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Accreditation for Inpatient Mental Health Services (AIMS)

Standards for Psychiatric Intensive Care Units (PICUs)

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Second Edition July 2010

Pub. No. CRTU078

A manual of standards written primarily for:
Psychiatric Intensive Care Units.

Also of interest to:
People affected by mental illness
Commissioners
Policy makers
Researchers

Second Edition July 2010

First edition published August 2009

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Standards have been classified 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 an accredited ward would be expected to meet;

Type 3: standards that an excellent ward should meet or standards that are not the direct responsibility of the ward.

Foreword

We are pleased to introduce this second edition of the AIMS *Standards for Psychiatric Intensive Care Units (PICUs)* and welcome the collaborative effort to improve the quality of psychiatric intensive care units.

These standards have been developed from a literature search and in consultation with stakeholder groups. Care has been taken to include information from a wide range of sources, including the National Association of Psychiatric Intensive Care Units and Low Secure Units (NAPICU), and to take into account the views of unit staff, service users and carers.

We hope the standards will provide staff with a clear and comprehensive description of best practice within psychiatric intensive care units. We hope they will be educative and expect they will promote healthy debate in more contentious areas. They will be reviewed each year, so please give the Project Team any comments, using the form provided at the back of this document.

These standards will be applied each year in self- and external peer-review by AIMS-PICU member units. If you work in a psychiatric intensive care setting, we hope you will support this important network and join in the review cycle.

Joanne Cresswell RMHN
AIMS Programme Manager and Nurse Advisor
July 2010

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Introduction

The accreditation standards, drawn from key documents, will help units demonstrate compliance with the Healthcare Commission's 'Standards for Better Health' and will support implementation of NICE guidelines and the National Service Framework. They have been subject to extensive consultation with all professional groups involved in the provision of acute inpatient mental health services and with service users and their representative organisations.

The standards are reviewed on an annual basis and are applied each year during the self- and peer-review processes by AIMS member units.

The standards cover the following topics:

- General Standards
- Timely and Purposeful Admission
- Safety
- Environment and Facilities
- Therapies and Activities

The full set of standards is aspirational and it is unlikely that any unit would meet all of them. To support their use in 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 an accredited unit would be expected to meet;

- **Type 3:** standards that an excellent unit should meet or standards that are not the direct responsibility of the unit.

A copy of these standards will be sent to every unit that becomes a member of AIMS.

The standards are also available on our website at: www.rcpsych.ac.uk/AIMS.

Acknowledgements

Consultation and support

The following people have given us continued advice and support in compiling and editing these standards:

National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) Executive Committee:

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Dr Dominic Beer	NAPICU Honorary Treasurer
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Dr Rob Baskind	Bradford District Care Trust
Ms Helen Bennett	Cardiff and Vale NHS Trust
Ms Glenda Bryan	Cheshire & Wirral Partnership NHS Foundation Trust
Ms Anna Burke	North West Regional Offender Health Team, Bury PCT
Mr Godwin Calafato	Carer Representative
Dr Rob Chaplin	Royal College of Psychiatrists' Research and Training Unit

Mrs Rachel Christian-Edunits	College of Occupational Therapists
Ms Aoife Coyne	Cheshire & Wirral Partnership NHS Foundation Trust
Dr John Hanna	British Psychological Society
Ms Marion Janner	Service User Representative
Dr Peter Jarrett	Oxleas NHS Foundation Trust
Mrs Sarah King	Service User Representative
Ms Maria Kordowicz	Royal College of Psychiatrists' Research and Training Unit
Dr Paul Lelliott	Royal College of Psychiatrists' Research and Training Unit
Catherina McKenning	South West Yorkshire Partnership NHS Foundation Trust
Mrs Elizabeth Moody	Northumberland, Tyne and Wear NHS Trust
Ms Jennifer Nix	South West Yorkshire Partnership NHS Foundation Trust
Ms Che Rosebert	South West London and St. George's Mental Health NHS Trust
Mr James Rutherford	Cheshire & Wirral Partnership NHS Foundation Trust
Ms Catherine Seabourne	Oxleas NHS Foundation Trust
Ms Yvonne Stoddart	Care Services Improvement Partnership
Mr Allan Tan	Sheffield Health and Social Care NHS Foundation Trust
Dr Trevor Turner	Royal College of Psychiatrists
Dr Jonathan West	Oxleas NHS Foundation Trust
Mr Adrian Worrall	Royal College of Psychiatrists' Centre for Quality Improvement
Mr Norman Young	Royal College of Nursing

The Service Users

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Section 1

General Standards

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Policies and Protocols		
NUMBER	**TYPE**	**STANDARD**
1.1	1	All staff are informed how to access policies, procedures and guidelines, and are able to do so when required.
1.2	2	MDT staff are consulted in the development of policies, procedures and guidelines that relate to their practice.
1.3	2	Managers audit the implementation of policies and procedures, and provide feedback to MDT staff.
1.4	2	All policies and protocols are reviewed at a minimum of every three years with the support of the policy development/clinical governance teams.
1.5	1	The Unit's Operational Policy should include: • the patient population to be served by the Unit • if service users subject to Ministry of Justice restrictions are included in that patient population.
1.6	2	There is a specific and separate policy relating to absconding or non return from leave which includes agreed definitions of absconding, escape and non return from leave
Staffing		
2.1	1	The unit has an agreed minimum staffing level across all shifts, which is met.
2.2	1	There are systems in place that ensure that all factors affecting staffing numbers and skill mix are taken into consideration, and staffing levels are reviewed on a daily basis. These factors are: • levels of observation; • sickness and absence; • training; • supervision; • escorts; • therapeutic engagement; • acuity levels; • conformance with local human resources guidance; • staff capabilities; • clinical meetings.
2.3	1	The unit has a dedicated lead clinician (medical or nursing) with the appropriate designated authority to lead the unit.

2.4	1	The unit has its own dedicated lead consultant who will provide expert input into key matters of service delivery, staff support and supervision, and overall service co-ordination. Specific sessions are set aside in the consultant's job plan to ensure sufficient time is available for their consistent and regular input to the team and related forums.
2.5	2	The unit manager has control over the unit budget.
2.6	2	There is visible and accessible leadership at unit level, e.g. medical consultant, nurse consultant, modern matron.
2.7	2	There is access to relevant faith-specific and cultural support, preferably through someone with an understanding of mental health issues.
2.8	2	The available administrative support meets the needs of the unit.
2.9	1	The unit is able to access interpreters, sign language and other communication mediums.
2.10	1	Levels of sickness, absence and injuries are monitored.
2.11	2	Positive actions are identified that can be taken to reduce sickness levels.
2.12	1	At all times, a doctor is available to quickly attend an alert by staff members when interventions for the management of disturbed/violent behaviour are required, according to NICE CG25 or within 30 minutes.
2.13	1	Staff carrying out physical examinations are either of the same sex, or there is a same-sex chaperone present, or patients can choose the sex of the staff member.
2.14	2	All support staff receive a general induction/information pack regarding safety in the PICU.
Recruitment and Retention of Staff		
3.1	2	When posts are vacant, or in the event of long-term sickness, immediate arrangements are made for temporary staff cover.
3.2	2	There is a clear and written policy on the recruitment and use of bank and agency staff including: • a system to ensure staff have the basic skills, attitudes and competencies required; • proper arrangements for the induction and management of bank and agency staff; • a system to routinely monitor and report on the use of bank and agency staff.
3.3	2	Managers receive feedback from staff exit interviews.

3.4	2	Arrangements are in place so that Service User representatives can be involved in interviewing potential members of the MDT during the recruitment process.
3.5	3	Arrangements are in place so that Carers/carer representatives can be involved in interviewing potential members of the MDT during the recruitment process.
Appraisal, Supervision and Staff Support		
4.1	1	The unit has clear clinical supervision guidelines which incorporate supervision contracts between supervisor and supervisee to cover: • learning/training objectives; • resolution of conflict (arbitrator identified); • roles and responsibilities; • practicalities, e.g. location; • boundaries, e.g. time and agreed agenda; • documentation to be used; • confidentiality (adherence to professional code of conduct and Trust policy); • actions in event of non-attendance or cancellation; • frequency and duration.
4.2	1	Evidence based models of supervision are identified and implemented for unit staff as appropriate to their professional group.
4.3	1	All staff receive an annual appraisal and personal development planning.
4.4	2	At the start of employment, the supervision process is made clear to all new members of the MDT.
4.5	1	Staff receive regular managerial supervision from a person with appropriate experience and qualifications.
4.6	1	Supervision occurs at a minimum of once every four weeks or more frequently, as per professional body guidance. Implementation is reviewed and monitored.
4.7	2	Non-clinical staff receive regular line management supervision.
4.8	2	Supervisors receive appropriate training as agreed in local policy, taking into consideration profession-specific guidelines.
4.9	1	Emergency ad hoc supervision is available.
4.10	2	The unit has a clear system of monitoring and auditing supervision. This is reviewed every 12 months.
4.11	2	All staff are able to contact an appropriate operational manager/senior colleague as necessary, 24 hours a day.

4.12	1	All staff are aware of their level of authority/accountability and what decisions they can and cannot take.
4.13	2	Staff have access to a unit-based reflective practice/staff support group to discuss clinical work.
4.14	1	All staff are able to take allocated breaks.
Staff Education and Training		
5.1	1	All staff attend identified statutory and mandatory training including risk assessment and safeguarding and six other practice associated days per year.
5.2	1	Staff complete a unit-based induction programme which ensures basic understanding of core skills.
5.3	2	All staff have access to the Trust's intranet, knowledge-based systems (such as Medline) and online journals.
5.4	2	Training budgets enable all staff to meet requirements for their continuing professional development and the Knowledge and Skills Framework.
5.5	1	There is a strategy in place to ensure training is available.
5.6	1	Access to training is facilitated, and there are arrangements for staff cover to allow staff to attend training.
5.7	1	All new staff are allocated a mentor/preceptor who oversees their induction.
5.8	1	Before being asked to carry out any clinical work, all staff receive mandatory training in fire, manual handling and basic life support.
5.9	1	All staff based on the unit are trained in the management of disturbed behaviour.
5.10	1	All visiting staff to the unit are trained in breakaway techniques and conflict resolution.
5.11	3	There is a monthly partnership forum that includes the MDT, Service User representative(s), managers and patient advocacy to discuss how the unit is functioning.
5.12	1	There is a weekly minuted community meeting.
5.13	2	The unit has active representation on the local Acute Care Forum, or a monthly team business meeting with managers.

5.14	2	Teams engage in at least one team training day and one protected learning time away-day each year.
5.15	3	Shared in-house MDT training, education and practice development activities occur on the unit on at least a monthly basis.
5.16	1	Staff who undertake assessment and care planning have received training in: • risk assessment, management and risk-taking; • assessing mental capacity; • self-harm and suicide awareness and prevention techniques; • CPA including transfer/discharge planning; • assessing carers' needs; • Diversity Awareness Training; • Safeguarding Children and Vulnerable Adults.
5.17	2	Staff who undertake assessment and care planning receive training in: • locally agreed outcome measures.
5.18	2	Staff who undertake assessment and care planning receive training in physical health needs and referrals.
5.19	1	There is an investment in the development of managerial and leadership competencies of unit managers and sisters/charge nurses.
5.20	1	All education and training in the safe and therapeutic management of aggression and violence is based upon the recommendations contained in the interim Mental Health Policy Implementation Guide 2004 and the NICE Guideline 2005.
5.21	1	All practitioners who administer medications are assessed as competent to do so.
5.22	1	All prescribers are assessed as competent in the prescribing of medications.
5.23	2	Clinical staff receive training and support from staff with appropriate clinical skills to provide basic psychological and psychosocial interventions (including, but not limited to, conflict resolution/de-escalation, engagement activity scheduling, group facilitation).
5.24	1	The unit can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology are developing the necessary skills to provide a repertoire of problem-specific, low intensity psychological interventions in line with NICE guidance.
5.25	3	The unit can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology professions receive ongoing training and supervision to provide a repertoire of problem-specific, high intensity psychological interventions in line with NICE guidance.
5.26	2	The unit has a 6 monthly forum for meeting with all stakeholders to consider important topics such as referrals, service developments, and

		issues of concern and to re-affirm good practice.
5.27	2	The unit is a member of NAPICU.
Advocacy		
6.1	1	The unit provides access to an independent advocacy service that includes IMCAs/IMHAs.
Compliments and Complaints		
7.1	1	There are clear policies and procedures for managing complaints.
7.2	2	Information is available for patients/carers about: • how to make a verbal complaint; • how to make a written complaint; • how to suggest service improvements/enhancements; • how to make a written compliment; • how to make a donation.
7.3	2	There is evidence of audit, action and feedback from complaints.
7.4	2	Staff receive positive feedback from compliments received.
7.5	3	The unit has a system for collecting real time feedback from patients.
Smoking		
8.1	1	There is a smoke-free policy for staff and patients, which follows HDA guidance and best practice.
8.2	1	There is support for staff and patients to assist with the smoking policy, including: • consideration of the use of NRT while on the hospital premises, to help with withdrawal or as a coping strategy; • a comprehensive support programme, with information available about the support on offer; • strategies to make sure staff know and understand the Trust's policy, and monitor levels of comprehension.

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Section 2

Timely and Purposeful Admission

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TIMELY AND PURPOSEFUL ADMISSION		
NUMBER	**TYPE**	**STANDARD**
9.1	1	There is an information-sharing protocol confirmed at Trust board level of which all staff are aware, and this is publicised to visitors and patients.
9.2	2	At the point of admission, information on previous care planning and interventions are sourced by the unit staff/acute care team within 24 hours.
9.3	2	There is an identified and documented contact or link person for each agency involved with each patient.
9.4	1	The specific reasons for admission are agreed between referrer and assessing team.
9.5	1	All service users referred to the Unit have an assessment of their needs and risks undertaken by members of the Unit team who make a decision to admit, prior to the service user arriving in the unit.
9.6	2	All community assessment paperwork is available to the admitting team when the patient arrives on the unit, including mental health and current risk assessments.
9.7	1	Where a patient is being admitted directly from the community, the admitting nurse checks that the referring agency gives clear information as to the security of the patient's home, whereabouts of children/animals etc.
9.8	2	The unit uses a shared information system, e.g. MDT case notes or the use of an Electronic Health Record.
Control of Bed Occupancy		
10.1	1	Bed management decisions/resources are made by staff who remain clinically accountable to a registration authority, e.g. NMC, GMC, HPC.
10.2	1	There are systems in place to raise concerns about inpatient mix, and the unit manager's views are equally considered by the senior team.
10.3	2	When a patient is sent on leave they are able to return and/or contact the unit and/or crisis team if problems arise, and are told how to do this.
10.4	1	There are arrangements in place with other units concerning patient transfers, to ensure that beds are available for new admissions.
10.5	1	When a patient is sent on leave the bed remains available initially, unless the patient was recently under the care of or is well known to the treatment unit, and a bed is available on that unit.

Admission Systems		
11.1	2	When talking to patients and carers, health professionals avoid using clinical language and jargon.
11.2	1	Managers and practitioners have written standards for the admission process.
11.3	2	Following assessment, if admission to a PICU is not thought to be appropriate, PICU staff offer advice, guidance and support on the management of the patient.
11.4	2	The admission policy describes how decisions regarding the appropriate place of admission for older people is primarily based on mental and physical need.
11.5	1	Admission to an adult unit of people under the age of 18 only happens if: • the local authority is informed of the admission; • the CQC (or equivalent) is informed (if the patient is detained); • all unit staff who have contact with the patient have enhanced CRB checks; • there is access to child and adolescent psychiatric consultation and advice throughout admission.
11.6	1	Admission to an adult unit of people under the age of 18 only happens if: • the length of stay anticipated is less than three months; • a single room is available; • the patient is under constant observation, if needed following risk assessment, for the duration of their stay.
11.7	2	There are protocols for transfer or shared care between LD and generic mental health services, which clearly specify: • consultant responsibility; • the roles and responsibilities of in-patient and community teams in both mental health and learning disability services; • the requirement for joint care planning at an individual level; • the requirement for written care plan to specify what support each service can expect from the other; • roles and responsibilities in relation to CPA; • information sharing.
11.8	2	Essence of Care standards are implemented and regularly reviewed by the MDT.
Admission Process		
12.1	1	The patient and accompanying person (where appropriate) are met on arrival, shown to an appropriate area, and offered refreshments etc.
12.2	1	The patient is introduced to a member of staff who will be their point of contact for the first few hours of admission.

12.3	1	The patient is orientated to the unit environment including toilets as soon after admission as it is safe to do so.
12.4	1	On the day of their admission or as soon as they are well enough, the patient is given a "welcome pack" or introductory booklet that contains the following: • a clear description of the aims of the unit; • the current programme and modes of treatment; • a clear description of the purpose of the unit. • a description of what is expected, and rights and responsibilities; • a simple description of the unit's philosophy, principles and their rationale, and the unit team membership, including the name of the patient's Consultant Psychiatrist and Key Worker/Primary Nurse; • visiting arrangements; • personal safety on the unit; • unit facilities; • unit programme of activities; • what practical items patients need in hospital and what should be brought in; • resources to meet ethnic and gender needs; • restricted and controlled items.
12.5	1	On the day of their admission or as soon as they are well enough, detained patients are given written information on their rights, including rights to advocacy and second opinion, right to move hospital, right of access to interpreting services, professional roles and responsibilities, and the complaints procedures, in accordance with section 132 of MHA.
12.6	2	On the day of their admission or as soon as they are well enough, the patient (and carer, where permitted) is told the name(s) of their Primary Nurse/care team and how to arrange to meet with them.
12.7	2	A full physical examination is carried out as part of the admission process.
12.8	1	Further targeted examinations are undertaken if the physical history or physical symptoms demand (including blood tests, urinalysis, ECG, EEG, x-rays, brain imaging). This is undertaken promptly and a named individual is responsible for follow-up.
12.9	1	Where the patient is found to have a physical condition which may increase their risk of collapse or injury during restraint and or rapid tranquilisation, this is: • clearly documented in their records; • regularly reviewed; • communicated to all MDT members; • evaluated with them and, where appropriate, their carer/advocate.
Initial Assessment and Care Planning		
13.1	2	The patient is able to involve the people they rely on for support (e.g. carers, relatives, friends) in their assessment(s).

13.2	1	The immediate risk assessment of the patient includes: • identification of whether they may be predatory or likely to abuse or offend; • potential physical, psychological and social risks to themselves and/or others; • risk of self-harm; • level of substance use; • absconding risk; • consent or refusal of consent to treatment; • self-neglect; • Public Protection and safeguarding issues.
13.3	1	Risk management plans include risk to carers and incorporates carers' views (usually with the patient's consent).
13.4	2	Information for victims is shared in accordance with legislation and local guidance (Chapter 18.18-18.20 of the MHA Code of Practice).
13.5	1	The patient meets with their allocated Nurse to complete the initial Nursing Unit assessment and initiate their care plan within the first 24 hours following admission. This includes: • Activities of Daily Living; • a level of supervision/observation using NICE definitions; • ethnicity; • employment status; • gender needs; • assessment of mental capacity (if required); • spiritual and cultural needs; • continuing consent or refusal of consent to treatment.
13.6	2	The patient has access to an Occupational Therapist/Activity Therapist for assessment during the first 72 hours.
13.7	2	The patient's Care Co-ordinator (CCO) is contacted by the end of the CCO's next working day. For new patients, a CCO is appointed within seven days of admission. The CCO will come from the community team which is most likely to be providing support at the point of transfer/discharge.
13.8	1	The care plans are based on a comprehensive physical, psychological and socio-cultural assessment, which includes a comprehensive risk and strengths assessment.
13.9	2	Where poor concordance, poor engagement and/or poor insight are factors, an assessment is made of the psychological and socio-cultural factors contributing to these problems, and a treatment plan is formulated and initiated.
13.10	2	The patient is informed of the process of how and when they may access their current records, if they wish to do so.
13.11	2	The patient is offered a copy of their care plan and the opportunity to sign this, and/or is able to access their care plan when requested.

13.12	2	A copy of the care plan is given to their carer if the patient agrees.
13.13	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.
13.14	2	The patient is given the opportunity to discuss and plan their preferences regarding the use of physical healthcare interventions, such as blood glucose monitoring, blood pressure and weight checks. This is recorded in their individualised care plans or advance directives.
13.15	2	The unit team agrees a team management plan for risk/violent/abusive behaviour that the Primary Nurse or a delegated deputy negotiates with the patient, outlining issues and appropriate interventions.
13.16	1	If a patient is identified as presenting with a risk of absconding, then a contingency plan is described within the crisis plan, which includes instructions for alerting carers and any other person who may be at risk.
13.17	1	Findings from risk assessments are communicated across relevant agencies and care settings, in accordance with the laws relating to patient confidentiality.
13.18	1	At the point of admission or transfer, medicines reconciliation is assessed.
Carers		
14.1	1	The patient's main carer(s) are identified and contact details are recorded.
14.2	2	An identified carer or relative is informed within 24 hours of admitting, transferring or discharging a patient to/from the unit.
14.3	2	The principal carer is advised how to obtain an assessment of their own needs.
14.4	3	Protocols for carers' assessment are agreed with local community services.
14.5	2	The principal carer is offered a meeting with a named professional, within three working days of admission, during which: • the carer's views about ongoing and future involvement are recorded; • the carer is given an explanation and information sheet about unit procedures etc.; • the carer is offered information on carer advocacy, welfare rights and mental health services.
14.6	2	If any restriction to carer involvement applies, there is a clear unit policy and carers are notified accordingly.

14.7	2	With the consent of the patient, carers are entitled to have their views expressed at weekly multidisciplinary reviews.
14.8	1	The unit has a process and an environment that provides safety, privacy and dignity during visits, and includes guidance on children visiting where permitted.
14.9	3	A carer support network or group exists and is available to carers of patients admitted to the unit.
Continuous Assessment		
15.1	2	If needs are identified that cannot be met by the unit team, then a referral is made to a service that can. The referral is made within a specified time period after identifying the need, and the date of the referral recorded in the patient's notes.
15.2	2	Where an unmet need is identified there is a clear mechanism for reporting it.
15.3	2	There is evidence within the notes of assessment of mental capacity, using a formal document/standardised assessment tool, as required.
15.4	1	Patients have a comprehensive, ongoing assessment of their needs, risk to self and others with full involvement of the patient and their carer (if the patient gives consent) and have corresponding care plans.
15.5	1	Risk Procedures should include Positive Risk Management / Risk Taking in addition to Risk Assessment. There is evidence of a considered balance between restriction and autonomy
Reviews		
16.1	1	There is a daily handover between the nursing staff, doctors and other relevant members of the MDT.
16.2	1	Full MDT clinical review meetings occur at least once a week.
16.3	1	Each handover contains a discussion of risk factors, patient needs and progress. This results in an MDT action plan for the shift, with individual and group responsibilities.
16.4	2	Patient's involvement in decisions about their care are documented in the notes.
16.5	2	Traditional style unit rounds, where the patients sits in front of a large MDT meeting, do not take place, and the responsible clinician meets individually with the patient outside and in addition to the weekly MDT meeting.

16.6	2	Managers and practitioners have agreed standards for unit rounds/reviews.
16.7	1	There is prompt access to senior clinical staff to allow rapid decisions to be made about patients and their management.
Liaison with Other Units		
17.1	2	Patients have information on the other agencies involved in their care, and the care plan reflects this.
17.2	1	During admission to the PICU, weekly contact takes place between the PICU and the unit/unit where the patient was admitted from (and is most likely to be transferred to/discharged to/returned to).
17.3	2	A transfer sheet/electronic record is completed outlining current management plans and treatment details to facilitate a smooth handover of care to the receiving unit or team.
17.4	2	The patient is given a minimum of two hours' warning of transfer to another unit.
17.5	2	An attempt is made to inform the carer of the patient's transfer within one hour.
Discharge Planning		
18.1	2	There is a transfer/discharge summary from all disciplines within the MDT outlining problems, needs, progress and recommendations specific to each of the disciplines.
18.2	2	A comprehensive review takes place of the current community care plan, in conjunction with the patient's Care Co-ordinator, carer and other significant parties, to determine the factors leading to the current admission, and to agree and initiate the steps required for their remediation.
18.3	2	Managers and practitioners have agreed standards for transfer/discharge planning.
18.4	2	The patient is actively involved in developing their transfer/discharge plan.
18.5	3	The patient and carer (if requested by the patient) are actively involved in who takes part in transfer/discharge planning.
18.6	1	Patients are not sent on leave into the care of carers without agreement and contact with the carers beforehand.

18.7	1	If the patient is discharged directly from the PICU, the patient is given a copy of a written aftercare plan, agreed on discharge, which sets out: • the care and rehabilitation to be provided; • the name of the care co-ordinator (if they require further care); • the action to be taken should signs of relapse occur or if there is a crisis, or if the patient fails to attend treatment; • specific action to take in the first week.
18.8	2	If the patient is discharged directly from the PICU, prior to discharge the date of the next CPA review or other review date is recorded in the notes and communicated to the patient and members of the MDT.
18.9	2	Service users whose discharge or transfer back to another unit is delayed are routinely reviewed by senior clinical staff and hospital managers and action is taken to review any identified problems.

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Section 3

Safety

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SAFETY		
NUMBER	**TYPE**	**STANDARD**
19.1	1	All units are compliant with national guidance on single sex accommodation and this is audited and monitored.
19.2	1	There is an annual and comprehensive general risk assessment to ensure the safety of the clinical environment.
19.3	1	There is a management plan to address any shortfalls in the safety of the clinical environment.
19.4	1	High risk activities, which are essential to practice, are accurately documented, audited and reviewed to ensure good clinical practice and positive learning. These activities could include: • restraint; • seclusion and other restrictive practices; • rapid tranquillisation and high dose medication; • adverse incidents and 'near misses'; • leave. A central reporting mechanism supports this process.
Observation		
20.1	1	There is a policy on patient safety, the use of therapeutic interventions and observation that includes: • how activities, therapies and staff skill mix are used specifically to improve patient safety; • how patients are informed about maintaining their personal safety including the use of alarms; • who can instigate observation above the general level and who can change the level of observation; • who should review the level of observation and when reviews should take place (at least every shift for Within Arms Length and Within Eye Sight); • how the patient's perspective will be taken into account; • the process through which a review by the MDT will take place if observation above the general level continues for more than one week.
20.2	1	Patients receive information about the level of observation that they are under, or there is a record of this being discussed including how it is instigated, the review process and how patient perspectives are taken into account.
20.3	1	Due to the risks of extensive use of intrusive observations e.g. secondary gains, incorrectly implemented , where a service user is observed Within eye sight or Within Arms length for greater than 72 hours are reviewed by the MDT

Management of Violence		
21.1	1	There is an operational policy on searching, based on legal advice, which complies with NICE Guidance and the Human Rights Act.
21.2	1	There is a written mutual code of conduct for unit behaviour, of which patients are advised.
21.3	2	Adherence to the code of conduct for unit behaviour is monitored.
21.4	2	There are agreed protocols in place with the local police that ensure effective and sensitive liaison regarding incidents of criminal activity/harassment/violence.
21.5	1	Where appropriate, in the case of criminal justice engagement, policies include: • victim issues; • change of risk in the community; • contact with the police; • communication with MAPPA; • communication with MoJ.
21.6	2	There are local protocols to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies. The policies set out what constitutes an emergency requiring police intervention.
21.7	1	Local policy on the use of Physical Intervention and Rapid Tranquilisation are consistent with NICE G25 on the short term management of disturbed behaviour, and this is audited.
21.8	1	Any incident requiring rapid tranquillisation, physical intervention or seclusion is recorded contemporaneously, using a local template, which records the use of these interventions and the procedures taken during these interventions and any adverse outcomes.
21.9	1	The unit has mechanisms to document and monitor all incidents of violence and aggression.
21.10	1	There are systems in place to ensure that post-incident support and review are available and take place. The following groups are considered: • staff involved in the incident; • patients; • carers and family, where appropriate; • other patients who witnessed the incident; • visitors who witnessed the incident.
21.11	1	A collective response to alarm calls is agreed before incidents occur and consistently rehearsed and applied.

21.12	1	Where risk assessment indicates, there is an established, reliable and effective means of communication during escorted leave etc., such as two-way radios or mobile phones.
Management of Alcohol and Illegal Drugs		
22.1	1	The unit has a strategy for the comprehensive care of patients with dual diagnosis that includes: • liaison between mental health and substance misuse services; • regular drug/alcohol screening to support decisions about care/treatment options; • liaison between mental health and statutory and voluntary agencies; • staff training (which includes input from the police); • the appointment of key staff who will lead clinical developments; • clear protocols, agreed with the police; • consideration as to the impact on other patients of adverse behaviours due to alcohol/drug abuse.
22.2	1	There are clear and comprehensive policies and procedures regarding positive risk-taking and illicit drug use within the inpatient unit.

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Section 4

Environment and Facilities

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Safety		
NUMBER	**TYPE**	**STANDARD**
23.1	1	The internal design of the unit is arranged to promote a safe environment: • sight lines are unimpeded; • measures are taken to address blind spots within the facility.
23.2	1	Potential ligature points are managed as part of individual and unit risk assessments.
23.3	1	Facilities ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour.
23.4	1	Furniture is arranged so that alarms can be reached and doors are not obstructed.
23.5	2	An assessment of the necessity of any fitting that could be a potential ligature point is undertaken. Where this is unavoidable, fixings are not able to bear a load larger than 20 kilos.
23.6	2	All doors have a solid core construction of at least 50mm thickness.
23.7	2	There are as many doors as possible opening out into the unit.
23.8	2	Double doors are installed in rooms such as the day room, dining room, activities room and other areas in which more than two patients gather.
Security		
24.1	1	Whilst ensuring appropriate levels of security, patients are cared for in the least restrictive environment.
24.2	2	There is secure, lockable access to a patient's room, with external staff override.
24.3	2	All security measures, for example window restrictors, are as discreet as possible.
24.4	1	In reception: • a single main entry point is controlled by an airlock; • the air lock entrance is access controlled from within a main staff area. In addition it can be operated by specifically designated electronic fobs and by manual means; • the entrance has an emergency override allowing both doors to open at the same time. This is so that people can move quickly through the air lock in the event of emergency.

24.5	2	The fence around garden areas provides a significant obstacle to absconding. Specifications that include anti climb and tamper are considered.
24.6	1	Gates in the secure perimeter are constructed so as not to aid climbing.
24.7	1	A Standard Operational Procedure describes the use of the garden and includes: • which patients require escorted access; • use of CCTV and general monitoring; • maintenance of litter, greenery and furniture. Furniture in the secure garden is fixed or removed when not in use. Items used for activities are also removed when not in use.
24.8	1	Windows: • are designed to prevent passing of contraband; • have a maximum opening width of 125mm. • are capable of being locked both open and shut.
24.9	3	Windows that operate by sliding and include a security grill can provide increased ventilation and security over just restricted opening windows.
24.10	1	Eaves are protected or designed to protect access to roofs by climbing.
24.11	1	There is a locally agreed and robust system for the safe use and storage of keys / swipe cards. The policy includes instructions to staff with a defined induction procedure in relation to key management.
24.12	1	All staff complete a security induction programme prior to being issued with secure keys/pass cards/fobs.
24.13	1	There are standard operational procedures (SOP) to support escorted and unescorted leave. The SOP includes: • what to do in the case of an absconding attempt or other problematic event; • methods of communication and use of equipment.
Alarm Systems		
25.1	1	• Security measures, for example alarm systems or call buttons to alert staff, are available. • Alarm systems/call buttons are available to patients and visitors, and instructions are given for their use. • Alarms are accessible in interview rooms, reception areas and other areas where one patient and one staff member work together.
25.2	1	All staff based on the unit have access to a personal alarm at all times.
25.3	1	All staff not based on the unit have access to a personal alarm when required.

25.4	1	Alarm systems/call buttons are checked and serviced regularly.
25.5	1	There is a system and procedure for calling for assistance from neighbouring units / facilities
Medical Equipment		
26.1	1	A crash bag is available within three minutes. This equipment includes: • an automatic external defibrillator; • a bag valve mask; • oxygen; • cannulas; • fluids; • suction; • first-line resuscitation medications; • intubation tray.
26.2	1	The crash bag is maintained and checked weekly and after use.
26.3	2	The unit has access to a specific room for physical examination and minor medical procedures.
Confidentiality		
27.1	1	All patient information is kept in locked cabinets, locked offices or securely password protected on IT systems.
27.2	2	In spaces where personal and confidential discussions are held, such as interview rooms and consulting/examination/treatment spaces, conversations cannot be heard outside the room.
27.3	1	All staff adhere to the Department of Health Guidance on confidentiality (HSC 2000/009: Data Protection Act 1998: protection and use of patient information. Department of Health, 2000).
Seclusion		
28.1	1	There is a clear written policy on the use of seclusion, which complies with the MHA and NICE Guidance 25.
28.2	1	In services where seclusion is practiced, there is a designated room fit for the purpose. The seclusion room: • allows clear observation; • is well insulated and ventilated; • has access to toilet/washing facilities; • is able to withstand attack/damage; • has a two-way communication system; • has a clock that patients can see.

Use of Rooms and Space		
29.1	2	Areas which need to be quiet are located as far away as possible from any sources of unavoidable noise.
29.2	2	There is at least one room for interviewing and meeting with individual patients and relatives, which is furnished with comfortable seating.
29.3	2	The unit environment is sufficiently flexible to allow for specific individual needs in relation to ethnicity.
29.4	2	The unit environment is sufficiently flexible to allow for specific individual needs in relation to disability.
29.5	2	The unit offers a range of semi-private and public spaces outside the private bedroom, which allow people a different level of participation with the life of the unit.
29.6	1	In mixed facilities, there is a female-only sitting room always available.
29.7	3	In mixed facilities, there are permanent dedicated areas for males.
29.8	2	Social spaces are located to provide views into external areas.
29.9	2	There is a quiet room with a variety of comfortable chairs.
29.10	1	A room is available for use when children are visiting which is separate to the main body of the unit.
29.11	1	Children are not allowed on to the unit.
29.12	2	There is a games room with provision for a variety of activities available.
Catering		
30.1	1	The dining area is big enough to allow patients to eat in comfort and to encourage social interaction, including the ability for staff to engage with and observe patients during meal times.
30.2	1	The dining area is reserved for dining only during allocated mealtimes.
30.3	1	There are water/soft drinks available to patients 24 hours day.
30.4	1	Hot drinks are available to patients 24 hours a day upon request. Any restrictions are individually care planned and not implemented as a blanket rule.
30.5	2	Patients' views on catering are audited as part of the Performance

		Assessment Framework.
30.6	2	Meals or snacks are available outside of mealtimes.
Dignity		
31.1	2	All patients have access to lockable storage, which may include their own individual rooms, or access to a safe on the unit.
31.2	1	Patients can access resources that enable them to meet their individual self-care needs, including ethnic- and gender-specific requirements.
31.3	2	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.
31.4	2	Patients can make and receive telephone calls in private.
31.5	1	There is a policy on the use of devices with the capacity to communicate and/or record, which is communicated to staff, patients and visitors, e.g. by means of a poster/unit leaflet.
31.6	1	Laundry facilities are available to all patients or an ability to wash patients' clothes on site and in a timely manner is available.
31.7	2	Patients have access to items associated with specific cultural, religious or spiritual practices, e.g. covered copies of faith books.
31.8	1	Relevant assistive technology equipment, such as hoists and handrails are provided to meet individual needs and to maximise independence in self-care needs.
31.9	2	Patients have access to the following within or near to the unit/hospital site: • gym; • multi-faith prayer/worship room; • bank facilities; • basic shop; • music facilities; • internet access.
31.10	2	All doors (with the exception of the bathrooms and toilets) are fitted with an observation panel.
Patient Comfort		
32.1	2	The unit is able to control light.
32.2	2	The unit is able to control temperature.
32.3	2	The unit is able to control ventilation.

32.4	2	The unit has arrangements to control avoidable noise.
32.5	3	There is an alternative (such as nightlights) to bright fluorescent lighting in the bedrooms providing different levels of lighting which both the patients and staff can control.
32.6	1	The design of windows considers safety and patient comfort and is consistent with Health Building Notes.
32.7	2	Corridors are wide enough to allow three abreast comfortably.
32.8	3	Ceiling height is three metres in some areas to give the feeling of space.
32.9	3	Ceilings are fitted with skylights that allow increased daylight into the main corridor (if stand-alone, single storey building).
Provision of Information		
33.1	3	Information on vocational opportunities and services is clearly displayed.
33.2	2	Information leaflets about relevant psychiatric conditions are readily available, which include: • medications and their side effects; • treatment alternatives and their relative effectiveness, including complementary therapies.
33.3	2	Information is available for staff and patients/carers about mental health and local public and voluntary sector services that are available which include: • services and expected waiting times; • facilities; • advocacy services; • local support/advice organisations for patients and carers; • health promotion.
33.4	2	All information leaflets about the unit for patients and carers are reviewed yearly by a team involving either patients or carers.
Activity Equipment		
34.1	1	All patients can access a range of current culturally-specific resources for entertainment, which reflect the unit's population, and which includes the following: • good quality magazines; • daily newspapers; • board games; • cards; • a TV and VCR/DVD with videos/DVDs; • games console.
34.2	2	Rooms such as the day room and dining area will, for the majority of the

		time, remain open for free access by patients.
34.3	2	There are dimmer switches inside and outside bedrooms.
Outside Space		
35.1	1	All patients, including those who are acutely disturbed, have access to fresh air and secure external space.
35.2	2	Where smoking is permitted, there is a designated smoking area.
Staff		
36.1	2	Unit-based staff have access to a dedicated staff room, either on or off the unit.
36.2	2	All staff have access to a locker or locked area to store personal belongings.

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Section 5

Therapies and Activities

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Medication		
NUMBER	**TYPE**	**STANDARD**
37.1	2	Patients preferences are taken into account and acted upon as far as possible, following a discussion of: • the relative benefits of the medication; • the side effects; • alternatives; • the patient's physical, emotional and social needs. These discussions will involve the patient's advocate or carer where appropriate.
37.2	2	The patient's allocated nurse monitors the tolerability and side effects of medication on a daily basis, where medication management is an active or current issue.
37.3	2	Members of the MDT monitor the therapeutic response to medication on a weekly basis.
37.4	2	Patients have access to a specialised pharmacist.
37.5	2	In preparation for transfer/discharge, and where possible, the unit helps all patients to understand the functions, limitations and side effects of their medications, and to self-manage as far as possible.
37.6	1	Polypharmacy and high doses of medication are, as far as possible, avoided. However, when used, the Prescribing Observatory for Mental Health (POMH-UK) guidelines are adhered to.
37.7	1	NMC standards for the administration of medicines are adhered to.
Engagement		
38.1	2	Patients have a minimum of 3-weekly documented sessions with their Primary/allocated nurse to review their progress.
38.2	2	There is evidence of daily documented sessions with the Primary/allocated nurse relating to patient need and the care plan/recovery pathway.
38.3	1	Each patient is invited to meet with a member of staff for one-to-one contact each waking shift and this is documented. Time is set aside purposely for this.
38.4	2	Each patient has the opportunity to have supportive one-to-one sessions with staff every day.

38.5	2	Each patient is offered structured psychological intervention for one hour per week, e.g. motivational interviewing, solution-focused therapy, appropriate to identified need.
38.6	1	Recreational activities and interventions, including engaging in creative work, hobbies and special interests, are available within the unit seven days a week, particularly for patients without leave.
38.7	2	Recreational activities and interventions including engaging in creative work, hobbies and special interests, are available within the unit seven days a week and up to 12 hours per day, particularly for patients without leave.
38.8	2	Life skills training, incorporating psycho-education on topics relating to Activities of Daily Living, interpersonal communication, relationships, coping with stigma, stress management and anger management is available.
38.9	2	Health promotion activities including diet, nutrition, exercise, substance misuse and smoking cessation are available.
38.10	2	Boundary setting is practised within the context of physical and psychological containment. This may include contracting, de-escalation, restraint, time-out and seclusion.
Staffing		
39.1	2	Healthcare assistants, nurses, occupational therapy support workers, volunteers and activity workers are involved in facilitating a broad range of therapeutic and leisure activities.
39.2	1	The available staff are sufficient to meet the needs of the unit on a shift basis.
39.3	1	Staff are appropriately trained in the management of acute disturbance including conflict resolution, and physical interventions are available 24/7. This provision would ordinarily be immediately available from within the unit staff team, supported by robust emergency procedures (site response).
Psychological Interventions		
40.1	2	During the delivery of the formal therapeutic programme, there is at least one member of staff in each group and activity, and others available if needed.
40.2	2	Patients who would benefit have access to an assessment for psychological interventions within two days of the request being made.
40.3	1	Inpatients have access to specialist practitioners of psychological interventions for one half-day (four hours) per week per unit.

40.4	3	Inpatients have access to specialist practitioners of psychological interventions for two and a half days (20 hours) per week per unit.
40.5	3	All patients have access to local complementary therapies, delivered by trained practitioners, in accordance with local policy and procedures.
40.6	1	At least one staff member linked to the unit is regularly delivering one basic, low intensity psychological intervention.
40.7	2	Staff are given planned and protected time to make sure activities and interventions are provided regularly and routinely.
Provision of Activities and Therapies		
41.1	2	Each patient has the opportunity to be involved in negotiating an activity and therapy programme, relevant to their identified needs, that includes evening and weekend activity. This is recorded in their care plan, and regularly monitored and reviewed.
41.2	2	Systems are in place to regularly review with patients and staff the quality and provision of therapeutic and social activities.
41.3	2	The frequency, regularity and diversity of activities are audited.
41.4	2	At least one staff member linked to the unit is delivering one problem-specific, high intensity psychological intervention.
41.5	3	At least one staff member linked to the unit is delivering two or more problem-specific, high intensity psychological interventions (to correspond to two or more diagnostic criteria as per NICE guidance).
41.6	1	Social/recreational activities are provided on a daily basis.
41.7	1	Social/recreational activities are provided at weekends.
41.8	1	Social/recreational activities are provided during the evenings.
41.9	1	Gender-sensitive groups are provided.
Group Activities and Therapies		
42.1	2	Group activities are protected and not interrupted.
External Activities and Therapies		
43.1	1	Following risk assessment, patients are able to leave the unit to attend activities elsewhere in the building and, with appropriate supports and escorts, to access usable outdoor space every day.

43.2	2	Following risk assessment, patients are supported and encouraged to access local organisations, advocacy projects and religious and cultural groups from their own community.
43.3	3	Following risk assessment and where legally permitted, patients have access to weekly outreach visits to community centres promoting recovery and social inclusion.

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Glossary of Terms and Abbreviations

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CCQI

Allocated Nurse	The nurse allocated responsibility for the patient's care for the duration of a shift
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment
CRB	Criminal Records Bureau
HDA	Health Development Agency
HoNOS	Health of the Nation Outcome Scales
IMCA	Independent Mental Capacity Advocate
LD	Learning disabilities
MDT	Multi-Disciplinary Team - all health professionals involved in patient care
MHA	Mental Health Act
MHAC	Mental Health Act Commission
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NRT	Nicotine Replacement Therapy
OT	Occupational Therapist
PALS	Patient Advice and Liaison Services
Primary Nurse	Inpatient nurse responsible for the individual patient's care
STR	Support, Time, Recovery

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AIMS-PICU Standards Feedback Form

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

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

Comments:

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

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3. Do you have suggestions for new standards or criteria you would like to see included in future versions?

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

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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 this form to:

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