectives for the home, so that the development of staff is linked to that of the home and the organisation."*

12.2	The Trust has supplied appraisal training and the relevant documentation to managers	E	**C5c)**

Standard:

13 Staff receive ongoing education and training appropriate to their role in the unit. This includes training on:

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 89:*** *pg.47, Standards 31.1, 31.2, 31.3 & 31.4 (see document for full details).*
- ***Ref 56:*** *LAC(93)13 Paragraph 14340*
- ***Ref 95:*** *pg.133, "We recommend that all staff having access to children should be trained to a full understanding of children's rights and an appropriate level of awareness of the needs of children, and that they should be required by their employers, as a matter of specific contractual obligation to respect and apply those rights rigorously." (para 1.13, 1.14, 1.15 & 1.20)*

13.1	Aetiology, symptoms and assessment of the range of relevant conditions	E	**C5c)**

Section 2: Staffing

Criteria continued:

13.2	A range of therapeutic interventions, for staff to use with young people and their families, including cognitive and behavioural techniques, brief psychotherapy techniques, family interventions, parent counselling • ***Ref 23:*** *pg.44, 4.43 "Professionals need ready access to the most up-to-date evidence about cost-effective strategies, and they need training, education and support to deliver these".*	E	**C5c)**
13.3	Pharmacological interventions for medical and qualified nursing staff	E	**C5c)**
13.4	Policy and procedures, e.g. referral procedures	E	
13.5	The use of support or supervision networks	E	**C24**
13.6	Risk assessment and awareness of risk factors in abuse and abuse to others, indicators of abuse and procedures for dealing with abuse • ***Ref 1:*** *pg.18, "Everyone working with children has a duty to protect them and needs to be alert to signs of child abuse."* • ***Ref 55:*** *pg. 34, 5.20.01 "All those involved with the provision of care for children in residential settings, including schools, must be alert to the possibility of abuse by other children, visitors, and members of staff. Policies and managerial procedures must openly recognise the possibility of abuse and must prevent creating circumstances which could encourage abuse. There must be clear written procedures on how suspected abuse is dealt with, for children and staff to consult and available for external scrutiny."*	E	**C7c)**
13.7	Child protection procedures, the avoidance of abusive situations and creating child-safe environments and other related issues • *As above for 13.6* • ***Ref 56:*** *Section 5.1 Physical Restraint* • ***Ref 90:*** *pg. 117, M36.2 "A copy of the child protection policy, compiled in collaboration with the local Area Child Protection Committee (ACPC), is available. The provision of training, on induction and thereafter annually, in child protection procedures is mandatory. A designated person for child protection is identified."*	E	**C2**
13.8	The issue of touching in general and the problem of sexual attraction between staff and young people	E	**C2**
13.9	The role of other services and the range of local services and activities	D	
13.11	Culturally sensitive practice, disability awareness, and other equality issues • ***Ref 18:*** *pg. 17, "You can expect the NHS to respect your child's privacy, dignity, and religious or cultural beliefs."* • ***Ref 47:*** *pg.13, Standard 8.2 "Staff take into account the religious, racial, cultural and linguistic backgrounds of children and their families and any disabilities that they may have".... Standard 9.6 "Staff are sensitive to gender issues especially when dealing with children of the opposite sex."*	E	**C7e)**
13.12	Clinical governance	D	**C5d)** **C7a)**
13.13	Audit and research skills	D	**C5d)**

Section 2: Staffing

Criteria continued:

- ***Ref 93:*** *CASPE/HAP 2001 Standards for Accreditation (fourth edition) 6.11 Mental Health Services*

13.14	Legal frameworks such as the Children Act 1989, Mental Health Act 1983 and the revised Code of Practice	E	

- ***Ref 73:*** *pg.47, Recommendation 30 - "Particular Training with regard to leave and parole, special observations, security matters in general, and relevant mental health law should be undertaken on a continuing basis with all nursing staff."*

13.15	Resuscitation (child and adult)	E	**C5c)**
13.16	Management of imminent and actual violence, breakaway techniques and restraint measures	E	

- ***Ref 87:*** *CHI Clinical Team Self-assessment tool updated May 2002, item 20, "All staff receive training in the management of potential violence."*
- ***Ref 73:*** *pg.52, Recommendation 31 – "All clinical staff and support staff must be trained in breakaway techniques. All registered nursing staff should be trained in control and restraint."*

13.17	Members of the nursing team including all newly appointed senior nurse managers, have undertaken further training in child and adolescent mental health	D	
13.18	Unit managers who are nursing staff are at the level of F/G grade	D	
13.18a	Unit managers who are nursing staff have had further training in management and team leadership	D	**C5b)**
13.19	Staff have received training in skills to respond to special needs, e.g. staff are encouraged to acquire British Sign Language (BSL) skills or know how to access and work with relevant interpreters	D	
13.20	Educational staff have been trained to teach pupils with special educational needs, for example those who are visually impaired, have hearing problems or who have learning difficulties	D	
13.21	Non clinical staff have received relevant mental health awareness training	D	
13.22	All staff have had mandatory training in relevant health and safety issues	E	
13.23	The organisation is committed to ensuring equality of opportunity in the development of staff	E	**C11c)**

- ***Ref 111:*** *"The organisation is committed to ensuring equality of opportunity in the development of staff"*

Section 2: Staffing

Standard:

14 Appropriate training methods are used to ensure staff training is effective

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 11:*** *point 7.20 "Employers need to start by recognising that the nature of work in children's homes requires a properly trained workforce whose knowledge is kept up-to-date."*

14.1	All staff participate in continuing professional development	E	**C11c)**
14.2	Whenever appropriate staff training and induction is multidisciplinary and multi-agency	D	**C6**

- ***Ref 105:*** *Annex C "Multi-professional training and consultative work, undertaken both within and across agencies, is essential"*
- ***Ref 90:*** *standard M6.2, "Joint programmes of staff training are made available to optimise the working of the multi-professional teams and to establish a mutual understanding of issues and each others roles"*

14.3	Staff have access to books, journals, video tapes and access to the internet, e.g. from a unit library	E	

- ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, items: 29, 30 and 54 – 59, which states that "There is a dedicated learning area on the ward for staff which contains a range of materials/aids:-Journals, books, video, computer/internet, visual aids."*

14.4	Induction training is provided for temporary and permanent staff before they have unsupervised access to the young people	E	**C11b)**

- ***Ref 5:*** *Standard 7:2 "Management will ensure that new staff undertake a planned and well structured induction programme."*
- ***Ref 11:*** *pg 196, Recommendation 65 "Employers should provide structured induction training to all new employees in children's homes before they have unsupervised access to children, and use this period to set goals for the successful completion of the probationary period."*

14.5	All staff have a comprehensive induction which covers key aspects of care (e.g. observation, child protection)	E	**C11b)**

Standard:

15 All staff receive regular supervision from a person with appropriate experience and qualifications

Criteria:
Rating: E= Essential; D= Desirable.

15.1	All staff receive regular supervision totalling at least one hour per month from a person with appropriate experience	E	**C5b)**

Section 2: Staffing

Criteria continued:

- ***Ref 5:*** *Standard 7:2 "Staff receive supervision that addresses the clinical framework of the therapeutic model and their ability to work within it"; Standard 7.4 "Staff have the ability to reflect on themselves and their practice and on the feelings that are evoked by working and living with very troubled children."*

15.2	Junior staff have regular supervision totalling at least one hour per week and are able to contact a senior colleague as necessary	E	**C5b)**
15.3	Staff performance is managed within the unit	D	**C5b)**
15.4	All staff receive annual appraisal and personal development planning	E	**C8b)**
15.5	Managers and practitioners have agreed clear and realistic clinical performance targets	D	
15.6	There is a mechanism for formally recognising good performance, e.g. at events, in newsletters or with achievement awards	D	
15.7	Staff are provided with opportunities for de-briefing	E	

- ***Ref 114:*** *"Opportunities for de-briefing are available and on-going support is provided".*

Standard:

16 There is a recruitment policy to ensure vacant posts are filled quickly with well qualified and checked candidates

Criteria:
Rating: E= Essential; D= Desirable.

16.1	There is a selection and assessment procedure which is consistent with the Recommendations of LAC(93)17/WOC 54/93 and the Warner and Utting reports	D	**C10a) C11a)**

- ***Ref 11 & Ref 19***

16.2	The selection of candidates is guided by awareness of desirable gender and ethnic representation within the team	D	

- ***Ref 102:*** *point 2c), "Has an Equality and Diversity strategy in place which shows local action/progress to support regional and national vital connection equality targets, including those relating to a workforce being representative of the community they serve."*

16.3	All staff are selected using specially designed application forms, preliminary interviews, and when appropriate aptitude and personality tests	D	

- ***Ref 11****: pg. 184, Recommendation 8 "Employers should require applicants for posts in all children's homes to complete application forms specifically designed for these posts and that collect core information relevant to the posts, as defined in the job descriptions and person specifications."*

- ***Ref 11:*** *pg.185, Recommendation 10 " Employers should use written exercises in the selection process to test the ability of candidates to think clearly and express themselves." & Recommendation 13 "Employers should use appropriate aptitude tests as part of the normal selection process for shortlist candidates."*

Section 2: Staffing

Criteria continued:

16.4	All unit staff are police checked before their appointment	E	**C10a)**
	• ***Ref 90:*** *pg.117, M36.3, "Routine reference collection before interview, and police checks prior to appointment, are required for all staff with substantial access to children."*		
16.5	In addition to routine references, the most recent employer or place of study is asked to provide a record of time taken off on grounds of sickness	D	
16.6	All clinical staff undergo formal health screening when they obtain their first posts after qualifying	D	
16.7	Staff with a professional regulatory body (e.g. Nursing and Midwifery Council, Royal College of Psychiatrists, Council for Professions Supplementary to Medicine or the General Medical Council) are checked for appropriate registration on recruitment and again at renewal date	E	**C10a)** **C10b)**
	• ***Ref 90****: pg.117, M36.4 "Staff with a professional regulatory body (e.g. Nursing and Midwifery Council, Royal College of Psychiatrists, Council for Professions Supplementary to Medicine or the General Medical Council) are checked for appropriate registration on recruitment and again at renewal date."*		
16.8	When posts are vacant or in the event of long term sickness or maternity leave, prompt arrangements are made for temporary staff cover	D	
16.9	Reasons for staff leaving are established, particularly where there is a high staff turnover, e.g. exit questionnaires or interviews are used	D	
16.10	Staff vacancies are advertised as widely as possible	D	

SECTION 3: ACCESS, ADMISSION AND DISCHARGE

Standard:

17 Referrers and other related professionals have ready access to information about the unit

Criteria:
Rating: E= Essential; D= Desirable.

17.1	Referrers can access information in a service directory, provided by the Health Authority, which supplies general information, e.g. about who can refer, and how the in-patient unit can be accessed in an emergency	D	**C16**
	• ***Ref 21:*** *pg.53, 4.62 "At a local level, information about health and social care services being utilised can be incorporated into the Minimum Data set."*		
17.2	An information booklet is available for referrers and other related professionals	D	**C16**

Standard:

18 Provision and procedures ensure that in-patient care is available to all those who would need it

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 18:*** *pg. 2, "The NHS is committed to the health and wellbeing of every child. This includes children's mental health as well as their physical health."*

18.1	There is a local provision of a range of domiciliary, community and day services so that young people are not admitted to in-patient units inappropriately	E	**C18**
18.2	There are sufficient numbers of beds properly matched to need, i.e. young people who would be admitted on clinical grounds are not refused admission due to limitation of resources such as bed availability	E	
18.3	The in-patient unit has clear, written criteria for admission. These consider: i. Age restrictions, ii. Psychiatric condition and severity, iii. Exclusion criteria, iv. Case mix	E	
	• ***Ref 89:*** *pg.9, Standard 5.7 -"Both the needs of the child concerned, and the likely effects of his/her admission upon the existing group of residents, are taken into account in decisions on admission to the home."*		
18.4	A local protocol has been agreed regarding the age for referral to adult services and there are working arrangements for this	E	
18.4a	For all young people referred to adult services, the arrangements stipulated under the Care Programme Approach (CPA) are employed for the transfer of young people to adult services	E	

Section 3: Access, Admission & Discharge

Criteria continued:

- ***Ref 94:*** *pg 19, IHA consultation 2002 (Document held by QNIC)*

18.5	Measures are in place to record and audit refusals, terminated referrals and waiting lists	D	
18.6	Where young people are refused admission to the service, the reasons for refusal are explained to the young person/parents/referrer, and they are informed about alternative options	D	

- ***Ref 115:*** *point 3.2.1. and 3.2.2 "When entry to the service has been declined, children/young people and/or their parents/relevant caregiver(s) will be informed of the reason(s)" "Where entry to the service has been declined children/young people and/or their parents/relevant caregiver(s) will be informed of the alternatives which are considered to be suitable to assist them with their needs and risks".*

Standard:

19 Assessment and treatment are offered without unacceptable delay

Criteria:

Rating: E= Essential; D= Desirable.

19.1a	Young people do not experience delay in assessment that leads to deterioration in health	E	
19.1b	Young people do not experience delay in treatment that leads to deterioration in health	E	

- ***Ref 21:*** *pg.35, 4.12 "Delays in access to assessment, effective treatment and care result in unnecessary distress, an increased risk of relapse and potential harm to the patient and others."*

19.2a	Young people do not experience delay in assessment that leads to care being offered in inappropriate settings, e.g. in adult and paediatric wards or as a day patient	E	
19.2b	Young people do not experience delay in treatment that leads to care being offered in inappropriate settings, e.g. in adult and paediatric wards or as a day patient	E	
19.3	Those at risk or with more severe conditions are given priority with assessment	E	
19.4	Young people at severe risk can be admitted as emergencies (i.e. within 24 hours) including out of hours	E	
19.5	Mechanisms are in place to monitor and report placements in inappropriate settings to Primary Care Trusts	D	**C18**

Section 3: Access, Admission & Discharge

Standard:

20 There is equity of access to in-patient units in relation to ethnic origin, social status, disability, physical health and location of residence

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 105:*** *Annex C, "Access to CAMHS should be available to all children and young people regardless of their age, gender, race, religion, ability, class, culture, ethnicity or sexuality"*
- ***Ref 24:*** *pg.47, 4.50, " Action is needed to ensure that those with mental health problems, are treated fairly, on the basis of need, in a manner which preserves their autonomy, and in a way which promotes opportunity for choice. This is central to the means to deliver a better quality of care for women, people from black and ethnic minority populations, and socially disadvantaged groups who may be excluded from, or thought unsuitable for, treatment."*
- ***Ref 18:*** *pg 17, "You can expect the NHS to respect your child's privacy, dignity and religious or cultural beliefs."*

20.1 The special needs of young people from different ethnic, cultural or religious backgrounds are reflected in the unit's policies, e.g. there are special dietary arrangements when needed — E — **C7e) C18**

- ***Ref 89:*** *pg 13, Standard 8.2, "Staff take into account the religious, racial, cultural and linguistic backgrounds of children and their families and any disabilities that they may have."*
- ***Ref 18:*** *pg.17, "You can expect your child to be offered a choice of children's menus which are healthy and which suit all dietary and cultural needs."*
- ***Ref 89:*** *pg. 11. Standard 7.6 -"The registered person ensures that professional services are provided where necessary to help children develop individual identity in relation to their gender, religious, racial, cultural or linguistic background or sexual orientation." pg. 16, Standard 11.3 "Cultural, racial, ethnic or religious expectations regarding the choice of clothes or personal requisites are supported and positively promoted."*
- ***Ref 90:*** *pg.119, M38.6, "The special needs of, and specific services for, children from different ethnic, cultural or religious backgrounds are reflected in local policies as appropriate to the patient population."*

20.2 Advocacy services are easily available — E

- ***Ref 95:*** *pg.133, Recommendation 2 - "We recommend that there should be competent, independent, trained, accessible, informed and funded children's advocates available to all children in the NHS." (Para 12.3); Recommendation 5 - "We recommend that advocates should generally be allowed to see children in private, and also to introduce themselves in wards and explain their roles direct to patients and families."*

20.3 The environment meets the needs of people with physical disabilities, and complies with current legislation on disabled access — E — **C18**

- ***Ref 87:*** *CHI Clinical Team Self-assessment tool updated May 2002, item 31 "The team base is designed to facilitate access for people with a physical disability including wheelchair users."*
- ***Ref 26****: point 18 "All the Government's objectives and sub-objectives apply to disabled children just as much as to non-disabled*"

Section 3: Access, Admission & Discharge

Criteria continued:

20.4	Young peoples' location of residence does not affect their access to services, e.g. young people from remote areas have access to services and where necessary special arrangements are made for families who need to stay overnight, e.g. in a nearby hotel • ***Ref 24:*** *pg.47, 4.50, " Action is needed to ensure that those with mental health problems, are treated fairly, on the basis of need*	D	**C18**
20.5	Interpreters are easily available and a minimum level of access is agreed so that relatives are not used as interpreters (this includes Welsh interpreters in units in Wales)	E	**C18**

Standard:

21 Units are parent-friendly

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 5:*** *pg.9, Standard 3.6 "From the point of joining the community, the child or young person and their family will be made aware of the pathways through the experience and the process leading up to their leaving." Standard 3.2 "The process of assessment and joining is inclusive of the individual child or young person, parents and significant others"*

21.2	Children's units have access to nearby facilities for parents to stay overnight when appropriate	E	
21.3	The unit information leaflet clearly states that the participation of parents is encouraged • ***Ref 86***: *pg.14, point 35 "The main elements of the policy of child and family-centred care should be set out in information leaflets which are given to parents."*	D	
21.4	Parents have access to tea, coffee or soft drinks • ***Ref 86***: *pg.35, point 94 "All hospitals should provide somewhere for parents to… make tea or coffee."*		D
21.5	Parents who need privacy have this provided where appropriate, e.g. there is a family room where parents can meet (see also criterion 1.4 in the environment and facilities section) • ***Ref 86:*** *pg.35, point 94 "All hospitals should provide somewhere for parents to….sit in privacy."*	E	

Standard:

22 Care of all young people takes place within the Care Programme Approach (CPA) framework to avoid protracted stays within the in-patient unit

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 37:*** *pg. 10, "And specific arrangements should be in place to ensure … integration of care management and the Care Programme Approach (CPA)".*

Section 3: Access, Admission & Discharge

Criteria continued:

- ***Ref 99:*** *"Effective Care Programme Approach (CPA) systems are essential to providing seamless care for service users with a severe mental illness". "There are records for all service users receiving specialist mental health care in the trust on CPA system(s)".*
- ***Ref 90:*** *pg.138, Standard M37.7, "Children are kept in hospital only if their needs cannot be met at home and they are discharged as soon as possible".*

22.1	The place of discharge is known before admission where possible	D	
22.2	There is a frequent decision-making forum, e.g. weekly ward rounds rather than monthly reviews, to prevent unnecessary delays to discharge	E	
22.3	Where discharge is delayed the reason for the delay is documented	D	

Standard:

23 Before discharge, decisions are made about meeting any continuing needs

Criteria:

Rating: E= Essential; D= Desirable.

- ***Ref 89:*** *pg.9, Standard 6.1, "The registered manager ensures that there is a comprehensive leaving care plan for young people preparing to leave care which specifies the support and assistance they will receive to enable a successful transition into adulthood, and which is implemented in practice. This plan is consistent with the young person's placement plan and any care or pathway plan.*"

23.1	When young people are referred back to local services for further treatment, e.g. to CAMHS, Education or SSDs, these services are included in discharge and further treatment planning	E	**C6**
23.2	When a young person needs to transfer to adult services a joint review must be undertaken to ensure effective hand-over takes place	E	**C6**

- ***Ref 122:*** *"The transition arrangements between CAMHS and adult services must be improved, possibly through the appointment of staff to 'bridge' both services"*

23.3	The care co-ordinator informs the young person's general practitioner and involves local services prior to discharge	E	**C6**

- ***Ref 89:*** *pg. 12, Standard 7.11, "Subject to the agreement of the placing authority, relevant personal, educational and health information concerning each child is passed on to the child's subsequent placement."*

23.4	A CPA meeting is held for all young people to plan discharge	E	
23.4a	A CPA record noting the discharge plan is produced and copied to all those concerned	E	

- ***Ref 37:*** *pg.41, "All mental health service users on CPA should … have a copy of a written care plan…"*
- ***Ref 89:*** *pg. 10, Standard 6.4, "Such plans (leaving care plans) are in written agreement with the young person who is given a copy of the plans".*

23.4b	Young people are involved in CPA meetings and agree plans for discharge	D	

Section 3: Access, Admission & Discharge

Criteria continued:

- ***Ref 97:*** *"It was widely agreed that all young people who are receiving in-patient care, should …be involved in agreeing plans for discharge….young people talked of the need to have something to aim for and that it was important to be able to prepare themselves."*

23.5	Section 117 meetings are held prior to the discharge of all young people detained under a treatment section of the Mental Health Act	E
23.6	Parents are invited to CPA meetings and involved in decisions about care after discharge from the in-patient unit	E
23.7	Young people and parents know the names of workers involved in follow-up after their discharge	E
23.8	Young people and parents know before their discharge the dates and times of appointments with the workers involved in their care after their discharge	E
23.9	On-going care planning with the relevant social services departments is arranged for "looked after" young people	E
23.10	Plans for ongoing education are arranged	E

SECTION 4: CARE AND TREATMENT

Standard:

24 All young people are assessed for their health and social care needs

Criteria:
Rating: E= Essential; D= Desirable.

24.1a	For units caring for young people who are high risk, a formal risk assessment tool is used and the risk is regularly reviewed	E	**C7c)**
	• ***Ref 94:*** *IHA Consultation 2002 (Document held by QNIC)*		
24.2	Case notes show evidence of the assessment interview/s with the young person and parent, and the person who conducted the interview is named	E	
24.7	Case notes show evidence of assessment of social care needs, including establishing if the young person and parent are involved or have access with other agencies	D	
24.3	Case notes show that a physical examination has been conducted and the name of the person who conducted the examination, or if part or all of the examination has been refused the reason why has been recorded	E	
24.4	A second opinion can be accessed	E	
24.5	Each assessed case has a formulation and/or diagnosis	E	
24.6	Assessment is clearly linked to the Care Programme Approach (CPA) to ensure continuity of care is achieved	E	
	• ***Ref 90:*** *point M12.7 " The assessment is clearly linked to the CPA/Care Management plan to ensure a follow-through is achieved".*		

Standard:

25 A comprehensive range of treatments is available at the in-patient unit. This will depend upon the nature of the group of young people, but is likely to include:

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 24:*** *pg.44, 4.43 "Professionals need ready access to the most up-to-date evidence about cost-effective treatment strategies, and they need the training, education and support to deliver these in an environment where quality matters."*

25.1	Drug therapy	E
25.2	Cognitive therapy (e.g. CBT, brief solution focused therapy)	E
25.3	Behavioural therapy	E

Section 4: Care & Treatment

Criteria continued:

25.4	Group therapy	E	
25.5	Family therapy and family work	E	
25.6	Psychodynamically informed psychotherapy	D	
25.7	Parent training/ counselling/ guidance	D	
25.8	Social skills training	D	
25.9a	Art therapy	D	
25.9b	Music therapy	D	
25.9c	Drama therapy	D	
25.9d	Play therapy	D	
25.11	Dietetic advice	D	
25.12	Physiotherapy	D	
25.13	Occupational therapy	D	

Standard:

62 There is a structured programme of care and treatment

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 94:*** *pg. 28, IHA consultation 2002 (Document held by QNIC)*

62.1	A structured therapeutic programme is run during weekdays	E	

- ***Ref 90:*** *pg.138, Standard M38.3, "A structured therapeutic programme should be run during the day."*

62.2	A programme of activities should be available for other times including evenings and weekends, for example outings, sport and social time	E	

- ***Ref 94:*** *pg.28, IHA consultation 2002 (Document held by QNIC)*
- ***Ref 93:*** *CASPE/HAP 2001 Standards for Accreditation (fourth edition) 6.11 Mental Health Services 8.1.2.5.*
- ***Ref 97:*** *"The young people agreed that it was important that the unit offer some range of activities in the evening times and at weekends - weekends in particular were viewed as times when there is very little to do and those who do not go home feel overlooked and bored."*

62.3	The therapeutic programme is needs led, risk assessed, and is reviewed on a regular basis	D	**C7c)**

Section 4: Care & Treatment

Criteria continued:

62.4 Activities provided for the young people are appropriate to their developmental needs and take account of their culture, language, religion, interests, abilities and disabilities — D

- ***Ref 89:*** *point 15.2 "Children are encouraged and given opportunities to take part in activities and leisure interests which take account of their race, culture, language, religion, interests, abilities and disabilities". Point 6.7 "The daily life of the home provides opportunities for all children in the home appropriate to the age and needs of each child, for the development of knowledge and skills needed by the child for future independent living".*

62.5 The programme of activities offered is planned in consultation with the young people — D

Standard:

26 Wherever possible the treatment provided is evidence-based

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 24:*** *pg.44, 4.43, "Professionals need ready access to the most up-to-date evidence about cost-effective treatment strategies, and they need the training, education and support to deliver these in an environment where quality matters."*

26.1 Staff know the evidence underpinning the range of treatments they provide — D

- ***Ref 100:*** *pg.14,"Each Tier 4 service should have developed evidence based protocols for the management of all conditions which cause young people to be admitted to that service"*

26.2 Treatments are selected according to the evidence of their effectiveness or according to nationally agreed best practice or guidance — E

- ***Ref 104:*** *standard C6, "Health care organisations have systems in place to ensure that treatment and care are based upon nationally agreed best practice or nationally agreed guidance, including NICE technology appraisals".*

Standard:

65 Outcome measurement is undertaken routinely using validated outcome tools (e.g. HoNOSCA, C-GAS, SDQ)

- ***Ref 120:*** *"Resources should be available so that routine evaluation of outcome can be carried out in all services." "The following are suggested as an example of a likely set of core measures for many services: Health of the nation Outcome Scales – Child and Adolescent (HoNOSCA), Strengths and Difficulties Questionnaire (SDQ), Service satisfaction survey, A context or complexity measure such as the Paddington Complexity Scale".*

- ***Ref 107:*** *7.18 "Ensure Outcome measurement undertaken routinely e.g. from perspective of child, parent/guardian and clinician to include different aspects of outcomes such as service satisfaction, changes in child and family stress and psycho-social adaptation".*

65.1 Outcome is evaluated from the perspective of staff, users and carers at a minimum — E

Section 4: Care & Treatment

Criteria continued:

- ***Ref 120:*** *"As a minimum, all services should evaluate outcome from the perspective of users of the service and providers of the service."*

65.2	Staff have been trained in the use of appropriate clinical outcome measures (e.g. HoNOSCA)	D	
65.3	Information from outcome measurement is fed back to the whole staff team, users and commissioners	E	

Standard:

27 The in-patient team has good access to a range of services, as appropriate to the needs of the young people. These include the following:

Criteria:
Rating: E= Essential; D= Desirable.

27.1	General and community paediatric services	E	**C6**
27.2	Adult mental health services	E	**C6**
27.3	Forensic mental health services	D	**C6**
27.4	Paediatric neurological services	D	**C6**
27.5	Substance and alcohol misuse services	D	**C6**
27.6	Learning disability services	D	**C6**
27.7	Laboratory services	E	**C6**
27.8	Accident and emergency facilities	E	**C6**

Standard:

28 All young people have a written care plan as part of the Care Programme Approach (CPA)

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 15***
- ***Ref 88:*** *'Modernising the Care Programme Approach 2001'- Describes the need to apply the CPA to all people receiving mental health care- i.e. all children as well as adults.'*

28.1	There is a written management or care plan for every young person	E	**C16**
28.2	Young people and parents are actively involved in the development of their management or care plan	E	**C16**

Section 4: Care & Treatment

Criteria continued:

- ***Ref 73:*** *pg.33, "Patients have a critical and central role to play in their treatment and management and within the limitations of the smooth running of the service, mental state and legal status, should be given as much autonomy as possible."*
- ***Ref 97:*** *"It was widely agreed that all young people who are receiving in-patient care, should have a clear care plan and that this should be fully discussed and agreed with them at the start of their stay."*

28.3	Educational staff are involved in the development and review of the management or care plan	E	**C6** **C16**

- ***Ref 5:*** *pg.22, "The learning programme is an integral part of the overall treatment plan and approach."*
- ***Ref 5:*** *pg.22, "Educational and care staff work closely and coherently together for the best interests of the pupils."*

28.4	The views of young people and parents are noted in the management or care plan	E	**C16**
28.5	The plan is signed by the young person, or if the young person is not competent, the plan is signed by the parent	D	**C16**
28.6	All people with parental responsibility have been consulted if they are readily available and sign the management plan, e.g. both parents are invited to sign including when divorced or separated	D	**C16**
28.7	Young people and parents are given a copy of the management or care plan or have ready access to it	D	**C16**
28.8	The management or care plan is reviewed at defined and agreed intervals during admission (e.g. a weekly ward round and 3-monthly CPA review)	E	**C16**
28.9	When a care order is in place the Local Authority fulfils the role of the person with parental responsibility with regard to all aspects of the management or care plan, e.g. the consent of the Local Authority is obtained	E	**C16**

- ***Ref 18:*** *pg.21, "Local authority social services departments are expected to act as good parents to children in their care. This includes looking after their health... Local authorities are required to make a plan for the care of a child while away from home."*

28.10	When a care order is in place there is also consultation with the parent with regard to the management or care plan	E	**C16**

- ***Ref 18:*** *pg.21, "Local authorities are required to make a plan for the care of a child while away from home. You may take part in drawing up this plan"*

28.12	The unit holds regular CPA reviews for every young person to ensure that continuing needs are met, regardless of the Mental Health Act or Children Act status of the young person	E	**C16**
28.13	Education and social services are included in the CPA, and adult services are included when appropriate	D	**C6** **C16**

Section 4: Care & Treatment

Standard:

29 Young people and parents can meet easily with members of staff, and particularly the key worker

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 90:*** *pg. 129, Standard M24.5, "Carers and family members are informed of opportunities to make appointments to see the care co-ordinator, responsible medical officer, consultant or other staff within a reasonable time."*
- ***Ref 73:*** *pg.33, "Patients should be able to see any member of their clinical team upon request and within a reasonable timescale"*

29.2 There are regular meetings planned for all young people and their families with the consultant — E

- ***Ref 73:*** *pg.33, "Patients should be able to see any member of their clinical team upon request and within a reasonable timescale"*

29.1 Young people and parents have access to the consultant when needed, for example, outside planned meetings — E

- *As above for 29.2*

29.3 Parents are invited to review meetings — E

- *As above for 29.2*

29.4 Young people and parents can arrange appointments with other staff as needed — E

- *As above for 29.2*

Standard:

30 During admission good communication is maintained with the young person's family and local services

30.1 Staff regularly update parents about their child's treatment and progress — E

30.2 Staff ask parents for their views about their child's care and treatment — E

Standard:

31 Drugs are administered according to the relevant guidelines

Criteria:
Rating: E= Essential; D= Desirable.

31.1 Nursing and Midwifery Council (formerly UKCC) standards relating to the control and administration of drugs are applied — E

- ***Ref 83:*** *Standards relating to the control and administration of drugs are applied*

Section 4: Care & Treatment

Criteria continued:

- ***Ref 83:*** *pg.4, "As a registered nurse, midwife, or health visitor, you are accountable for your actions and omissions. In administering any medicine, or assisting or overseeing any self-administration of medication, you must exercise your professional judgement and apply your knowledge and skill in the given situation."*

31.2	Where medication is used it is at the minimum effective dose, e.g. a graded approach to medication has been taken	E
31.3	Maintenance doses are in the accepted dose range for the age and weight of the young person	E
31.4	In the unit there are written guidelines for the use of rapid tranquillisation	E

Standard:

32 Young people can continue with their school work when admitted

Criteria:

Rating: E= Essential; D= Desirable.

- ***Ref 18:*** *pg.18,"Your child has a right to receive suitable education while in hospital for a long time."*
- ***Ref 90:*** *pg 139, Standard M38.5 "Children are required to receive education when in hospital for more than five days; if necessary the registered person contacts the Local Education Authority about its obligation to meet this need (under Section 19 of the Education Act 1996)."*

32.1	The minimum recommended time is provided for the education of young people by the in-patient unit.	E
32.2	Each young person has a formal assessment of their educational needs	E
32.3	The young person's educational progress is assessed with reference to their academic potential	D
32.4	Educational staff at the unit liase with the young person's own school and where possible maintain progress with the topics or lessons being covered at school	D

- ***Ref 5:*** *pg.22, "Teaching staff have contact with pupils' previous schools and liase with future placements to develop continuity of learning."*

32.5	Educational staff at the unit assist in steps to reintegrate the young person back to their local educational facility, this may include giving advice/consultation	D

- *As above for 32.4*

32.6	The unit can cater for diverse educational needs, including the needs of those with a learning disability and the needs of 16/17 year old "A" level students	D
32.7	Educational outings are provided	D

Section 4: Care & Treatment

Criteria continued:

32.8 Educational videos, textbooks and games are provided appropriate to core curriculum subjects — E

- ***Ref 5:*** *pg. 22, "A wide range of high quality teaching resources are available."*

32.9 Interactive learning material and software is provided — D

- *As above for 32.8*

32.10 Educational materials are available as required for each Key Stage — E

- *As above for 32.8*

32.11 There are facilities for the teaching of science, technology, sport and languages — D

- *As above for 32.8*

32.12 There is access to facilities to meet young people's special educational needs — E

32.13 Young people may access local school facilities as needed — D

32.14 The educational staff maintain communication with the young people's parents — D

SECTION 5: INFORMATION, CONSENT & CONFIDENTIALITY

Standard:

33 Young people and parents have good access to information

Criteria:

Rating: E= Essential; D= Desirable.

- ***Ref 86:*** *pg.14, point 35 "Good personal communication and written information are equally important. Families need constant reassurance, time to take in information and review what they have been told, and an opportunity to ask questions."*

33.1	A full range of appropriate leaflets and posters relevant to the services offered are on clear display and are readily available	E	**C16**

- ***Ref 95:*** *Recommendation 3 "We recommend that every NHS establishment should display prominently in foyers, waiting areas and resource areas notices containing information about how to contact a representative selection of crisis and advice organisations and advocacy services. (Para 4.46 and 12.4)."*

33.2	Information is kept up-to-date, and is relevant and age-appropriate	E	**C16**
33.3	Young people are presented with information in a way that they can understand, for example, the language used is plain and "child friendly"	D	**C16**
33.4	Information when necessary is in languages other than English and in forms in which people with sight, learning and other disabilities can use	D	**C16**

- ***Ref 89:*** *pg.11, Standard 7.4 -"Support is provided for any child for whom English is not their first language (or whose main communication is through sign language), enabling them to communicate their needs, wishes and concerns, and to communicate with staff and other children within the home."*

33.5	There is access to interpreter services and where appropriate the young person's language is recorded in notes	E	**C13a) C16**

- ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, item 43, "Service users have easy access to services which provides practical assistance with communication, interpreting, and advice on disability and specific religious or cultural issues."*

33.6	Telephone numbers of help lines, social services departments, and advocacy services are displayed	D	**C14a) C16**

- ***Ref 52:*** *pg.16, Standard 1.36 "There is a range of helpline services for example NSPCC, Childline, and such information is available and publicised to children."*

33.7	A "welcome pack" or introductory booklet is provided when people first use the service	E	**C16**

- ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, item 48, "There is an introductory booklet relating to the ward/unit which is given to people on admission. This provides information for users and carers in relation to what their general rights and responsibilities are and how the service aims to meet their needs."*

Section 5: Information, Consent & Confidentiality

Criteria continued:

33.8 Young people have access to health promotion advice and information covering issues such as sexual health, pregnancy, drugs, smoking and healthy eating — D — **C16**

- ***Ref 109:*** *point 4.16 "Children and young people have access to health promotion advice and information covering issues such as sexual health, pregnancy, drugs, smoking and healthy eating."*

Standard:

34 Each young person has a key worker or care co-ordinator

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 86:*** *pg.14, point 33 "All hospitals should adopt a policy of allocating a named nurse to be responsible for the care of each child throughout their stay, and to provide a link with staff involved in post-discharge care."*

34.1 The young person's views are taken into account if they are not satisfied with their key worker or care co-ordinator and there is a process in place to deal with this — E

Standard:

35 Young people know the names of the staff team looking after them

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 18:*** *pg.16 " …you can expect your child to have a qualified children's nurse responsible for the nursing care. You and your child will be told the nurse's name."*

35.3 Staff wear name badges, so that young people and visitors know who they are, and for reasons of security — D

- ***Ref 18:*** *pg.17, "You can expect all the staff you meet to wear name badges. This is so that you know who everyone is, and for security."*

35.4 There is a board on display with the names and photographs of staff — D

35.5 There is a board showing who is keyworker for each young person — D

35.6 There are procedures for letting the young person know who the named nurse is at each handover between shifts — D

Standard:

36 Young people and parents can find out about the in-patient unit before the admission

Criteria:
Rating: E= Essential; D= Desirable.

36.1 Young people and parents can visit the unit and find out about the services offered before agreeing to admission (with the exception of emergency admissions) — E

Section 5: Information, Consent & Confidentiality

Criteria continued:

- ***Ref 97:*** *"The major theme for this section was the lack of information at the admission. In particular, the respondents highlighted the need for units to provide* ***written information****, since at the time of admission it is often hard to remember every thing that is said. Such information should cover unit daily routines and rules and /or sanctions, in order to help young people know what to expect during their time as an inpatient."*
- ***Ref 5:*** *Standard 3.3 "Before a final decision is made, the child or young person has the opportunity to visit, and preferably, stay for a short period."*
- ***Ref 89:*** *pg.8, Standard 5.2 "The home's expectations of the child and what s/he can expect of staff are clearly explained, prior to admission wherever possible, and, where not possible, are explained immediately on admission, and are reiterated as often as is necessary to ensure that the child fully understands."*
- ***Ref 18:*** *pg.16 " If you want to, you and your child can expect to see the children's ward before being admitted."*

36.2 There is a pre-admission meeting to discuss the aims of the admission (with the exception of emergency admissions where aims should be discussed upon admission) — D

36.3 Information is available about aspects of the treatment programme, including the education facilities — E

- ***Ref 97:*** *"Several of the respondents suggested that information about medication is often lacking and that this is something units should provide written information about."*

36.5 There is a leaflet giving general information about the unit available to young people and parents before admission to the unit — E

- ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, item 48, "There is an introductory booklet relating to the team which is given to people on first contact. This provides information for users and carers in relation to what their general rights and responsibilities are and how the service aims to meet their needs."*

Standard:

37 Young people and parents are involved in decisions about their treatment

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 86:*** *pg.13, point 30 "Involvement of a child's family is a crucial part of their care…Parents should also be encouraged to continue providing care and support for their child as they would at home, and to gain the knowledge and confidence to do more themselves."*

37.1 Staff ask young people and parents what information they need to receive about the service, their care and treatment, their diagnosis etc. — D — **C16**

- ***Ref 90:*** *pg.139, Standard M39.1 "Clinicians speak with children and their families to ensure that children are fully aware of the treatment they are to receive."*

37.4 Young people and parents are given a clear explanation of their diagnosis or the assessment programme if diagnosis has not been determined on admission — E — **C16**

Section 5: Information, Consent & Confidentiality

Criteria continued:

37.5	Young people's views and parents' views are explicitly sought about their condition to help treatment compliance	E	**C16**
	• ***Ref 113:*** *point 2.2, "Objectives: … to establish child-centred services which take into account the views of young people and families using them"*		
37.6	Sufficient time is available to young people and parents to make decisions without being detrimental to the young person's treatment	E	
37.7	Young people and parents can discuss the diagnosis, treatment, side effects and prognosis in as much detail as they need	E	
	• ***Ref 5:*** *standard 3.6, "From the point of joining the community, the child or young person and their family will be made aware of the pathways through the experience and the process leading up to their leaving."*		
37.8	Unit staff systematically obtain young people's feedback about the service, e.g. a discharge questionnaire has been completed	E	**C14a)**

Standard:

38 Young people and parents have access to their health records

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 10:*** *Competence: Section 3 subsection 1(a) identifies the child and section 4 subsection1 describes competence. Child's interest: Section 5 subsection 1(a)(I). Consent of others identifiable: Section 5 subsection 1(a)(ii). Expectation of future disclosure: Section 3 subsection 1(c) identifies the parent and section 5 subsection 3(a) and (b) describes expectation of future disclosure.*

38.1	Young people and parents are informed of their rights to see the health records of the young person and the limitations on those rights	E	
	• ***Ref 18:*** *pg.3, "Your child has a right to have access to his or her health records. He or she has a right to know that everyone working for the NHS has, by law, to keep those records confidential …If children under your parental concern are considered too young to make their own decision then you usually have access to their health records. Exceptionally, information may be withheld from you, e.g. if it might cause serious harm to the physical or mental health of the patient".*		
38.2	Access to health records is not denied unless i. The applicant is under 16 years and judged not to be capable of understanding the nature of the application, ii. Access would be likely to cause serious harm to the physical or mental health of the young person or any individual, or iii. This would disclose information of another identifiable person who has not consented to the application	E	
38.3	The consent of the competent young person is obtained before disclosing case material to parents	E	
38.4	Where an application is made by a parent, access to health records is not given where this would disclose information provided by the young person, including as a result of any examination or investigation, to which the young person consented in the expectation that the information would not be so disclosed	E	

Section 5: Information, Consent & Confidentiality

Criteria continued:

38.5	There are clear policy instructions regarding the availability of child assessment reports to parents where this might prejudice the welfare of the child or third party	E	

Standard:

39 Personal information about young people is kept confidential, unless this is detrimental to their care

Criteria:
Rating: E= Essential; D= Desirable.

39.1	Confidentiality and its limits are explained to young people and their families, e.g. it is made clear to young people that this is extended beyond the clinical team only if the quality of their care and/or the safety of another depends on this and then only to those who need to know	E	**C13c)**

- ***Ref 57:*** *pg.147, section 31.12 " Children's rights to confidentiality should be strictly observed. It is important that all professionals have a clear understanding of their obligations of confidentiality to children and that any limits to such an obligation are made clear to a child who has the capacity to understand them.*
- ***Ref 89:*** *pg.14, Standard 9.3 "Staff know how to deal with and share information which they are given in confidence for child protection."*
- ***Ref 98:*** *pg.10, "If there are limits to the level of confidentiality that a service can offer this should also be stated"*

39.2	For young people aged over 16 years or otherwise competent, information is not shared with parents without the young person's permission	E	**C13c)**

- ***Ref 52:*** *pg. 10, GUIDANCE "Young people aged 16 or 17 are entitled to the same duty of confidence as adults"*

39.4	Young people are told if information is passed on	E	
39.5	The unit holds data in compliance with the Data Protection Act (1984) to ensure maintenance of confidentiality	E	**C13c)**

- ***Ref 116:*** *pg. 4 " All agencies to maintain the confidentiality of any data held in compliance with the Data Protection Act (1984)."*

Standard:

40 All examination and treatment is conducted with the appropriate consent

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 52:*** *pg.12, standard 1.13 "The consent of children and young people under sixteen to treatment is always sought and where they are too young their views should be ascertained and taken account of."*

Section 5: Information, Consent & Confidentiality

Criteria continued:

40.1	The young person is approached by a person capable of performing that procedure to obtain consent, for example if a young person needs psychotherapy then the young person is approached by a psychotherapist for consent	E	**C13b)**
40.2	Consent is obtained in writing whenever appropriate	E	**C13b)**
40.3	Information is provided on the perceived risks and benefits of specific treatments and investigations, and the alternatives	E	

- ***Ref 57:*** *Section 15.15 "The information which must be given should be related to the particular patient, the particular treatment and the relevant medical knowledge and practice. In every case sufficient information must be given to ensure that the patient understands in broader terms the nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Additional information is a matter of professional judgement for the doctor proposing the treatment."*

40.4	The young person or parent is informed about how to obtain additional information if they want it, for example, staff recommended websites and reading material	E	
40.5	Examination and treatment is conducted with the parent's consent and the incompetent young person's agreement, or the competent young person's consent	E	**C13b)**

- ***Ref 117:*** *Shaw (2001). Competence and consent to treatment.*

40.6	When a competent young person is treated against their will this is conducted within the appropriate legal framework which is noted in the young person's health record	E	**C13b)**
40.7	Examination or treatment is conducted against the will of the young person only if discussion and modification of the examination or treatment has been exhausted	E	**C13b)**
40.8	Audio and/or video recording facilities and one-way screens are not used without the consent of young people and parents except in exceptional circumstances where a person's safety may depend on it	E	**C13b)**

Standard:

41 There is a review of any placement in secure accommodation

Criteria:

Rating: E= Essential; D= Desirable.

- ***Ref 6:*** *Children Act 1989, pg 188, Guidance and Regulations Volume 4: Residential Care - Secure accommodation – Sect. 25 (1)*

41.1	A review is conducted not more than one month after placement	E	
41.2	The review is conducted by at least three people, at least one of which is not a member of the Local Health Authority or Local Authority	E	

Section 5: Information, Consent & Confidentiality

Criteria continued:

41.3	The review considers whether the criteria for keeping the young person in secure accommodation still apply and whether other accommodation would be more appropriate	E
41.4	The review considers the wishes and feelings of the young person and parents	E

Standard:

42 The in-patient unit maintains useful and informative health records about the young people

Criteria:
Rating: E= Essential; D= Desirable.

42.1	Notes clearly indicate the young person's formulation and/or diagnosis or diagnoses at the point of admission	E
42.2	Notes clearly indicate the young person's formulation and/or diagnosis or diagnoses after the assessment period, e.g. usually 4-6 weeks	E
42.3	The health record clearly states the date of referral, assessments, admission, date of transfer to day patient status and date of discharge	E
42.4	There is a copy of any relevant court order kept with the young person's health records	E
42.5	Where a young person is looked after by the Local Authority a record is kept of the particulars of the Local Authority involved	E
42.6	The young person's legal status is recorded in the health record, e.g. if the young person has been formally detained the relevant section has been noted in the health record	E
42.7	When a young person is kept in secure accommodation information recorded includes the date and time of placement, the reason for placement, the name of the officer authorising the placement, those informed of the placement, reviews of the placement, where the young person was living before the placement, the date and time of any occasion on which the young person is locked on his own in any room other than his bedroom at bedtime, the name of the person authorising this action, the reason for it and the date on which and time at which the young person ceases to be locked in that room	E
42.8	Information about the date and time of discharge and the young person's address following discharge from secure accommodation should be recorded in the young person's health records	E

SECTION 6: RIGHTS, SAFEGUARDS AND CHILD PROTECTION

Standard:

43 Restriction of liberty of the young person occurs within the appropriate legal framework, under the provision of the Mental Health Act, Children Act or common law

Criteria:

Rating: E= Essential; D= Desirable.

- ***Ref 57:*** *Mental Health Act 1983, "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants"*
- ***Ref 6:*** *Children Act 1989*

43.2	If restriction of liberty occurs under the provisions of the Children Act then the criteria for "secure accommodation" are satisfied. These are that the patient has a history of absconding and is likely to abscond from any other accommodation, and, if he absconds, he is likely to suffer significant harm, or if he is kept in any other accommodation he is likely to injure himself and others	E
43.3	If restriction of liberty occurs under the provisions of the Mental Health Act then this occurs only in accordance with the terms of the relevant section, e.g. for emergency admission or admission for assessment the child or young person must have a psychiatric condition and must be at risk to themselves or others, for admission to treatment, the psychiatric condition must be treatable	E
43.4	Managers ensure that all staff understand the definition of restriction of liberty, the circumstances in which it can be used, and the distinction from "time out" and "seclusion"	E
43.5	All restrictions of liberty are recorded in the health record including the indications for its use, the type of restriction, its duration, and the name of the person who authorised its use	E
43.6	The running total number of hours of restricted liberty is monitored	E
43.7	Where the Trust is providing accommodation for a young person looked after by a Local Authority, there are procedures and policies concerning negotiations with the Local Authority about making an application for a secure accommodation order	E

Section 6: Rights, Safeguards & Child Protection

Standard:

44 The in-patient unit is patient-centred and young people have their rights respected

Criteria:
Rating: E= Essential; D= Desirable.

44.1	Young people can wear their own clothes and can take some of their own things with them when they stay on the unit	E	**C13a)**
	• ***Ref 18:*** *pg.17, "You can expect your child to wear his or her own clothes"*		
44.2	There is a choice of well prepared food from a young person's menu that suits all nutritional, personal, cultural and clinical dietary needs	E	**C7e)** **C13a)** **C15a)** **C15b)**
	• ***Ref 90:*** *pg.16, Standard 10.3 "Children are provided with food in adequate quantities, properly prepared, wholesome and nutritious, with regard to their cultural, ethnic and religious backgrounds and dietary needs and choices (including the choice of vegetarian meals for children who wish)."*		
	• ***Ref 104:*** *standard C18, "Health care organisations have systems in place to ensure that a) patients are provided with a choice of food which is prepared safely and provides a balances diet; and b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day".*		
44.14	The food provided is of a good standard	E	**C15a)**
	• ***Ref 112:*** *pg.4, "…they suggested inspectors should look for… good food…"*		
44.15	All aspects of food procurement, production, preparation, storage, transportation and delivery comply with current legislation, regulations and guidelines	D	**C15a)**
	• ***Ref 115:*** *point 5.4.4.*		
44.16	There are facilities for young people to make their own hot and cold drinks and snacks	D	**C15a)** **C15b)**
44.3	The unit is sensitive to the needs of different ages, for example, age appropriate recreational facilities are provided	E	**C13a)**
	• ***Ref 18:*** *pg.17, "You can expect the hospital to be appropriately furnished for the needs of children and young people of all ages."*		
44.4	Young people can ask to see the doctor on their own, e.g. without other nursing staff or family present, although this may be refused in certain circumstances, e.g. if the young person is particularly aggressive	E	
	• ***Ref 89:*** *pg 18, Standard 12.7, "Children, subject to their age and understanding, can choose whether or not they are accompanied by a member of staff when being seen by a doctor, nurse or dentist, and as far as is practicable, to see a doctor of either gender if they wish."*		
44.5	Young people can ask to see a doctor of the gender of their choice	E	**C13a)**
	• *As above for 44.4*		

Section 6: Rights, Safeguards & Child Protection

Criteria continued:

44.6 Staff are friendly and approachable and young people feel respected and liked by staff — E — **C13a)**

- ***Ref 89:*** *Standard 21.1 "Relationships between staff and children are based on mutual respect and understanding and clear professional and personal boundaries which are effective for both the individuals and the group."*
- ***Ref 98:*** *page viii, "In general for all young people, the responsiveness of the professionals that they came into contact with played a major role in determining how they felt about the service". "Young people valued professionals who were friendly (nice, knew how to talk to people, happy, good for a laugh)". "Respondents wanted to be treated with respect by the professionals. This was variously interpreted to mean being treated as an equal or as an adult".*
- ***Ref 114:*** *standard, "Values and attitudes – Respect for service users".*
- ***Ref 112:*** *pg.4, "… they suggested inspectors should look for… positive staff attitudes towards children…"*

44.7 Young people's rights and what they can expect are explained, for example, they are given a copy of the Patient's Charter — E — **C13a)**

- ***Ref 109:*** *standard 1.4, "There is information available for children and young people on their rights… in a form… and manner… appropriate to all ages and abilities"*

44.8 Books and magazines are provided in recreation areas for young people D

44.9 There are facilities for playing games appropriate to the client group, e.g. a pool table and board games are provided D

44.10 A television, video and audio system are provided D

44.11 Access to media (e.g. TV, video, audio and internet) is age-appropriate, based on consideration of individual young people, and monitored with safeguards in place D

- ***Ref 89:*** *point 15.8 "Consideration is given to individual circumstances of children in watching videos and television, and in using computer games and accessing the internet. Videos, games consoles and computer games may be watched/played only by children of the intended age range."*

44.12 The unit has a young people's notice board D

44.13 Appropriate support is provided for young people who are refugees and for asylum seeking young people, taking into account the particular circumstances of each young person's flight from his or her country of origin and the advice of specialist agencies where necessary E **C13a)**

- ***Ref 89:*** *point 7.13*

Standard:

45 Young people can complain or ask questions if they are unhappy with their care and treatment

Criteria:
Rating: E= Essential; D= Desirable

Section 6: Rights, Safeguards & Child Protection

Criteria continued:

45.1 Complaints procedures are well-publicised and there is help on how to use them E **C14a)**

- ***Ref 89:*** *pg.23, Standard 16.2, "Children, and where appropriate their families, significant others and independent visitors are provided with information on how to complain, including how they can secure access to an advocate."*
- ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, item 51, "The Trust provides clear information for service users and carers in how to make a complaint."*

45.2 There is information available on how to get independent help and advocacy in making complaints E

- ***Ref 89:*** *pg.23, Standard 16.2, as above for criterion 45.1 plus "Where necessary, this access is to an advocate who is suitably skilled (e.g. in signing or in speaking the complainant's preferred language)."*

45.3 There is information available on young people's rights to access a mental health tribunal E

- ***Ref 57:*** *Mental Health Act 1983, section 132*

45.4 It is explained how complaints may be made without the knowledge and involvement of the person complained about E

45.5	Young people have access to a telephone helpline on which they may raise concerns without being overheard	E	**C14a)**

Standard:

46 The unit operates within the appropriate legal framework in relation to control and discipline

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 6:*** *Children Act 1989, Guidance and Regulations Volume 4: Residential Care p137, (Children's Homes Regulations 1991 part II section 8)*
- ***Ref 56:*** *LAC (93) 13: Guidance on permissible forms of control in children's residential care. Paragraph (14309)*

46.1	The "grounding" of young people, (e.g. voluntary restriction to unit) is not enforced by locking them in or by their physical restraint	E
46.2	Young people are not "grounded" for an unreasonable length of time as this constitutes the accommodation being used to restrict liberty even if no locking up is involved	E
46.3	Social isolation is not used to discipline or punish young people, e.g. young people are not locked in their bedrooms or deprived of social opportunities	E
46.4	No disciplinary measures are used which include any form of corporal punishment, any deprivation of food or drink, any restriction of visits or communication by phone or post, any requirement that a young person wears distinctive or inappropriate clothes or the imposition of fines	E

Section 6: Rights, Safeguards & Child Protection

Standard:

47 The unit operates within the appropriate legal framework in relation to the use of physical restraint

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 56:*** *LAC (Local Authority Circular) (93) 13, Paragraphs 14301, 14302, 14315 and Annex A*

47.1	Physical restraint is used only when immediate action is needed to prevent a young person from significantly injuring themselves or others, or causing serious damage to property, or, when a young person is detained under the MHA, they attempt to leave the unit without authority	E
47.2	After restraint the young person is counselled on why it was necessary and their views are sought and included in de-briefing about the incident	E
47.3	Physical restraint is only attempted when there are sufficient staff who have undergone control and restraint training at hand to ensure it can be achieved safely	E

47.4 The circumstances and justification for using physical restraint are recorded immediately; every such incident is documented within 24 hours (one working day); the RMO is informed and a report is submitted by the nurse in charge to the Trust management in line with Trust incident reporting policy — E

47.5 The care worker's line manager discusses the incident within the same day or shift and staff meetings include a formal analysis of the event — D

Standard:

48 Practitioners are kept well informed with up-to-date information on legal issues

Criteria:
Rating: E= Essential; D= Desirable.

48.1 The unit has clear guidance endorsed by the Trust on procedures for administering treatment without consent and for the detention of young people — E

48.2 Legal advice is available for practitioners when needed — E

48.3 The Mental Health Act Commission visits are facilitated and co-operated with — E

Standard:

49 Staff are aware of the legal status of those admitted

Criteria:
Rating: E= Essential; D= Desirable

Section 6: Rights, Safeguards & Child Protection

Criteria continued:

49.1 The child protection status of young people is known to staff to help give clear guidance if abuse is suspected — E

49.2 Mental Health Act or Children Act status is known to staff — E

Standard:

50 The unit complies with local ACPC procedures and with the guidance contained in the "What to do if you're worried a child is being abused" (2003) document

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 103:*** *What to do if you're worried a child is being abused: Children's service guidance*
- ***Ref 110:*** *The Victoria Climbié Inquiry (2003)*
- ***Ref 90:*** *pg.137, Standard M35.2 "A copy of the child protection policy, compiled in collaboration with the local Area Child Protection Committee* ***(ACPC),*** *is available. The*

provision of regular training in child protection procedures is mandatory. A designated person for child protection is identified."

- ***Ref 6:*** *Children Act 1989*

50.2	Staff at the unit know the role of these "senior professionals" on the ACPC and how they co-ordinate aspects of child protection within the unit and relevant agencies	E	**C2**
50.3	Staff at the unit know who the named professionals are, designated to be responsible for ensuring child protection supervision, and providing day to day advice and support	E	**C2**
50.4	The unit has policies and procedures which are compatible with ACPC guidelines, including the conduct of Part 8 reviews	E	**C2**
50.5	The unit has policies and procedures on how to deal with allegations of abuse during and out of working hours	E	**C2**
50.6	The unit's policies and procedures are dated and indicate when and by whom they will be reviewed	E	**C2**
50.8	Local ACPC guidelines, Working Together under the Children Act, Clarification of Arrangements, Medical Responsibilities and Guidance to Senior Nurses are available and accessible to all staff members	E	**C2**
50.9	Ongoing training of staff includes child protection policies and procedures and recognition of abuse	E	**C2**

- ***Ref 89:*** *pg.26, Standard 17.8, "The registered person ensures the provision of training for all staff, including ancillary staff, agency staff and volunteers, in the prevention of abuse, recognition of abuse, dealing with disclosures or suspicions of abuse, and the home's child protection procedures. This training is included in induction programmes for new staff... and is ongoing for the staff group in keeping with the aims and objectives of the home."*

Section 6: Rights, Safeguards & Child Protection

Standard:

51 The unit has a policy on dealing with allegations of abuse against staff, other young people or visitors, including contact visits by relatives or friends

Criteria:

Rating: E= Essential; D= Desirable.

- ***Ref 89:*** *pg 25, Standard 17.3, " There are clear procedures in line with the Regulations 2001 (3967), which are known, understood and followed by all staff, for responding to allegations or suspicions of abuse, either by staff or by children, or by others." (see standard for further details)*

51.1	The unit follows the procedures for working together produced by their local ACPC	E	**C2**
51.2	The Trust informs the Home Office or the Welsh Office if there is reason to believe that an offence has been committed against a young person by a member of staff	E	**C2**

Standard:

52 The necessary notification of young people accommodated is performed as stated in the Children Act 1989 (section 85 and 86)

Criteria:
Rating: E= Essential; D= Desirable.

52.1	NHS trusts inform the responsible SSD when a young person is accommodated or is intended to be accommodated for a consecutive period of 3 months or more, and when the young person leaves the accommodation	E	

Standard:

53 Unit staff work with the local authority to safeguard and promote the welfare of longer staying young people

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 6:*** *Children Act 1989 - Sect. 85*
- ***Ref 43,*** *pg. 13.*

53.1	Where necessary the local authority promotes contact between the young person and his or her family	E	**C2 C6**
53.2	After discharge young people who have stayed for over 3 months are assisted and advised by their local authority	E	**C2 C6**
53.3	Permissible treatments have been agreed for young people staying 3 months or longer between the local authority and the in-patient service	E	**C6**
53.4	The registered child protection person informs the local authority if a child remains or is likely to remain an in-patient for a period of over three months (in line with section 85 of the Children Act 1989)	E	**C2 C6**

SECTION 7: AUDIT AND POLICY

Standard:

54 All available information is used to evaluate the performance of the unit

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 56****: Sect 13 Annex A.*
- ***Ref 89:*** *pg.14, Standard 8.12, "The registered person takes the views of children, parents and placing authorities into account in the development and any necessary change in the operation of the house."*
- ***Ref 120:*** *pg.5, "All dedicated CAMHS should routinely monitor and evaluate their work and the findings should be used to enhance their work, to further service development and to inform users and other stakeholders"*

54.2	Information from users is used to evaluate the unit through a number of means e.g. suggestion boxes, surveys and user groups	E	**C14c) C17**

- ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002: item 3, "Service users and carers are involved in the clinical audit process."*

54.3	The complaints procedure informs the service evaluation	D	**C14c)**

- ***Ref 89:*** *pg.24, Standard 16.5, "The registered person has provided the home with a written policy and procedural guidelines on considering and responding to representations and complaints in accordance with legal requirements and recent government guidance…"*

54.4	The views of referrers are used in the service evaluation	D	

- ***Ref 86:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002: item 2 "Team members engage in multidisciplinary clinical audit as part of the Directorate audit programme."*

54.5	The use of procedures for the management of violent young people is monitored	D	

- ***Ref 89:*** *pg.33, Standard 22.11, "The registered person will regularly monitor the record books to monitor compliance with the home's policy, procedure and guidance and to identify any patterns in incidents leading to disciplinary action or restraint action becoming necessary."*

54.6	The service evaluation includes the views of all unit staff including educational staff	D	
54.7	The service evaluation includes accident and incident records, key performance data (e.g. waiting times, number of rejected referrals, bed occupancy, non-attendance), and the findings of key audits	D	**C1a)**
54.8	Senior managers monitor every incident involving the use of physical restraint and are prepared to investigate units where, for example, there is a pattern of young people absconding or where there is frequent use of physical restraint	E	**C1a)**

- ***Ref 87:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002: item 14 "Trust policy for the reporting of and recording of accidents/incidents is applied consistently."*

Section 7: Audit & Policy

Criteria continued:

54.10	There is a regular standards-based service review	D	**C5d)**

Standard:

63 Unit staff learn from information collected on clinical risks

Criteria:
Rating: E= Essential; D= Desirable.

63.1	Incident reviews and other information on clinical risks inform action plans	E	**C1a) C7c)**

Standard:

64 Unit staff are involved in clinical audit

Criteria:
Rating: E= Essential; D= Desirable.

64.1	A range of audits is conducted	E	**C5d)**
64.2	Unit staff develop action plans in response to audit reports and recommendations	E	**C5d) C14c)**
64.3	There are dedicated resources to support clinical audit within the directorate or specialist areas, for example, staff time and dedicated budget	E	**C7a)**
64.4	Practitioners are involved in identifying priority audit topics in line with national and local priorities	D	**C5d)**

- ***Ref 121:*** *standard 6.6*

64.5	The quality of the implementation of the Care Programme Approach (CPA) is audited, to ensure consistent and appropriate application	D	**C5d)**

Standard:

56 The unit has a comprehensive range of policies and procedures

Criteria:
Rating: E= Essential; D= Desirable.

56.1	There are written referral criteria	E	

- ***Ref 73:*** *pg. 39, "Admission criteria must be clear and practicable."*

56.2	There is a written procedure for emergency referrals	E	

- ***Ref 89:*** *pg.8, Standard 5.1, "There are procedures for introducing children to the home, the staff and the children living there which cover planned and, where permitted under the home's Statement of Purpose, emergency admissions."*

Section 7: Audit & Policy

Criteria continued:

56.3	There are written admission and discharge procedures	D	
	• ***Ref 86:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, item 53, "The multidisciplinary team have developed written standards in relation to key elements of the care pathway e.g. admission process, elements of ongoing care/treatment, discharge etc. These standards are audited" and on pg 9, Standard 5.4 "There are procedures for children leaving the home covering both planned and emergency departures."*		
56.4	There are policies and procedures on the management of violence and the use of physical restraint, which includes warning the young person before restraint may be needed	E	**C2**
	• ***Ref 86:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, item 61: "The deployment of control and restraint techniques are consistent with Trust policy."*		
56.5	There is a policy on clinical risk assessment	E	**C7c)**
	• ***Ref 86:*** *CHI Ward-based Clinical Team Self-Assessment tool updated May 2002, item 12: "There is a policy for clinical risk assessment and management [part of CPA]."*		
56.21	There are policies and procedures regarding young people's self harm and the notification of self harm to parents	D	
	• ***Ref 89:*** *pg 29, Standard 20.2 "The registered person ensures the notification to the parents of the child concerned of any other significant incident affecting their child's welfare, unless such a notification is either not reasonably practicable, or would be likely to place the child's welfare at risk."*		
56.7	There are policies and procedures regarding young people's absence with or without permission	E	**C2**
56.8	There are policies and procedures on the use of control and discipline, "time out", coercive strategies, seclusion, and restriction of privileges, including a written list of permissible sanctions	E	**C2**
56.9	There are policies and procedures regarding the involvement of the police if offences are committed in the unit	D	
56.10	There is a contingency plan and procedures to cover accidents and emergencies and disasters such as suicide	E	**C2** **C24**
56.11	The unit has procedures for the management of bullies and for those who have been bullied	D	**C2**
56.12	There are policies relating to the safety of the environment, e.g. detailed fire procedures	E	**C2**
56.13	There is a procedure regarding obtaining consent from young people	D	
56.14	There is a locked door and restriction of liberty policy	E	
56.15	There are procedures covering child protection issues	E	**C2**
56.16	There are procedures describing the explanation of confidentiality	D	

Section 7: Audit & Policy

Criteria continued:

56.17	There are appropriate procedures where units close at weekends	E	
56.18	There are procedures relating to NMC standards on the control and administration of drugs	E	**C2 C4d)**
56.19	There is a clear policy on smoking, e.g. with or without parents' permission, when this is permitted, in what areas and how many cigarettes	D	
56.20	There is a policy on the use of drugs and alcohol, and on the management of young people who may be abusing drugs and alcohol	E	

- ***Ref 93:*** *CASPE/HAP 2001, Standards for Accreditation (fourth edition) 6.11 Mental Health Services*
- ***Ref 90:*** *standard M19.1, "There are written policies and procedures, reviewed at least every three years, for the management of patients who may be abusing alcohol or drugs."*

56.22	There are policies on visiting, and contact between young people and their family and friends is encouraged	E	

- ***Ref 90:*** *standard M24.1, "There is a written policy and information on arrangements for patients to have visits from family, friends and their carers".*

56.23	There are policies and procedures in place for the management of unwanted visitors (i.e. those who pose a threat to young people)	E	**C2**
56.24	There are written policies and procedures that implement the requirements of the Care Programme Approach (CPA)	D	

- ***Ref 90:*** *standard M11.1 "There are written policies and procedures, reviewed at least every three years, that implement the requirements of the Care Programme Approach (CPA)/Care Management in accordance with Health Service Guidelines."*

56.25	There are policies, procedures and guidance for infection control practice	D	**C4a)**

- ***Ref 90:*** *standard M9.2, "Written policies, procedures and guidance for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance".*
- ***Ref 115:*** *standard 5.6.4., "Infection control principles are integrated into the design and delivery of new and existing services".*

56.26	There are policies and procedures regarding searches of young people's rooms and of visitors	D	

- ***Ref 118:*** *pg.15, "Search policy – patient rooms and visitors"*

56.27	Policies, procedures and guidelines are formatted, disseminated and stored in ways front-line staff find accessible and easy to use	D	

- ***Ref 121:*** *standard 6.3*

Section 7: Audit & Policy

Standard:

57 There are written and signed service level agreements for child and adolescent psychiatric in-patient units. These include:

Criteria:
Rating: E= Essential; D= Desirable

57.1	A description of the services	E	
57.2	Staff and training details	E	
57.3	A range of protocols, e.g. for clinical procedures	D	
57.4	Formal lines of communication	D	
57.5	Child protection procedures	D	**C2**
57.6	Monitoring methods, e.g. for collecting outcome data	D	**C1a)**
57.7	Regular review of the content of the agreement	D	
	• ***Ref 86:*** *pg.40, point 107: "Outcome measurement has a major role to play in every hospital to ensure that the most effective services are being provided."*		
57.8	Service and funding details	E	
57.9	Explicit detail of quality standards	D	
57.10	Risk identification and contingency measures	D	**C7c) C24**
57.11	Advocacy services for young people	D	
57.12	Recognition of the services' work with families	D	
57.13	Recognition of their role in the support of other professional groups, such as education staff, social workers, health visitors, school nurses and voluntary sector services	D	

SECTION 8: LOCATION WITHIN A PUBLIC HEALTH CONTEXT

Standard:

58 The Health Authority has a recent written strategy, developed in consultation with all relevant parties, which addresses the provision of child and adolescent services

Standard:

59 Adequate levels of local in-patient services are provided for those who require it

Criteria:
Rating: E= Essential; D= Desirable.

59.1 Assessment and treatment are offered without unacceptable delay D

59.2 There are appropriate arrangements for young people at weekends E

59.3 Any restrictions on admissions to the unit are matched by alternative resources D

59.4 There is adequate, local provision of a range of domiciliary, community and day services so that young people are not admitted to in-patient units inappropriately D

59.5 The in-patient unit is in an accessible location for the population served to allow family contact and interventions D

- ***Ref 109:*** *standards 3.2, "The service is provided in an accessible location for the population served".*

59.6 There are regular meetings between unit staff and representatives from all relevant agencies responsible for commissioning the service D

- ***Ref 105:*** *point 7.4, "High quality commissioning is vital for CAMHS. Hence commissioners need the appropriate skills, knowledge, time and authority to commission effectively."*
- ***Ref 114:*** *"Active involvement of commissioning authority".*
- ***Ref 109:*** *standard 5.1, "The service participates in a multi-agency group with representatives from all relevant agencies (including trusts and local authorities) responsible for commissioning CAMHS across all four tiers."*

59.7 The service contributes to a local audit of elements of a comprehensive CAMHS and the mapping of existing services, according to the Department of Health four-tiered model D

- ***Ref 109:*** *standard 5.6*

Section 8: Location within a Public Health Context

Standard:

60 The in-patient unit contributes to effective multi-disciplinary and multi-agency working, between health, education, and social services

Criteria:
Rating: E= Essential; D= Desirable.

- ***Ref 63***
- ***Ref 105:*** *point 7.7, "There should be effective joint working between services and smooth transitions between tiers and services when required"*
- ***Ref 108:*** *point 1.3,"Good inter-agency collaboration exists at the provider level"*

60.1 In-patient services contribute to the development of Children's Service Plans, together with all relevant agencies, youth justice, probation services and the voluntary sector — E

60.2 There is close collaboration with education services — E

- ***Ref 106:*** *"Child psychiatrists should collaborate more effectively with teachers to promote mental health and manage children with behavioural and psychological problems"*

60.3 There are regular meetings with local authority residential services, e.g. the unit offers advice, supervision and training — D

60.4 The unit is aware of and able to provide information about other types of services available in its locality, in particular about possible sources of support for young people and families post-discharge — D

- ***Ref 123:*** *pg.22, "Inpatient CAMHS should be aware of and able to provide information about other types of service available in their locality, in particular about possible sources of support for young people and families post-discharge."*

Standard:

61 The in-patient unit liases effectively within the Health Service and has a good working relationship between disciplines, departments and levels of care

Criteria:
Rating: E= Essential; D= Desirable.

61.1 The in-patient team meets regularly with the paediatric team where in-patient treatment is provided on paediatric wards — D

- ***Ref 73:*** *pg.39, "Insufficient bed numbers generate unacceptably high occupancy levels causing tension, frustration and over-stretched staff, leading to increased behavioural disturbance…."*

61.2 The in-patient team meets regularly with the senior managers — D

61.3 The in-patient team work closely with general paediatric, children's, and adult psychiatry services, e.g. there are joint protocols — D

Section 8: Location within a Public Health Context

Criteria continued:

- ***Ref 105:*** *Annex C, "Where interfaces exist between services, as between adult and children's mental health services, arrangements should be negotiated to ensure clarity and effectiveness of separate and joint service responsibilities and smooth transitions of care"*

61.4	There are close links with other sub-specialities, for example substance misuse, learning disability services and forensic services	D
61.5	Joint training is an ongoing activity	D
61.6	Joint budget pooling exists across health and social services, e.g. for training	D
61.7	There are joint protocols between the unit and adult mental health services to ensure collaborative working and joint provision where appropriate	D

- ***Ref 107:*** *point 7.8, "Protocols between CAMHS and Adult Mental Health to ensure collaborative working and joint provision, where appropriate".*

Bibliography Year 1

The key documents referenced in the standards are not intended to be a definitive list but rather a guide for further reading.

1. **Action for Sick Children (1996)** *Health Services for Children and Young People.* Action for Sick Children.
2. **Association of Therapeutic Communities (2001)** *Kennard-Lees Audit Checklist II (2001)* London: Association of Therapeutic Communities.
3. **Audit Commission: National report (1999)** *Children in mind*: *Child and adolescent mental health services.* Oxon: Audit Commission Publications.
4. **Briggs-Gowan, M.J., McCue-Horowitz, S, *et al* (2000)** Mental Health in Paediatric Settings: Distribution of Disorders and Factors Related to Service Use. *Journal of the American Academy of Child and Adolescent Psychiatry.* **39/7,** 841-849.
5. **Charterhouse Group (2000)** *Standards and Criteria for Therapeutic Community Childcare, Health and Education.* Charterhouse Group
6. **Children Act 1989**. London: HMSO.
7. **Clinical Standards Board for Scotland (2001)** *Clinical Standards for Schizophrenia: Self-Assessment Manual and Self-Assessment Tool.* Edinburgh: Clinical Standards Board for Scotland.
8. **Commission for Health Improvement (CHI) (2001)** *Clinical Governance Reviews: Review Issues.* Commission for Health Improvement.
9. **Department for Education and Employment (1996)** *The Education (Areas to which Pupils and Students Belong) Regulations 1996.* London: Department for Education and Employment.
10. **Department of Health (1990)** *Access to Health Records Act 1990.* London: HMSO
11. **Department of Health (1992)** *Choosing with Care: The Report of the committee of inquiry into the selection, development and management of staff in children's homes.* London: HMSO.
12. **Department of Health (1992)** *Health of the Nation White Paper*. London: Department of Health.
13. **Department of Health, Local Authority Circular 10/Department for Education National Health Service Executive Circular 24 (1994)** *The Education of Sick Children.* London: Department of Health.
14. **Department of Health (1995)** *Health of the nation: A handbook on child & adolescent mental health services*. London: HMSO.
15. **Department of Health (1996)** *Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people*. London: Department of Health.
16. **Department of Health: (1996)** *NHS Indemnity: Arrangements for Clinical Negligence Claims in the NHS.* London: Department of Health.
17. **Department of Health (1996)** *Services for the Mental Health of Children and Young People: Assessment of Needs and Unmet Need.* London: Department of Health.
18. **Department of Health (1996)** *The Patient's Charter: Services for Children and Young People*. London: Department of Health.

Bibliography continued

19. **Department of Health (1997)** *People Like us: The Report of the Review of the Safeguards for Children Living Away From Home.* London: HMSO.
20. **Department of Health (1998)** *Executive Summary-The New NHS.* London: Department of Health.
21. **Department of Health (1998)** *Modernising Mental Health Services: Executive Summary.* London: Department of Health.
22. **Department of Health (1998)** *Modernising Mental Health Services: Promoting independence, Improving Protection, Raising Standards*. London: Department of Health.
23. **Department of Health (1998)** *Modernising Mental Health Services: Safe, sound and supportive.* London: HMSO.
24. **Department of Health (1998)** *Modernising Social Services: Executive Summary*. London: Department of Health.
25. **Department of Health (1998)** *Quality Protects - Framework for Action*. London: Department of Health.
26. **Department of Health (1998)** *Quality Protects - Objectives for Social Services for children*. London: Department of Health.
27. **Department of Health (1998)** *Quality Protects – Programme - Transforming Children's Services.* London: Department of Health.
28. **Department of Health/NHS Executive (1999)** *Clinical Governance - Quality in the new NHS.* London: Department of Health.
29. **Department of Health (1999)** *Clinical Standards Advisory Group: Services for Patients with Depression*. London: Department of Health.
30. **Department of Health (1999)** *Convention on the Rights of the Child: Second Report to the U.N Committee on the Rights of the Child by the United Kingdom 1999 Executive Summary.* London: Department of Health.
31. **Department of Health (1999)** *A First Class Service - Feedback on consultations.* London: Department of Health.
32. **Department of Health (1999)** *A First Class Service – Quality in the New NHS.* London: Department of Health.
33. **Department of Health (1999)** *Government's objectives for Children's Social Services.* London: Department of Health.
34. **Department of Health and Welsh Office (1999)** *Mental Health Act 1983 Code of Practice.* London: HMSO
35. **Department of Health (1999)** *Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children.* London: Department of Health.
36. **Department of Health (1999)** *Modernising Social Services: Implementation Diary*. London: Department of Health.
37. **Department of Health (1999)** *National Service Framework for Mental Health: Modern Standards and Service Models.* London: HMSO.
38. **Department of Health (1999)** *The Personal Social Services Performance Assessment Framework.* London: Department of Health.
39. **Department of Health (1999)** *Reform of the Mental Health Act 1983, Proposals for Consultation.* London: Department of Health.
40. **Department of Health (1999)** *Report of the NHS Taskforce on Staff Involvement*. London: Department of Health.
41. **Department of Health (1999)** *Social Services Performance in 1998-1999*. London: Department of Health.

Bibliography continued

42. **Department of Health (1999)** *Still Building Bridges: The Report of a National Inspection of arrangements for the inspection of care programme approach with care management.* London: Department of Health
43. **Department of Health (1999)** *Working Together to Safeguard Children.* London: HMSO.
44. **Department of Health (2000)** *Children and Young People on Child Protection Registers.* London: Department of Health.
45. **Department of Health (2000)** *Safety, privacy and dignity in mental health units: Guidance on mixed sex accommodation for mental health services.* London: Department of Health.
46. **Department of Health (2000)** *Protection of Children Act 1999 Consultation Draft: A practical guide to the Act for all organisations working with children.* London: Department of Health.
47. **Department of Health (2001)** *National Minimum Standards for Children's Homes: Consultation document.* London: Department of Health.
48. **Goldberg, D. (2000)** Findings from 'London's Mental Health': a service in crisis. *Acta Psychiatrica Scandinavica* **101,** (57-60).
49. **Health Advisory Service (HAS 2000)/Substance Misuse Advisory Service (2000)** *Commissioning Standards: Drug and Alcohol Treatment and Care.* London: Health Advisory Service.
50. **Health Advisory Service (HAS 2000) (2000)** *Standards for Child & Adolescent Mental Health Services*. Pavilion Publishing.
51. **Health Advisory Service (HAS 2000) (2000)** *Child and Adolescent Services: Safeguards for young minds: Young people and Protective Legislation.* London: Health Advisory Service.
52. **Health Quality Service/National Children's Bureau (2000)** *Child and Adolescent Mental Health Service Standards.* Health Quality Service/National Children's Bureau.
53. **Health & Safety Executive (1992)** *Workplace Health Safety and Welfare: a short guide for managers*. Health & Safety Executive.
54. **Healy, E., Fitzgerald, M. (2000)** A 16-year follow-up of a child inpatient unit. *European Child & Adolescent Psychiatry*. **9**, 46-53.
55. **Home Office (1991)** *Working Together under the Children Act 1989.* London: HMSO
56. **Local Authority Circular (1993)** *Guidance on permissible forms of control in children's residential care.*
57. **Mental Health Act 1983**. London: HMSO.
58. **Mental Health Act Commission (1999)** *Eight Biennial Report.* London: HMSO.
59. **Mental Health Foundation (1999)** *Bright Futures Policy Events: Summary of the key Government documents relevant to the recommendations in the Bright Futures Report.* Mental Health Foundation.
60. **McCulloch, A., Muijen, M., Harper, H., (2000)** New Developments in Mental Health Policy in the United Kingdom. *International Journal of Law and Psychiatry.* **23/3-4,** 261-276
61. **NHS Health Advisory Service (1986)** *Bridges over Troubled Waters: A report from the NHS Health Advisory Service on services for disturbed adolescents*. London: HMSO
62. **NHS Health Advisory Service (HAS)/Mental Health Act Commission/Department of Health Social Services Inspectorate (1994)** *A Review of the adolescent forensic psychiatry service-based on the Gardener Unit, Prestwich Hospital, Salford, Manchester.* London: Health Advisory Service.
63. **NHS Health Advisory Service (HAS) (1995)** *Child and Adolescent Mental Health Services-Together we stand.* London: HMSO.

Bibliography continued

64. **Nicol, R., Stretch, D., Whitney, I., *et al* (2000)** Mental health needs and services for severely troubled and troubling young people and including young offenders in an NHS region. *Journal of Adolescence.* **23,** 243-261.
65. **Outcome of Social Care for Adults (OSCA)/Carers' and Users' Expectations of Services (CUES)** *CUES Questionnaire: Service User Version.* London: CUES.
66. **Patton, G.C., Glover, S.L., Bond, H.B., *et al*** The Gatehouse Project: A systematic approach to mental health promotion in secondary schools. *Australian and New Zealand Journal of Psychiatry.* **34,** 586-593.
67. **Royal College of Psychiatrists (1992)** *Mental Health of the Nation: the Contribution of Psychiatrists.* London: Royal College of Psychiatrists.
68. **Royal College of Psychiatrists (1993)** *Child Psychiatry and Sexual Abuse. Council Report CR24.* London: Royal College of Psychiatrists.
69. **Royal College of Psychiatrists (1993)** *Code of Practice for the Use of Video Recording in Child Psychiatric Practice.* London: Royal College of Psychiatrists.
70. **Royal College of Psychiatrists (1994)** *The Treatment of Perpetrators of Child Sexual Abuse: Council Report CR31.* London: Royal College of Psychiatrists.
71. **Royal College of Psychiatrists (1998)** *Guidance for Videotaping.* London: Royal College of Psychiatrists.
72. **Royal College of Psychiatrists (1998)** *Management of Imminent Violence.* London: Royal College of Psychiatrists.
73. **Royal College of Psychiatrists (1998)** *Not just Bricks and Mortar: Report of the Royal College of Psychiatrists Working Party on the Size, Staffing, Structure, Siting and Security of New Acute Adult Psychiatric In-Patient Units. Council Report CR62.* London: Royal College of Psychiatrists.
74. **Royal College of Psychiatrists (2001)** *Clinical Governance Standards.* London: Clinical Governance Support Service.
75. **Royal College of Psychiatrists (1999)** *Clinical Governance Support Service: Information Sheet 10: National Quality Organisations*. London: Royal College of Psychiatrists.
76. **Royal College of Psychiatrists (1999)** *FOCUS - An Introduction to Service Evaluation in Child and Adolescent Mental Health Services* London: FOCUS.
77. **Royal College of Psychiatrists (1999)** *FOCUS - Treatment Decisions in Young People-The Legal Framework.* London: FOCUS.
78. **Royal College of Psychiatrists (1999)** *Guidance on Staffing of Child & Adolescent In-patient Psychiatry Units.* London: FOCUS
79. **Royal College of Psychiatrists (2000)** *FOCUS - Nursing Children and Adolescents with Mental Health Problems-An Agenda for Action; Conference Proceedings.* London: FOCUS
80. **Royal College of Psychiatrists (2000)** *Good Psychiatric Practice: Council Report CR83.* London: Royal College of Psychiatrists.
81. **Sainsbury Centre for Mental Health (2001)** *The Capable Practitioner: A framework and list of the practitioner capabilities required to implement The National Service Framework*. London: Sainsbury Centre.
82. **Sawyer, M.J., Kosky, R.J., Graetz, B.W., et al (2000)** The National Survey of Mental Health and Wellbeing: the child and adolescent component. *Australian and New Zealand Journal of Psychiatry.* **34**, 214-220.
83. **United Kingdom Centre for Nursing, Midwifery and Health Visiting (2000)** *Guidelines for the administration of medicine*. London: UKCC.
84. **Wallace, S., Crown, J.M, Cox, A.D., Berger, M. (1997)** *Child and Adolescent Mental Health: Health Care Needs Assessment – The epidemiologically based needs assessment reviews.* Radcliffe Medical Press.

Bibliography continued

85. **Wyn, J., Cahill H., Holdsworth R., et al (2000)** MindMatters, a whole - school approach promoting mental health and wellbeing. *Australian and New Zealand Journal of Psychiatry*. **34**, 594-601.

Bibliography Year 2

86. **Audit Commission: National Health Service Report No. 7 (1993)** *Children First: A Study of Hospital Services.* London: HMSO
87. **Commission for Health Improvement (2002)** *CHI Ward-based and Clinical Team Self-Assessment tools updated May 2002.*
88. **Department of Health (2000)** *Effective care co-ordination in mental health services: Modernising the care programme approach - A policy booklet.* London: Department of Health
89. **Department of Health (2002)** *National Minimum Standards and Regulations for Children's Homes* London: Department of Health
90. **Department of Health (2002)** *National Minimum Standards and Regulations for Independent Health Care - Mental Health Establishments.* London: Department of Health
91. **Department of Health (2002***) National Minimum Standards - Care Homes for Younger Adults and Adult Placements.* London: Department of Health
92. **Furlong S and Ward M (1997)**. *Assessing patient dependency and staff skill mix*. Nursing Standard;11: 33-38
93. **Hospital Accreditation Programme (1999)** *Standards for Accreditation (4th Ed).* CASPE Research, London.
94. **Independent Health Care Association Consultation (2002)** *Independent Health Care Association Consultation.* London: IHA **(notes held by QNIC)**
95. **The National Assembly for Wales (2002).** *Too serious a thing: The review of safeguards for children and young people treated and cared for by the NHS in Wales (The Carlile Review).* Cardiff: National Assembly for Wales.
96. **O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., Brook, H., Scott, A., White, R., Nikolaou, V. & Lelliott, P. (2001)** *National In-Patient Child and Adolescent Psychiatry Study (NICAPS).* Final Report to the Department of Health. London: Royal College of Psychiatrists' Research Unit.
97. **Street C and Svenberg J (2002)** *Consultation with Young People Report.* London: YoungMinds (Consultation commissioned by QNIC, where the report is held)

Bibliography Year 3

98. **Ahmed, Y., Dalrymple, J., Daum, M., Griffiths, N., Hockridge, T., Ryan, E. (2003)** *Listening to Children and Young People.* UWE Bristol, Faculty of Health and Social Care. (http://www.southglos.gov.uk/acrobat/SocialServices/ListeningtoChildrenQ.pdf)
99. **Commission for Health Improvements (CHI) (2004)** *Key Targets for the Star Ratings 2004/05: Ket Targets for Mental Health Trusts.* Commission for Health Improvement. (http://www.chi.nhs.uk/eng/ratings/2005/2005mentalhealth_KT.pdf)
100. **Corbett, K., Evans, M. (2002)** *Improving Inpatient Child and Adolescent Mental Health Services in the West Midlands: Tier 4 CAMHS A Strategy for Consultation.* NHS.
101. **Department for Education and Skills (DfES) (2003)** *Every Child Matters - Summary.* Department for Education and Skills. (http://www.dfes.gov.uk/everychildmatters/summary.cfm)
102. **Department of Health (2000)** *Improving Working Lives: Evidence Matrix.* Department of Health.
103. **Department of Health (2003)** *What to do if you're worried a child is being abused: Children's service guidance.* Health Service Circular: Department of Health. (http://www.dh.gov.uk/assetRoot/04/06/97/81/04069781.pdf)
104. **Department of Health (2004)** *Standards for Better Health: Health Care Standards for Services under the NHS.* Department of Health.
105. **Department of Health (2004)** *Getting the right start: National Service Framework for Children Emerging Findings.* Department of Health. (http://www.dh.gov.uk/assetRoot/04/07/53/37/04075337.pdf)
106. **Ford, T., Nikapota, A. (2000)** Teachers' attitudes towards child mental health services. *Psychiatric Bulletin*, **24**, 457-461.
107. **Foster, B. (2003)** *National CAMHS Support Service: Assessment Matrix for a Comprehensive CAMHS (Draft).* National CAMHS implementation team.
108. **Health and Social Care Advisory Service (HASCAS) (2000)** *The HASCAS CAMHS Standards.* Health and Social Care Advisory Service.
109. **Health Quality Service (HQS) (2004)** *Health Quality Standards for CAMHS: CAMHS pre-survey assessment form*. Health Quality Service.
110. **Home Office (2003)** *The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming.* HMSO. (http://www.victoria-climbie-inquiry.org.uk/finreport/report.pdf)
111. **Investors in People (1991)** *Investors in people: The Standard.* Investors in People UK. (http://www.iipuk.co.uk/IIP/Internet/InvestorsinPeople/TheStandard/Default.htm)
112. **Morgan, R. (2003)** *Children's Views on What Inspectors Should Do - Report of the Children's Rights Director.* National Care Standards Commission (NCSC). (http://www.csci.org.uk/publications/childrens_rights_director_reports/childrens_views_what_inspectors_should_do.pdf)
113. **National Assembly for Wales (2001)** *Child and Adolescent Mental Health Services: Everybody's Business.* Primary & Community Healthcare Division, National Assembly for Wales.
114. **National Care Standards Commission (NCSC) (2003)** *Best Practice Guidelines on the Operation and Management of Registered Care Homes for People with Learning Disabilities who present significant challenges.* NCSC Policy group.

Bibliography continued

115. **New Zealand Standard (2004)** *Health and Disability Sector Standard (Children and Young People) Audit Workbook [Public Comment Draft].* New Zealand Standard. (http://spex.standards.co.nz/drafts.jsp)
116. **South West Drug Services Audit Project (2000)** *Standards for Drug Services 2000/01.* Bristol: NHS.
117. **Shaw, M. (2001)** Competence and consent to treatment in children and adolescents. *Advances in Psychiatric Treatment*, **7**, 150-159.
118. **Weller, P. (2003)** *Mental Health and Learning Disability Working Group: Report from the User Consultation Events.* Clinical Negligence Scheme for Trusts (CNST).
119. **Williams, R (2004)** *Safeguards for Young Minds: Young people and protective legislation* (second edn). London: Gaskell.
120. **Wolpert, M. et al. (2003)** *Emerging findings of outcomes subgroup of child and adolescent mental health external working group contributing to the development of the children's national service framework (NSF).* Outcomes sub-group of the child and adolescent mental health and emotional well being external working group. (http://www.dh.gov.uk/assetRoot/04/03/28/07/04032807.pdf)
121. **Worrall, A. (2002)** *Clinical Governance Standards for Mental Health and Learning Disability Services. Enabling Front-line Staff: Turning clinical governance strategies into practice.* CGSS, Royal College of Psychiatrists Research Unit.
122. **YoungMinds (2000)** *Whose crisis? Meeting the needs of children and young people with serious mental health problems.* London: YoungMinds.
123. **YoungMinds (2002)** *Towards a new adolescent mental health service. Outline of Report 2 - Provision of Adolescent Inpatient Care: Views from Young People, Families and Staff.* London: YoungMinds.

Appendix A – Acknowledgements

Standards Working Group – 21st January 2004

Paul Abeles (Chartered Clinical Psychologist, Booth Hall Children's Hospital)
Ottilie Dugmore (Research Worker QNIC, CRU)
Kevin Epps (Clinical Psychologist, Ardenleigh)
Judith Glancy (Approved Social Worker, Gardener Unit)
Caroline Harrison (Unit Manager, Snowsfield Adolescent Unit)
Emma Hartwell (Research Worker QNIC, CRU)
Dean Holyoake (Nurse Consultant, Priory Group)
Anne Jasper (Director of Forensic CAMHS, Ardenleigh)
Paul Lelliott (Consultant Psychiatrist/Director of the CRU)
Cesar Lengua (Consultant Psychiatrist, Roycroft)
Sean Maskey (Consultant Psychiatrist, Oak View)
Dionne Monarch (Senior Occupational Therapist, Snowsfield Adolescent Unit)
Lucy Palmer (Project Manager QNIC, CRU)
Pam Richold (Quality Officer, Northgate and Prudhoe NHS Trust)
Duncan Riley (Social Worker, Simmons House)
Angela Robinson (Nurse Consultant, Roycroft)
Ged Rogers (Lead Nurse, Lowther Adolescent Service)
Pete Russell (Charge Nurse, West End Children's Unit)
Toni Scales (Service Manager CAMHS, Longview Adolescent Unit)
Linda Scott-Brown (Unit Manager, West End Children's & Adolescent Units)
Angela Sergeant (Nurse Consultant, Leigh House Hospital)
Janine Smith (Unit Manager, Thorneywood Adolescent Unit)
Andy Stephenson (Charge Nurse, West End Adolescent Unit)
Sean Welsh (Clinical Nurse for Practice Development, Gardener Unit)
Adrian Worrall (Programmes Manager, CRU)
Jane Yeandle (Consultant Clinical Psychologist, Orchard Lodge)

Consultation Responses

Derek Henderson (Senior Nurse, Northgate & Prudhoe NHS Trust)
Greg Richardson (Consultant Psychiatrist, Limes Trees Unit)
Tony Jaffa (Consultant Psychiatrist, Phoenix Centre)
Janine Smith (Unit Manager, Thorneywood Adolescent Unit)
Tim Hawkins (Specialist Registrar, Young People's Centre, Mount Gould)
Tracey Knights (Unit Manager, The Priory Hospital Bristol)
Tony Livesey (Consultant Psychiatrist, Oakwood Young People's Centre)
Caroline Lambert (Ward Manager, Parkview Clinic, Heathlands Unit)
Andy Stephenson (Charge Nurse, West End Adolescent Unit)

Appendix B – QNIC Executive Committee

QNIC Executive Committee for 2005:

Dr Greg Richardson
Child and Adolescent Psychiatrist

Dr Tony Jaffa
Child and Adolescent Psychiatrist

Dr Sean Maskey
Child and Adolescent Psychiatrist

Mrs Angela Sergeant
Clinical Nurse Specialist in CAMHS

Dr Dean Holyoake
Nurse Consultant

Dr Anne Williams
Clinical Psychologist

Dr Peter Morris
Clinical Psychologist

Mr Guy Larrington
Social Worker

Professor Paul Lelliott
Consultant Psychiatrist/Director of the CRTU

Mr Adrian Worrall
Network Programmes Manager

Ms Lucy Palmer
QNIC Project Manager

Mr Peter Thompson
QNIC Project Manager

Ms Helen Thurley
QNIC Project Worker

Ms Amber Shingleton-Smith
QNIC Project Worker

Appendix C – QNIC Standards Feedback Form

We hope you have found the QNIC standards useful and would now very much appreciate your feedback. Your comments will be incorporated, with the approval of QNIC members, into future editions of this publication.

1. Have you found these standards useful? ☐ Yes ☐ No

Comments:

2. Do you have suggestions for new sections/topic areas or new standards or criteria you would like to see included in future versions?

4. Do you have any general suggestions about this document that would improve its usefulness?

5. What is your profession?

Thank you for taking the time to complete this form. Your comments will be considered carefully.

Please photocopy and return to: QNIC, Royal College of Psychiatrists' Research Unit, 4th Floor, Standon House, 21 Mansell Street, London E1 8AA. Fax: 020 7977 6693

Appendix D – QNIC Standards Order Form

Further copies of these standards can be obtained by photocopying and completing the form below:

☐ I would like to order _____ copies of the QNIC Standards at **£10** each

Title:(Dr, Mr, Mrs, Ms etc.):

First name:

Surname:

Job Title:

Organisation Name:

Address:

Postcode:

Tel:

Fax/E-mail:

Please indicate your preferred method of payment:

a) I enclose a cheque for £_____ made payable to 'The Royal College of Psychiatrists'

b) Please invoice my organisation for £_____

Today's Date:_____/_____/_____

Signed: _____

PLEASE RETURN TO: QNIC, The Royal College of Psychiatrists' Research and Training Unit, 4th Floor, Standon House, 21 Mansell Street, London E1 8AA.

Tel: 020 7977 6691/92/93. Fax: 020 7481 4831. E-mail: hthurley@cru.rcpsych.ac.uk

Quality Network for In-Patient CAMHS (QNIC)
Royal College of Psychiatrists' Research and Training Unit
4th Floor
Standon House
21 Mansell Street
London E1 8AA
Telephone: 020 7977 6691/92/93
Fax: 020 7481 4831

Charity Registration Number 228636
http://www.rcpsych.ac.uk/cru