QUALITY NETWORK FOR OLDER ADULTS MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Older Adult Mental Health Services 5th Edition

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A manual of standards written primarily for:

Older adult inpatient mental health services.

Also of interest to:

Patients, carers, commissioners, policy makers, and researchers.

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www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/older-adults-mental-health-services

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Foreword

I am delighted to introduce to you the 5th edition of Standards for the Quality Network for Older Adult Inpatient Mental Health Services.

The impetus for improving the quality of inpatient services for older adults has been gaining momentum and the publication of two key documents in the last year has helped focus the efforts of healthcare services in this area. *The NHS Long Term Plan Implementation Framework (June 2019)*, and *Delivering the NHS Long-Term Plan's ambition of ageing well: Old age psychiatry as a vital resource* (October 2019), published by the Royal College of Psychiatrists' Faculty of Old Age Psychiatry highlight the importance of specialist mental health services for Older People. In a healthcare sector where demand is rapidly outpacing provision, quality improvement across mental health services for older adults is now more important than ever, to improve and sustain high standards of care across all older adult mental health inpatient services and to ensure that the right resources are available for those who need them.

To this end, this latest edition of the standards for the Quality Network for Older Adult Inpatient Mental Health services support the provision of personalised, high quality, evidence-based care to patients within older adult inpatient units, enabling healthcare professionals to strive for best practice within these settings. The standards will promote consistency in the delivery of care across services, through benchmarking and review processes and encourage high standards of care and innovation within older adult services.

The development of these standards has involved extensive consultation with a range of stakeholders, including various multidisciplinary experts, service users and carers, and incorporates NICE guidance while aligning with the expectations set through CQC regulation.

The Quality Network for Older Adults Mental Health Services is committed to promoting, maintaining and developing high quality older adult services nationally and the opportunity to be a part of a national network of peers will

support members to share and develop best practice while providing resources to enhance and improve.

I would like to express my appreciation and gratitude to everyone who has contributed to the development of these standards and to all the members of the network for their ongoing support.

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Introduction

The Quality Network for Older Adult Mental Health Services (QNOAMHS) works with wards and units providing services to older people to assess and improve the quality of care they provide. QNOAMHS engages staff, patients and their carers in a comprehensive process of self and peer review to enable services to identify areas of good practice and areas for development. Member services are encouraged to use peer review visits, and other member events, to share knowledge and ideas with others, thereby creating a mutually supportive environment which encourages learning, and leads to positive change. QNOAMHS also offers accreditation for those members who can demonstrate a high level of compliance with the standards.

The 5th edition standards are drawn from key documents and expert consensus, as well as from the 4th edition, and work completed within the College Centre for Quality Improvement (CCQI.) The standards have been subject to extensive consultation with multidisciplinary professionals involved in the provision of inpatient mental health services, and with experts by experience and carers who have used services in the past.

Who are these standards for?

These standards are for service providers and commissioners of mental health services to help them ensure they provide high quality care to older adults experiencing mental illness and their carers. It is recognised that the 'older adults' umbrella covers a range of services and presenting problems. Most of these standards are applicable to all older adult services, however where a specific standard does not relate to a service, this will be scored as not applicable.

How to Read this Document

Standard Category

The full set of standards and criteria is aspirational, and it is unlikely that any service would meet all of them on the day of their accreditation visit.

To provide support in their use during the accreditation process, each standard has been categorised as follows:

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

Type 2 Standards that a service would be expected to meet.

Type 3 Standards that are aspirational or standards that are not the direct responsibility of the service.

To achieve accreditation services are required to meet 100% of type 1, 80% of type 2 and 60% of type 3 standards.

For reference purposes, the standards which either reflect or reference the core standards have their original core numbering in italics.

The key below can be used to help identify modified and new standards in this edition.

Key	**M**	Standard **modified** since last edition
	N	**New** standard since last edition

Sustainability Principles

The 5th edition QNOAMHS standards have been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee.

www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put the mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a focus on reducing the impact on the environment and the resources used in delivering health interventions. A Sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013.) In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.'

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability, i.e., the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health.)

2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care, e.g., emails instead of letters, tele-health clinics instead of face-to-face contacts. Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective team working facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

Services that meet 90% or more of the standards relevant to Sustainability Principles (marked with the logo, left) will be awarded a Sustainable Service Accreditation certification in recognition of provision of a sustainable mental health service.

Sustainability will automatically be examined alongside the usual review process and services will not have to submit extra evidence for this. Whether a service is awarded the sustainability certification or not will **not** affect the accreditation status of the service.

A range of guidance reports and papers has already been developed by the College to help improve the sustainability of mental health care. Please see below for further information:

- Guidance for commissioners of financially, environmentally, and socially sustainable mental health services
  https://www.jcpmh.info/good-services/sustainable-services/

- Choosing Wisely – shared decision making
  http://www.rcpsych.ac.uk/healthadvice/choosingwisely.aspx

- Centre for Sustainable Healthcare
  https://sustainablehealthcare.org.uk/

- Psych Susnet
  https://networks.sustainablehealthcare.org.uk/network/psych-susnet

Standards

NUMBER	TYPE	STANDARD	Ref.
WARD/UNIT ENVIRONMENT			
1.1	**1**	Male and female patients have separate bedrooms, toilets and washing facilities. *Core 17.1*	4, 14, 57
1.2	**2**	All patients have single bedrooms. *Core 17.2*	4, 57
1.3 M	**2**	Patients are able to personalise their bedroom spaces. *Guidance: This may include putting up photos and pictures.* *Core 17.3*	4, 10
1.4	**2**	The ward/unit has at least one bathroom/shower room for every three patients. Core 17.4	4, 10
1.5	**3**	Every patient has an ensuite bathroom. *Core 17.5*	4, 10

1.6 M	**1**	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room, access to groups. *Core 17.6*	4
1.7	**2**	All patients can access a range of current culturally-specific resources for entertainment, which reflect the ward/unit's population. *Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.* *Core 17.7*	4, 10, 24, 58, 59
1.8	**3**	All patients can access a charge point for electronic devices such as mobile phones. *Core 17.8*	4
1.9	**1**	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.* *Core 17.9*	4, 10, 54, 60
1.10 M 	**1**	The ward is a safe environment with no ligature points, clear sightlines (e.g. with use of mirrors) and safe external spaces. *Core 17.12*	4, 10
1.11 M	**1**	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. *Core 17.3*	4, 10, 35

1.12 M	**1**	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms and there is an agreed response when an alarm is used. *Core 17.14*	4, 10, 14
1.13	**2**	Staff members and patients can control heating, ventilation and light. *Guidance: For example, patients are able ventilate their rooms through the use of windows, they have access to light switches and they can request adjustments to control heating.* *Core 17.15*	22
1.14 M	**1**	Emergency medical resuscitation equipment is available immediately, and is maintained and checked weekly, and after each use. *Core 17.16*	61
1.15	**2**	The ward/unit has a designated room for physical examination and minor medical procedures. *Core 17.17*	4, 10
1.16	**1**	In wards/units where seclusion is used, there is a designated room that meets the following requirements: • it allows clear observation; • it is well insulated and ventilated; • it has adequate lighting, including a window(s) that provides natural light; • it has direct access to toilet/washing facilities; • it has limited furnishings (which includes a bed, pillow, mattress and blanket or covering); • it is safe and secure – it does not contain anything that could be potentially harmful; • it includes a means of two-way communication with the team; • it has a clock that patients can see. *Core 17.18*	10, 13

1.17	**2**	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms. *Core 17.19*	4, 10
1.18	**2**	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. *Core 17.21*	4, 62
1.19	**2**	Ward/unit-based staff members have access to a dedicated staff room. *Core 17.23*	4, 10
1.20 M	**1**	Staff members are easily identifiable, and for wards that admit patients living with dementia, identification should be dementia friendly.	22, 36
1.21	**1**	The dining area is big enough to enable patients to eat in comfort and to encourage social interaction, and enable staff to engage with, support and observe patients during mealtimes.	22, 36
1.22	**1**	Mealtimes are protected and should not be disrupted by routine ward tasks or activities.	22, 36

1.23	**1**	There is a range of the following that is appropriate to the needs of the resident population: • specialist feeding aids and/or supports; • food consistencies and supplements to meet assessed needs, such as soft, pureed and finger foods, thickened fluids, and dietary supplements.	22, 36
1.24	**1**	Wards that admit patients living with dementia have a dementia-friendly environment/layout. *Guidance: Corridors and artwork should be chosen with thoughtful use of colour, lighting and regular resting points. Install contrasting coloured toilet seats and grab rails. Maximise views of nature and when possible allow safe access to gardens.*	22, 36
1.25 M	**1**	Staff ensure that all patients wear their own clothing and footwear.	22, 36
1.26 M	**1**	There is a system in place on the ward to ensure, where appropriate, that patients: • are provided with a ready supply and an appropriate range of continence management aids; • have individualised toothbrushes, toothpaste and/or dentures and denture pots, and these are kept safe; • are wearing working hearing aids and glasses, where required.	22, 36
1.27 M	**1**	Patients have access to the following well-maintained equipment depending on clinical need; • wheel chairs; • ultra-lowering beds; • walking aids; • equipment to relieve and care for pressure ulcers and sores.	22, 36
1.28	**1**	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	14, 56

ADMISSION, LEAVE, AND DISCHARGE

Access			
2.1 N	**1**	The service provides information about how to make a referral. *Core 1.1*	1, 2, 3, 4, 5, 6
Admission – First 12 Hours			
2.2.1	**1**	On admission to the ward/unit, patients feel welcomed by staff members who explain why they are in hospital. *Guidance: Staff members show patients around and introduce themselves and other patients; Offer patients refreshments; Address patients using the name and title they prefer.* *Core 2.1*	4, 10, 11
2.2.3	**1**	The patient's carer is contacted by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details. *Core 2.2*	4
2.2.4 M	**1**	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: • their rights regarding admission and consent to treatment; • their rights under the Mental Health Act; • how to access advocacy services, a second opinion, interpreting services, and their records; • how to raise concerns, complaints and compliments. *Core 2.3*	4, 6, 12, 13, 14, 15, 55

2.2.5 M	**1**	Patients have an initial mental health assessment which is started within 4 hours and completed within 1 week. This involves the multi-disciplinary team, and includes patients': • mental health and medication; • psychosocial and psychological needs; • strengths and areas for development; • where clinically indicated, a diagnostic assessment of depression, dementia, and delirium. *Core 2.4*	4, 12, 15, 16, 36
2.2.6 M	**1**	Patients have a comprehensive physical health review. This is started within 4 hours of admission, or as soon as is practically possible. The assessment is completed within 1 week, or prior to discharge. *Guidance: Where the patient is unable to provide input into the assessment carers and/or friends and family are involved.* *Core 2.5*	4, 17, 18, 39
2.2.7 M	**1**	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality.) The assessment considers risk to self, risk to others, and risk from others. The team reviews and updates care plans according to clinical need and at least every four weeks. *Core 2.6*	4, 6, 19, 20
2.2.8 M	**1**	On admission the following is given consideration: • the security of the patient's home; • arrangements for dependants (children, people they are caring for); • arrangements for pets; • essential maintenance of home and garden. *Core 2.7*	10

2.2.9 N	**1**	People admitted to the ward outside the area in which they live have a review of their placement at least every 3 months. *Core 2.8*	5
2.2.10 N 	**1**	All patients are offered a complete examination for physical comorbidities.	46
Completing the admission process			
2.3.1 M	**1**	The patient is given an information pack on admission that contains the following: • a description of the service; • the therapeutic programme; • information about the staff team; • the unit code of conduct; • key service policies (e.g. permitted items, smoking policy); • resources to meet spiritual, cultural or gender needs. *Guidance: Staff members explain the main points of the welcome pack to the patient and ask if they need further information on anything explained.* *Core 3.1*	4, 14, 21, 55
Leave from the ward/unit			
2.4.1 M	**1**	The team and patient jointly develop a leave plan, which is shared with the patient, that includes: • a risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • conditions of the leave; • contact details of the ward/unit and crisis numbers. *Core 5.1*	4, 26

2.4.2 M	**1**	Staff agree leave plans with the patient's carer where appropriate, allowing carers sufficient time to prepare. *Core 5.2*	8
2.4.3 M	**1**	When patients are absent without leave, the team (in accordance with local policy): • activates a risk management plan; • makes efforts to locate the patient; • alerts carers, people at risk and the relevant authorities; • completes an incident form. *Core 5.3*	4
Discharge planning and transfer of care			
2.5.1 N	**1**	Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to reduce the risk of suicide on discharge. *Core 9.1*	5
2.5.2	**1**	Patients discharged from inpatient care have their care plan or interim discharge summary sent to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge. *Guidance: The plan includes details of:* • *care in the community/aftercare arrangements;* • *crisis and contingency arrangements including details of who to contact;* • *medication including monitoring arrangements;* • *details of when, where and who will follow up with the patient.* *Core 9.2*	4, 5, 10, 47

2.5.3 N	**1**	A discharge summary is sent within a week to the patient's GP and others concerned with persons consent, including why the patient was admitted and how their condition has changed, diagnosis, medication and formulation. *Core 9.3*	4, 5
2.5.4 M	**1**	The inpatient team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 3 days of discharge. *Core 9.4*	54
2.5.5 N	**3**	Teams provide specific transition support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. *Guidance: The team provides transition mentors; transition support packs; or training for patients on how to manage transitions.* *Core 9.5*	4, 47
2.5.6 M	**1**	When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, taking their wishes into account as far as possible, or are supported following best interests principles under the Mental Capacity Act. *Core 9.6*	4, 5, 10
2.5.7	**1**	There is a protocol for admission to general hospital that ensures that when a patient is transferred to a medical bed, advice on mental health care management and treatment is provided and they are actively followed up at least weekly.	22, 36

CARE AND TREATMENT

Reviews and care planning			
3.1.1 N	**1**	Patients know who the key people are in their team and how to contact them if they have any questions. *Guidance: Carers and family members are also aware.* *Core 4.1*	23
3.1.2 M	**1**	There is a documented Care Programme Approach (or equivalent) or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this with advanced preparation and feedback. *Core 4.2*	10
3.1.3 M 	**1**	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. *Guidance: The care plan clearly outlines:* • *agreed intervention strategies for physical and mental health;* • *measurable goals and outcomes;* • *strategies for self-management;* • *any advance directives or statements that the patient has made;* • *crisis and contingency plans;* • *review dates and discharge framework.* *Core 4.3*	1, 2, 4, 12
3.1.4 M	**1**	There is a clinical review meeting with the MDT for each patient at least every week, or more regularly if necessary, to which they and their carer/advocate are invited with the patient's permission.	22, 36

Therapies and activities			
3.2.1 M	**1**	Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within a timeframe which complies with national standards e.g. as set by NHS or professional bodies. Any exceptions are documented in the case notes. *Core 6.1.1*	4, 13, 27, 28, 29
3.2.2 M	**1**	There is a psychologist who is part of the MDT. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions. *Core 6.1.2*	30, 31
3.2.3 M	**1**	The ward has a minimum of 0.8 WTE input from an Occupation Therapist. They are part of the MDT and work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence based occupational interventions. *Core 6.1.3*	4, 14
3.2.4	**1**	All staff members who deliver therapies and activities are appropriately trained and supervised. *Core 6.1.13*	29, 37, 38
3.2.5	**2**	Patients have access to art/creative therapies. *Core 6.1.4*	4, 14
3.2.6 N	**2**	Patients receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management. *Guidance: Where it's not appropriate for patients to receive psychoeducation, this is noted in their care plan.* *Core 6.1.5*	4, 5, 8

3.2.7 M 	**2**	Every patient has a 7-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. *Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.* *Core 6.1.6*	4, 10, 12, 32, 33, 34
3.2.8	**1**	Each patient receives a pre-arranged 1-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns. *Core 6.1.7*	4, 10, 34
3.2.9 M	**1**	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment. *Core 6.1.8*	3, 4, 6, 10, 35
3.2.10 M	**2**	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. *Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.* *Core 6.1.9*	4, 5 ,10
3.2.11	**2**	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues. *Core 6.1.10*	26

3.2.12 M	**1**	Patients have access to safe outdoor space every day. *Core 6.1.11*	10, 32
3.2.13	**2**	The team provides information and encouragement to patients to access local organisations for SUS support and social engagement. This is documented in the patient's care plan and may include access to: • voluntary organisations; • community centres; • local religious/cultural groups; • peer support networks; • recovery colleges *Core 6.1.12*	4, 5, 10, 27, 32
3.2.14	**2**	Patients are able to meet their consultant outside reviews.	22, 36
3.2.15 M	**1**	Palliative care and end-of-life discussions take place with the patient, and carer, if appropriate. Where applicable, these discussions consider the management of nutrition when a patient's swallowing is deteriorating, and the management of chest infections.	46
Medication			
3.3.1 M	**1**	When medication is prescribed, specific treatment goals are set with the patient (and carer, where appropriate), the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded. *Core 6.2.1*	4

3.3.2 	**1**	Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.* *Core 6.2.2*	4, 26
3.3.3 M	**1**	Every patient's PRN medication is reviewed weekly, with consideration of the frequency dose and reasons. *Core 6.2.3*	4, 17
3.3.4 M	**1**	All staff members who administer medications have been assessed as competent to do so. Assessment is done using a competency-based tool. This assessment is repeated at least once every three years. *Core 6.2.4*	4, 10
3.3.5 N	**2**	A specialist pharmacist is a member of the MDT. *Core 6.2.5*	26
3.3.6 M	**1**	The covert administration of medication takes place with an appropriate care plan, and with the aid of an appropriate legal framework.	22, 36
Physical healthcare			
3.4.1	**1**	Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.* *Core 7.1*	26, 39, 40

3.4.2 M	**1**	Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan. *Core 7.2*	3, 21, 39, 40
3.4.3 M	**1**	The team including bank and agency staff are able to identify and manage an acute physical health emergency. *Core 7.3*	4
3.4.4 M	**1**	Patients in hospital for long periods of time, who are prescribed mood stabilisers or antipsychotics, have the appropriate physical health assessments at the start of treatment (baseline), at 6 weeks, at 3 months and then annually (or 6 monthly for young people) unless a physical health abnormality arises. *Core 7.4*	3, 4, 39, 41, 42, 43
3.4.5 M	**1**	A pressure risk assessment is completed for all patients on the ward using an appropriate scale.	46
Risk and safeguarding			
3.5.1	**1**	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the ward. *Core 8.1*	4, 44
3.5.2 M	**1**	Patients are involved in decisions about their level of observation by staff. *Core 8.2*	4, 12, 14, 56

3.5.3 N	**2**	Patients on constant observations receive at least 1 hour per day being observed by a member of staff who is familiar to them. *Core 8.4*	4
3.5.4 M	**1**	In order to reduce the use of restrictive interventions, patients who have been violent or aggressive are supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions, or are supported following best interest principles under the Mental Capacity Act. *Core 8.5*	19
3.5.5 N	**1**	The team uses seclusion or segregation only as a last resort and for brief periods only. *Core 8.6*	13, 19, 45
3.5.6 N	**1**	Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs including respiratory rate monitored by staff members and any deterioration is responded to. *Core 8.7*	13, 19, 45
3.5.7 M	**1**	Staff members do not restrain patients in a way that affects their airway, breathing or circulation. *Core 8.3*	13, 19, 45
3.5.8 M	**1**	The multi-disciplinary team collects audit data on the use of restrictive interventions and actively works to reduce its use year on year. *Guidance: Audit data are used to compare the service to national benchmarks where possible.* *Core 8.8*	19

3.5.9 M	**1**	The ward has a falls management processes which includes: • falls risk assessment; • falls management plans; • audit of falls.	22, 36
Interface with other services			
3.6.1 M	**3**	The team supports patients to attend an appointment with their community GP whilst an inpatient if they are admitted in the local area. *Core 10.1*	4
3.6.2 M	**1**	All patients have access to an advocacy service including IMHAs (Independent Mental Health Advocates) and IMCAs (Independent Mental Capacity Advocate.) *Core 10.4*	5, 15
3.6.3 M	**1**	Patients have access to the following referral services: • dental assessment and dental hygiene services; • visual reviews; • hearing reviews; • podiatry; • wound care services; • phlebotomy services; • specialist infection control services; • a tissue viability nurse; • specialist continence services; • speech and language therapy.	22, 36
3.6.4	**1**	The team supports patients to access support with finances, benefits, debt management and housing. *Core 10.2*	4, 23

Capacity and consent			
3.7.1 M	**1**	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation. *Core 11.1*	4, 6, 10, 13, 49
Carer/nominated person engagement and support			
3.8.1 M 	**1**	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. *Core 13.1*	3, 4, 10, 51, 56
3.8.2 M	**1**	Carers are supported to access a statutory carer's assessment, provided by an appropriate agency. *Core 13.2*	4, 52
3.8.3	**2**	Carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns, family history and their own needs. *Core 13.3*	4, 15, 51, 56
3.8.4 M	**2**	The team provides each carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.* *Core 13.4*	3, 4, 10, 59, 55

3.8.5 M	**2**	Carers feel supported by the ward staff members. *Core 13.5*	4, 8, 26, 51, 53
Treatment with dignity and respect			
3.9.1 M	**1**	Staff members treat all patients and carers with compassion, dignity, and respect. *Core 14.1*	12, 33, 54, 56
3.9.2 M	**1**	Patients feel listened to and understood by staff members. *Core 14.2*	23, 56
3.9.3	**1**	Staff recognise when patients are in need of help, e.g., feeling hungry or thirsty, or are in discomfort or pain.	22, 36
3.9.4	**1**	Staff members respect the patient's personal space, e.g., by knocking and waiting before entering their bedroom. *Core 17.10*	4, 10, 56
Provision of information to patients and carers			
3.10.1 M	**2**	The ward/unit uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. *Core 15.1*	4, 14, 25

Patient confidentiality			
3.11.1 M	**1**	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with 3rd parties are respected and reviewed regularly. *Core 16.1*	4, 14, 56
3.11.2	**1**	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.* *Core 16.4*	14, 56
Ward/unit environment			
3.12.1 	**1**	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs. *Core 17.22*	24, 62
Staff well-being			
3.13.1 M	**1**	Staff members, patients, and carers who are affected by a serious incident, including control and restraint and rapid tranquilisation, are offered post incident support. *Core 21.4*	15, 71

STAFFING

Leadership, team-working and culture			
4.1.1 **M**	**3**	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet together to think about team dynamics and develop their clinical practice. *Core 18.1*	4
4.1.2 **M**	**1**	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing. *Core 18.2*	4, 56, 63, 64
4.1.3	**1**	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans. *Core 18.3*	4, 10
Staffing levels			
4.2.1 **M**	**1**	The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • a method for the team to report concerns about staffing levels; • access to additional staff members; • an agreed contingency plan, such as the minor and temporary reduction of non-essential services. *Core 19.1*	4, 65

4.2.2 M	**2**	The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need. *Core 19.2*	4
4.2.3 M	**1**	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency. *Core 19.3*	4, 14
4.2.4	**2**	The ward has a minimum input of 0.5 WTE from a psychologist.	22, 36
4.2.5 M	**1**	The ward has a minimum of 0.4 WTE Consultant Psychiatrist input.	22, 36
4.2.6	**1**	The ward has a minimum of 0.8 WTE junior medical input.	22, 36
4.2.7 M	**2**	The ward has dedicated input from a physiotherapist.	4.7.9

Staffing recruitment, induction and supervision			
4.3.1 M	**2**	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting potential staff members. *Core 20.1*	4, 10
4.3.2 M	**1**	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes: • arrangements for shadowing colleagues on the team; • jointly working with a more experienced colleague; • being observed and receiving enhanced supervision until core competencies have been assessed as met. *Core 20.2*	13, 37, 65, 66
4.3.3	**1**	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.* *Core 20.3*	4, 10, 38
4.3.4	**2**	All staff members receive line management supervision at least monthly. *Core 20.4*	4

Staff wellbeing			
4.4.1 	**1**	The ward/unit actively supports staff health and wellbeing. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.* *Core 21.1*	1, 19, 37, 48, 65
4.4.2 N	**1**	Patients and staff members feel safe on the ward. *Core 21.2*	4
4.4.3	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: They have the right to one uninterrupted 20-minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks*. *Core 21.3*	4, 9, 10

Staff training and development			
4.5.1		Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: *Core 22.1*	
4.5.1a	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent); *Core 22.1a*	13, 10, 49, 50
4.5.1b	**1**	Physical health assessment; *Guidance: This could include training in understanding physical health problems, undertaking physical observations and when to refer the patient for specialist input.* *Core 22.1b*	5, 18, 20, 54, 56
4.5.1c	**1**	Safeguarding vulnerable adults and children. This includes recognising and responding to the signs of abuse, exploitation or neglect.	5, 18, 20, 54, 56
4.5.1d	**1**	Risk assessment and risk management; *Guidance: This could include assessing and managing suicide risk and self-harm; Prevention and management of violence and aggression.* *Core 22.1c*	4, 19, 20
4.5.1e	**1**	Recognising and communicating with patients with cognitive impairment or learning disabilities; *Core 22.1d*	4, 25
4.5.1f	**1**	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance, and basic life support*. *Core 22.1e*	4, 10

4.5.1g	**2**	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality. *Core 22.1f*	15, 59
4.5.1h	**1**	Therapeutic observation. *Guidance: Training includes principles around positive engagement with patients, when to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this and actions to take if the patent absconds.* *Core 22.1g*	7
4.5.2 M	**1**	All staff receive training in order to achieve core competencies working in an older adult inpatient setting. This training incudes: • monitoring of physical observations; • completion of NEWS and appropriate actions to take; • pressure area care; • dementia awareness; • falls prevention; • mental capacity act and mental health act; • infection prevention and control.	22, 36
4.5.3 N	**2**	All staff working with people living with dementia receive specialist training in dementia care and working with behaviour that challenges.	36
4.5.4 M	**2**	Experts by experience are involved in delivering and developing staff training face-to-face. *Core 22.2*	12

SERVICE MANAGEMENT

Patient involvement			
5.1.1 M	**1**	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. *Core 12.1*	6, 12, 33
5.1.2 N 	**2**	Services are developed in partnership with appropriately experienced patient and carers and have an active role in decision making. *Core 12.2*	4, 8, 12
Ward/unit environment			
5.2.1 M	**1**	Patients use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy. *Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.* *Core 17.11*	4, 13, 56
5.2.2	**2**	Patients are consulted about changes to the ward/unit environment. *Core 17.24*	4

Clinical outcome measurement			
5.3.1	**1**	Clinical outcome measurement, and progress against user defined goals is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible. *Core 23.1*	4, 10
5.3.2 M 	**2**	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge. *Core 23.2*	4, 10, 38, 58
The ward/unit learns from feedback, complaints and incidents			
5.4.1	**1**	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this. *Core 24.1*	4, 39, 40
5.4.2 M	**1**	When mistakes are made in care this is discussed with the patient and their carer, in line with the Duty of Candour agreement. *Core 24.2*	4
5.4.3 M	**1**	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons. *Core 24.3*	6, 24
5.4.4 N	**2**	The ward team use quality improvement methods to implement service improvements. *Core 24.4*	4
5.4.5 N	**3**	The ward team actively encourage patients and carers to be involved in QI projects. *Core 24.5*	4

Glossary

TERM	DEFINITION
Advance directive	A set of written instructions that a person gives that specify what actions should be taken for their health if they are no longer able to make decisions due to illness or incapacity.
Advocacy	A service which seeks to ensure that patients are able to speak out, to express their views and defend their rights.
Art/creative therapies	A form of psychotherapy that uses art media (e.g. paints) to help people express, understand and address emotional difficulties.
Assistive technology	Devices that promote greater independence by enabling people to perform tasks that they were formerly unable to/or found difficult to accomplish.
Bank and agency staff	Non-permanent staff members.
Care plan	An agreement between an individual and their health professional (and/or social services) to help them manage their health day-to-day. It can be a written document or something recorded in the patient notes.
Care Programme Approach (CPA)	A way of coordinating care for people with mental health problems and/or a range of different needs.
Carer	In this document a carer refers to anyone who has a close relationship with the patient or who cares for them.
Carer's Assessment	An assessment that looks at how caring affects a carer's life, including for example physical, mental and emotional needs, the support they may need and whether they are able or willing to carry on caring.
Clinical supervision	A regular meeting between a staff member and their clinical supervisor. A clinical supervisor's key duties are to monitor employees' work with patients and to maintain ethical and professional standards in clinical practice.

Co-produced	Refers to engaging and communicating with the service user and their family members (where appropriate) in the development of their care plan to ensure that support is person-centred.
Community meeting	A meeting of patients and staff members which is held on the ward.
Covert administration of medication	Covert medication is when medication is administered in a disguised form e.g. in a drink or mixed with food.
De-escalation	Talking with an angry or agitated service user in such a way that violence is averted, and the person regains a sense of calm and self-control.
Dementia	Dementia describes a set of symptoms that may include memory loss, mood changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases. Alzheimer's disease is the most common form of dementia, but there are more than 100 other types including vascular dementia and dementia with Lewy bodies.
Dementia friendly	Dementia-friendly can refer to environments, communities, people and objects who take the needs of people living with dementia into account and adapt services for them accordingly.
Duty of Candour	Legislation to ensure that services are open and transparent with people who use services about their care and treatment, including when it goes wrong.
European Working Time Directive	Initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety.
Experts by experience	People who have personal experience of using or caring for someone who uses health, mental health and/or social care services.
GP	General Practitioner or 'family doctor'.
Independent Mental Health Advocate (IMHA)	An IMHA is an independent advocate who is trained to work within the framework of the Mental Health Act 1983 to support people to understand their rights under the Act and participate in decisions about their care and treatment.

Ligature points	Anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bed steads, window and door frames, ceiling fittings, handles, hinges and closures.
Managerial supervision	Supervision involving issues relating to the job description or the workplace. A managerial supervisor's key duties are; prioritising workloads, monitoring work and work performance, sharing information relevant to work, clarifying task boundaries and identifying training and development needs.
Mental Capacity Act (MCA)	A law which is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.
Mental Health Act (MHA)	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interests or for the safety of themselves or others.
Multi-Disciplinary Team (MDT)	A team made up of different kinds of health professionals who have specialised skills and expertise.
NEWS	National Early Warning Score. A tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.
NICE	National Institute for Clinical Excellence. Publishes guidance for health services in England and Wales.
Palliative care	Palliative care is for people living with a terminal illness where a cure is no longer possible. It's also for people who have a complex illness and need their symptoms controlled.
Peer support network	Groups where other people in a similar situation can meet up to talk, ask for advice and offer support to each other.
PRN medication	Medicines that are taken 'as needed'. "PRN" is a Latin term that standard for "pro re nata" which means "as the thing is needed".
Psychoeducation	The process of providing education and information to those seeking or receiving mental health services, such as people diagnosed with

	mental health conditions and their family members.
Recovery colleges	A service that gives people with mental health problems the opportunity to access education and training programmes designed to help them in their recovery.
Recovery plan	A document, designed with a person who has mental health difficulties, stating everyday activities they can do to keep well, and triggers and warning signs that they are becoming unwell.
Reflective practice	The ability for people to be able to reflect on their own actions and the actions of others to engage in continuous learning and development.
Restrictive intervention	Deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to 1) Take control of a dangerous situations where there is a real possibility of harm to the person or others if no action is taken, and 2) End or reduce significantly the danger to the patient or others.
Risk assessment	A systematic way of looking at the potential risks that may be associated with a particular activity or situation.
Safeguarding	Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.
Signpost	To tell a person how to access a related service.
SUS	Secondary Uses Services. A repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

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