Patient Safety Procedure in Mental Health Services
A Review Article

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Abstract:

There is a growing national consensus that employing institutional measures of control, such as isolation, restraint, chemical restraint, and handcuffed transport, within psychiatric hospitals is far too prevalent and may be counter-therapeutic. Unfortunately, nothing is known about how to eliminate these last-resort methods. Research on patient safety in mental health has lagged in the adoption of a system perspective and approach. However, recognizing that no single factor or group of factors accounts for a patient safety incident, in light of the paucity of data, we describe factors, standards, and procedures that may contribute to adverse events in mental health.

Methods: PubMed and Psych info were searched to locate studies that specifically evaluated efforts to reduce seclusion and restraint in psychiatric units. Key search terms included seclusion, restraint, reduce, psychiatric patient safety, psychiatric safety, psychiatric sanctuary, and quality of care psychiatry. Based on this search, little is known about how to reduce such measures of last resort and improve the safety of psychiatric settings. The review of the available literature found a few descriptions of administrative efforts to reduce seclusion and restraint at specific psychiatric hospitals or units that were followed by limited objective documentation of fewer episodes of seclusion or restraint.

Conclusions: Hopefully, this discussion will stimulate research on this understudied topic and provide a framework for improving patient safety in the psychiatric setting.

Keywords: Psychiatric settings, Patient Safety, Seclusion.

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Limitations of Benchmarking in Mental Health Practice:

It might be argued that benchmarking is a valid exercise in mental health practice only if it produces an improvement in patient care. The use of a benchmarking team to improve an administrative or other support procedure is unsatisfactory if there is no benefit for patient care. For example, significant expenditure on an industry-leading information technology system does not automatically lead to improved patient care (although that potential obviously exists). Worse, it may

appropriate money from an existing service that was providing useful and appreciated support. **(2)**

There are other factors that limit the ability of a mental healthcare organization to use benchmarking effectively. First is the lack of good outcome measures for mental health services. Industrial companies can measure improvements in terms of reduced or improved profits, whereas mental health benchmarking outcomes are likely to be more qualitative and may require more careful deliberation. If it takes a long time to decide on measurable outcomes before setting up a project or too long (more than about 6 months) to complete, a project a team can lose enthusiasm and support from within the organization. The same can happen if healthcare services spend a lot of time in search of ideally compatible facilities against which to compare themselves rather than taking a broader approach and learning from wherever they can. Finally, initiating a project for the sake of undertaking benchmarking is usually much more difficult than starting one in an area where a specific breakthrough improvement has been long required.**(3)**

Emergency Rooms vs Psychiatric Hospitals for Mental Health Crises:

Psychiatric hospitals are the ideal facilities for mental health patients, but there aren't always enough beds available to accommodate those in need of them. When this happens while a patient has a mental health crisis, they often stay in the emergency room for an extended period. In fact, a survey by the American College of Emergency Physicians showed that **87%** of physicians said psych patients were being boarded in their emergency departments.

Emergency rooms are effective for immediate, life-threatening support, like suicide attempts, self-harm, and threats of harm to others. However, prolonged emergency room stays can lead to increased stress and anxiety due to factors such as bright lights **24/7,** constant hustle and bustle, beeping monitors, changing staff, and more. This type of environment can potentially inflame the crisis that brought the patient to the ER in the first place. **(1)**

Engagement Approach:

The Engagement Model of care represents an approach for changing the climate of psychiatric hospitals and other inpatient facilities. Specifically, the model represents a framework for improving the therapeutic milieu of inpatient settings

in order to reduce potential antecedents to adverse psychiatric events and the subsequent need for seclusion and restraint. The critical features and assumptions of the model. **(4)**

1) highlight the importance of patients' perspectives regarding their psychiatric care.

2) assume that psychiatric institutions are often coercive.

3) assume that coercive measures may recapitulate a patient's prior trauma.

4) acknowledge that staff in psychiatric facilities are often unaware of or unequipped to handle the trauma-related difficulties of patients.

This model was inspired largely by the work of Sandra Bloom, who has highlighted the importance.

Patient involvement in treatment planning involves a "teamwork" approach to each patient's care. Patients are involved in their own treatment planning as well as in caring for the hospital community. A group atmosphere is fostered through community meetings in which patients and staff openly discuss how to handle disruptions and inappropriate behavior. Patients are held accountable for their behavior, and disruptions to the therapeutic environment are viewed as affecting the community rather than just the individual. When incidents of seclusion occur, subsequent debriefing occurs at both the individual and community levels.

Although the inherent power differential of the psychiatric setting is acknowledged, perceptions of randomness are dispelled through clear communication regarding acceptable and unacceptable community behavior. Trauma-informed care emphasizes the importance of educating both patients and staff about relevant trauma-related issues. Patients are encouraged to consider how their trauma histories influence their perceptions and reactions to care. Trauma-informed care aims to ensure that institutional procedures do not re-expose patients to experiences that will recapitulate their traumatic histories. Thus, psychiatric advance directives or risk management approaches for managing disruptive behavior are encouraged to give patients a sense of control and to facilitate problem-solving regarding strategies to reduce distress. At both the staff and patient level, trauma-informed care means remaining cognizant of the role of trauma in the psychiatric setting. **(5)**

Three Principles Are Considered Critical Factors in Successfully Implementing the Model:

- Changes to the environment include basic structural changes as well as general changes in the climate of care in psychiatric settings that will foster a sense of community and safety for patients.
- Patient care areas can be de-institutionalized with minor changes such as the addition of comfortable furniture, neat surroundings, pleasant lighting, plants, or soft music.
- Environmental signs such as "seclusion room," code words such as **"take-downs,"** and patient safety terms such as "security check" can be relabeled or eliminated altogether to de-emphasize measures that might be perceived as punitive. Such changes foster an environment of care rather than one of institutional containment. **(4)**

Key Elements of Psychiatric Room Design:

Psychiatric rooms and wards are better environments than the **ER** for mental health patients because their designs are conceived to reduce safety risks — while helping the patients feel as comfortable as possible. At the same time, the appropriate design enhances visibility, so the behavioral health staff can always keep an **eye** on vulnerable patients.

An environment that helps decrease stress can positively impact the patient's healing process. In fact, the right physical environment can even influence patient aggression levels. A study in Sweden published by the Journal of Environmental Psychology compared restraint usage between a hospital with updated design features to a hospital with old features. The study found that restraint use declined by **50%** in the new hospital compared to the old. That's a significant reduction that undoubtedly supported their patient safety-focused efforts. **(4)**

Safety Features of Psychiatric Rooms:

Psychiatric rooms and hospitals have several key design features created for patient safety. Some of these measures include:

- No sharp objects in the room.
- Walls with rounded corners.
- Heavy or immovable furniture to prevent barricading or throwing.

- Doors that swing outward.
- Tamper-resistant fixtures and breakaway shower rods.
- High ceilings.
- Room placement away from entries and exits.
- No glass mirrors and televisions placed behind Plexiglass.
- Open floor plans for visibility. **(6)**

Design Features to Promote Healing and Reduce Stress:

Some of the environmental design features that help patients feel at ease include:

- Ample natural light.
- Walls and art in soft, calming colors.
- Soft lighting instead of harsh fluorescent lights.
- Comfortable furniture
- Bright, open public areas. **(6)**

Seven Actions to Ensure Safety in Psychiatric Office Settings

1. **Workplace violence assessment, response, and prevention plan:**
    - Conduct a workplace violence assessment and create a workplace violence prevention and response plan regardless of the size or location of your practice.
    - Assess for workplace hazards within and around the office and plan for the various types of violence that may occur, whether physical violence against staff or verbal violence/harassment/bullying.
    - Be sure to include, as appropriate, representatives from each discipline in your office.
    - If you sublet space, include the practitioners who use that space.
    - Consider involving law enforcement and risk management in your planning.
    - Review the plan with staff at least annually. **(7) , (3)**
2. **Office and Physical Safety:**
    - Control/restrict access to the office by patients, visitors, and contractors by providing individual access card readers and/or locks to staff only or limiting access to restricted areas.
    - Ensure patients, visitors, and contractors are escorted within the office and do not wander alone.

- Install video surveillance cameras at entrances and exits and post signs indicating their presence as a deterrent to violence.
- Employ an office **"buddy"** system—no one works alone, including after-hours, or goes to his or her car alone.

3. **Social Media: Your Patients Are Not Your Friends:**
   - Don't accept "friend" invitations from your patients on social media, and do not look up your patients on social media **(consider boundary issues and privacy).**
   - Be mindful of posting personal information about yourself, family, and friends that may reveal your habits.
4. **Be Aware of Stalking Behavior and Boundary Crossing:**
   - Be aware of behaviors that are unwanted or distressing including threatening, harassing, and stalking behaviors.
   - Develop policies and procedures to identify, communicate, document, and track concerning behaviors, boundary violations, boundary crossings, and patient stalking.
   - For each occurrence of workplace violence/behavior incidents, document it and discussions about behavior expectations in the patient's medical record.
   - Communicate concerning behavior to other multidisciplinary staff members.
   - Seek assistance from your risk manager, legal counsel, and security/law enforcement. **(5)**
5. **Communicate Concerns and Plan an Escape Route:**
   - Avoid having your back to the exit and turn your body sideways to allow a clear path to the exit if a quick escape is necessary.
   - Install panic buttons in each office, at the reception desk, and in bathrooms.
   - Wear an audible alarm.
   - Designate a safe room within the office should an escape not be possible.

6. **Call for Help if You Fear for Your Safety or The Safety of Others:**
   - There is a HIPAA exception for disclosure to prevent or lessen a serious and imminent threat to the health or safety of an individual

or the public. When disclosing the threat, limit the disclosure to nonclinical information.

- Terminate patients that display violent/aggressive/stalking behavior toward you or your staff and consider whether a restraining order/noncontact order is needed. **(4)**

7. **Education and Training:**
   - Provide clinical and nonclinical staff interactive, site-specific education and training.
   - Educate staff about the nonverbal cues of aggression, agitation, and behavior escalation that may lead to an assault.
   - Provide de-escalation and response training.
   - Consider self-defense/personal safety training. **(3)**

In the majority of cases, no single reason is responsible for an accidental failure such as a safety event, according to research conducted in non-healthcare settings Typical safety issues feature "a complicated Interaction between numerous factors, including Human conduct, technological aspects of the system, sociocultural elements, as well as an assortment of organizational and administrative flaws" Like safety events in other systems, patient safety occurrences in all health settings are the outcome of a complex combination of contributing and interacting elements, not a single failure by an individual or a system. Understanding these elements is a crucial first step in designing mitigation and prevention measures for patient safety issues. Some contributing elements are universal to health care settings, while others are specific to mental health. **(13)**

There are several approaches to classifying factors contributing to patient safety issues. Individual factors contributing to patient safety incidents (**e.g.,** human error) are distinguished from system factors (**e.g.,** physical environment, unit design, staffing levels, heterogeneity of patients, availability of structured activities, and policies and procedures) according to a common classification. In the past, there was a propensity to blame individuals for patient safety problems, whether it was the patients themselves for participating in risky behaviors or health care workers for making mistakes. Focusing on individual elements results in person-level solutions, such as practitioner-specific methods. This method, however, disregards the environment in which patient safety incidents occur, making it impossible to identify and avoid recurrences of particular "**active**

failures". Although a specific action or omission by a person may be the immediate cause of an incident, a broader systems analysis will typically uncover a series of events and departures from safe practice that are the result of environmental/organizational conditions. **(12)**

Understanding how system-level factors contribute to patient safety incidents has therefore become a priority of the National Steering Committee on Patient Safety, the system approach to understanding patient safety incidents recognizes adverse events as the result of complicated multiple system elements. The addition of system-level elements shifts the duty for responding to and enhancing patient safety from individual health care workers to the system. Consequently, when a patient safety incident happens, the focus is not on determining who committed the active failure, but rather on how and why the system failed and allowed the failure to occur **(Department of Health, 2000).** Similar changes have occurred in other high-risk industries, including aviation and nuclear power. Research on patient safety in mental health has lagged in the adoption of a system perspective and approach. However, recognizing that no single factor or group of factors accounts for a patient safety incident, the following sections review. **(1)**

Factors which May Contribute to Adverse Events in Mental Health

Patient Factors:

Patients at risk for one type of disruptive behavior **(e.g., absconding)** are typically at increased risk for other disruptive behaviors **(e.g., aggressiveness)** in mental health Absconding, self-harm and suicide, difficult and non-compliant behaviors, and violence are prone to co-occur in the same patients. While much of the literature on patient aggressiveness portrays patients as either aggressors or victims, in reality, patients actively manage the risks they pose to themselves and to others. According to research, patients actively make inpatient environments safer for themselves by avoiding risky individuals or situations, warning other patients about their volatility, de-escalating potentially risky situations, requesting surveillance or another safety intervention from staff, and engaging in protective behavior with other patients. These findings highlight the importance of patient participation in safety programs. **(4)**

The impact of the psychiatric diagnosis on patient safety in mental health settings is of special relevance. Psychiatric symptomatology impacts patient-provider

communication and may impede the appropriate reporting of both general medical and mental health issues. Patients with mental illness may be less likely to seek care if their condition worsens. It can also make it more difficult for people to navigate the health care system's intricacies. Other symptoms, such as co-occurring substance misuse, may put patients at risk for violence toward staff or other patients, as well as self-harm and suicide. As a result, doctors may be more likely to provide these patients with excessive quantities of medication due to fears of violence and communication issues. **(9)**

Provider Factors:

The rate of patient safety events on inpatient units is significantly influenced by mental health care professionals, according to research. The degree to which staff's ability to control their fear and anger towards patients and their behavior had a significant impact on aggression, self-harm, and elopement rates **(Bowers, Simpson, & Alexander, 2005).** Patient safety events are also intimately related to the demands of the workplace. Large caseloads and limited time to meet patients have been associated with patient safety issues in mental health settings. Patient safety problems have been connected to poor communication between health care providers and between health care providers and patients and families. High staff turnover, inexperienced workers, weariness, and interpersonal conflict may have an impact on communication. In normal medical settings, mental health care communication is particularly hard. **(8)**

Cognitive state and depressive symptoms are frequently omitted from the clinical information provided upon referral to home care in the United States, according to research. found that just 5% of depressed patients had depression status information recorded in their records. Improvements in communication are typically related to enhanced patient safety. There are fewer patient safety errors in systems with high levels of feedback and staff collaboration **(Australian Resource Centre for Hospital Innovations 2020).**

Organizational Factors:

Non-clinical systems such as human resources, recruiting and retention, training programs, and admission and discharge processes are relevant to patient safety but are outside the control of the individuals delivering mental health care to patients. Not only do organizational characteristics affect the incidence of patient safety incidents, but they also affect the likelihood that accidents and near misses

will be reported. This is influenced by the organizational reporting policies and processes as well as the corporate culture that stresses **(or downplays)** the importance of patient safety and the need to learn from accidents. Patient safety problems are exacerbated by fragmentation within mental health and across mental health and general medical systems. Particularly, information sharing, lack of community resources, bed constraints, and staffing shortages contribute to patient safety issues in the mental health system. **(3)**

It is believed that the functioning of the system as a whole, including access to diverse components of care across the continuum, also influences mental health patient safety. Inadequate community services, such as housing, exacerbate the strain on mental emergency departments, which become de facto inpatient units. These demands ultimately increase patient safety risks. Moreover, mental health settings reflect the populations they serve. Poor catchment areas, typified by poverty, substance abuse, and violence, would likely have a higher incidence of patient safety issues, including violence and absconding. **(9)**

Different care paradigms also affect patient safety. This is illustrated by the transition from psychiatric consultation in the emergency department to models of psychiatric emergency services. Historically, behavioral emergencies have been treated with psychiatric consultation in the emergency department. This arrangement strains the resources of medical emergency departments. In models of psychiatric emergency care, patients may be triaged by a separate staff of mental health specialists, but they are still assessed medically in collaboration with emergency department personnel. In psychiatric crises, this method provides fast psychiatric assessment and minimizes wrong judgments to accept or discharge patients. This paradigm is thought to enhance patient safety by reducing wait time, the use of emergency medicine, seclusion and restraint measures, and patient elopement, and by boosting the completion and thoroughness of mental health status evaluations. **(1) , (8)**

Physical Environment:

Poor physical design, including the physical environment's layout and characteristics, contributes to patient safety events and feelings of insecurity on the unit **(College of Registered Psychiatric Nurses of British Columbia, 2006; Department of Health, 2002a; McGeorge & Rae, 2007).** Several articles provide guidelines on the optimal physical design for inpatient wards **(Bolton, 2006;**

Department of Health, 2002a; Goodall, 2006; Marshall et al., 2004; Royal College of Psychiatrists, 1998) and contain insightful information and suggestions. Providing female-only places in psychiatric wards to prevent women from unwanted sexual contact, sexual harassment, and sexual assault; providing enough washing facilities, restrooms, sleeping spaces, and common areas are examples of safe physical design. high ceilings, natural light, wide corridors, quiet areas, and outdoor green spaces, to allow for space and reduce aggressive and impulsive behavior; installing unbreakable windows with a limited opening and avoiding fittings that could be used by patients to hang themselves **(including curtain rails, cupboard rails, mechanical door closers, exposed pipes, etc.);** providing doors to patient bedrooms that are lockable by the patients but allow fob access; and providing windows that are unbreakable with a limited opening **(Mental Health Act Commission, 2008; Royal College of Psychiatrists, 1998)**.

The impact of physical design on patient safety in outpatient and community mental health settings has received minimal attention, similar to the majority of patient safety literature dedicated to mental health. In addition, little is known about the environmental layout and design of private dwellings and the safety of **home-dwelling** mental health patients. **(10)**

How Patient Safety Affects Workplace Safety:

There are numerous ways in which patient and staff safety intertwine **(Kohn et al., 1999; Lang and Edwards, 2006).** Both groups have similar worries about safety and the variables that lead to mishaps. Sexual assault, harassment, and other forms of sexual violence pose a threat to the safety of healthcare workers just as much as they do to patients. Employees' ability to prevent, identify, and respond to accidents involving patient safety may be impacted by their working circumstances as well. **(1) , (3)**

The quality of care provided to patients and the risk of patient safety incidents are directly related to the safety difficulties faced by healthcare workers. Poor working conditions and a lack of autonomy in the workplace have been found to have a negative impact on both patient and staff safety. This is not surprising **(Banerjee et al., 2008).** An additional factor that affects the performance of employees who are involved in patient safety accidents is guilt and fear of being held accountable by their coworkers and the business. **(3)**

Patients' safety and employee safety are intertwined because of the transactional nature of both. The two groups appear to have different approaches to improving safety, but this doesn't mean they're incompatible. In the United Kingdom's National Health Service's psychiatric inpatient hospitals, Bowers et al. **(2002)** discovered two distinct approaches to security. Their argument was that the two methods might represent two different points of view. A patient's safety was the primary concern of the first, while the safety of the staff was stressed by security measures like guards and alarms. **(4)**

Review of Patient Safety Incidents

Aggression and Violence:

Violence and hostility in the mental health industry have gotten a lot of attention recently. As offenders, witnesses, and victims of hostility and violence, people with mental health issues are particularly susceptible. Although the phrases aggression and violence are commonly used interchangeably, experts in the field have tried to separate them. **No** universally agreed-upon nomenclature for what defines aggressiveness or violence has been found in the literature review, which shows that there is still a void in the field. The **MacArthur** violence risk assessment research is used to define the terms used in this paper. Any behavior in which a patient puts their hands on someone with the aim of harming them is referred to as aggression. Threats with a weapon, sexual assaults, and physical assaults are all examples of violence. **(14)**

However, most people with mental illness do not pose a threat to others, several large-scale studies have found a small but strong link between mental illness and the likelihood of violence. Patient safety incident reports are frequently triggered by incidents of aggressive and violent assault, there were **10,467** cases of disruptive and aggressive behavior in England and Wales based on over **45,000** incidents from **116** organizations, which is **23.4** percent of the total. Patient accidents **(34.7 percent)** were the most common cause of safety-related reports, but aggressive and disruptive behavior by staff members came in second. **(7)**

Violence and aggression have increased in the inpatient setting, where a growing number of patients with serious illnesses and special requirements are being treated by acute, tertiary, and forensic experts. Patients and residents at

mental health facilities have long been known to engage in violent behavior. An ever-increasing number of people are being diagnosed with both mental illness and substance abuse. According to the National Institute for Clinical Excellence **(2001),** substance abuse and mental illness are significant predictors of violence and aggression Healthcare Commission **(2005),** Patient safety issues such as violence and hostility are also closely linked to these other difficulties. Individuals who engage in risky behaviors like aggression and violence are more likely to have a history of other safety-compromising behaviors and are more likely to engage in other risky behaviors like absconding, **self-harm** or **suicide,** property damage or substance abuse in the future. **(11)**

Table 1. Safe Wards Interventions:

Intervention	Description	Purpose
Mutual Help Meeting	Patients offer and receive mutual help and support through a daily, shared meeting	Strengthens patient community, opportunity to give and receive help
Know Each Other	Patients and staff share some personal interests and ideas with each other, displayed in unit common areas	Builds rapport, connection, and a sense of common humanity
Clear Mutual Expectations	Patients and staff work together to create mutually agreed aspirations that apply to both groups equally	Counters some power imbalances create a stronger sense of shared community
calm Down Methods	Staff support patients to draw on their strengths and use/learn coping skills before the use of PRN medication or containment	Strengthen patient confidence and skills to cope with distress
Discharge Messages	Before discharge, patients leave messages of hope for other patients on a display in the unit	Strengthens patient community, generates hope
Soft Words	Staff take great care with their tone and use of collaborative language. Staff reduce the limits faced by patients, create flexible options and use respect if limit setting is unavoidable	Reduces a common flashpoint. Builds respect, choice and dignity.
Talk Down	The de-escalation process focuses on clarifying issues and finding solutions together. Staff maintain self-control, respect, and empathy	Increases respect, collaboration, and mutually positive outcomes
Positive Words	Staff say something positive in handover about each patient. Staff use psychological explanations to describe challenging actions	Increases positive appreciation and helpful information for colleagues to work with patients
Bad News Mitigation	Staff understand, proactively plan for, and mitigate the effects of bad news received by patients	Reduces the impact of common flashpoints, offers extra support
Reassurance	Staff touch base with every patient after every conflict on the unit and debrief as required.	Reduces a common flashpoint, increases patients' sense of safety and security

Theme	Icon
Patient/carer information	
Care planning	
Medication	
Safety	
Wellbeing	
Healthy lifestyle	
General environment	
Patient and carer involvement	
Training and competencies	
Service development	
Policies and procedures	

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Standard for Forensic Mental Health Services

Admission and Assessment		
No.	**Standard**	**Key**
1	Patients will receive a multi-disciplinary pre-admission assessment of need and risk that ensures admissions to theservice are appropriate and the needs of patients are clearly identified. *Guidance: The pre-admission assessment includes:* • *Assessment of mental health needs;* • *Security risks and needs;* • *Problem areas and risk factors;* • *Physical health needs;* • *Safeguarding needs;* • *Cultural/spiritual needs (including language andtranslation needs);* • *Personal needs;* • *Strengths, protective factors and goals;* • *A clinical formulation;* • *Victim issues.*	
2	The multi-disciplinary team make decisions about patient admission or transfer. They can refuse to accept patients if they anticipate that the patient mix will compromise safetyand/or therapeutic activity. *Guidance: Decisions to accept or refuse patients are recorded.*	
3	On admission to the service, staff members introducethemselves, other patients and show them around. *Guidance: This may also include the use of a 'buddy system' prior to and on admission.*	 
4	All information is provided in a format which is easilyunderstood by patients. *Guidance: Information can be provided in languages other than English and in formats that are easy to use for peoplewith sight/hearing/cognitive difficulties or learning disabilities. For example, audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is culturally relevant.*	 

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5	Patients are given a 'welcome pack', or introductoryinformation, at the first appropriate opportunity thatcontains, at a minimum, the following: • A clear description of the aims of the service; • The current programme and modes of treatment; • The service team membership; • Personal safety in the service; • The code of conduct on the service; • Service facilities and the layout of the service; • What practical items can and cannot be brought in; • Clear guidance on the smoking policy in smoke-freehospitals and how to access nicotine replacement options; • Resources to meet spiritual, cultural and genderneeds. *Guidance: Patients are offered a verbal explanation of the information contained in the welcome pack.*	
6	Clear information is made available, in paper and/orelectronic format, to patients, carers and healthcarepractitioners on: • Admission criteria; • Clinical pathways describing access and discharge; • How the service involves patients and their carers; • Contact details for the service.	
7	Patients are given verbal and written information on: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.	 
	Physical Healthcare	
8	All records held by the service are integrated into onepatient record. *Guidance: External clinicians, such as GPs, are encouraged to use hospital recording systems.*	
9	Patients are offered a staff member of the same gender as them, and/or a chaperone of the same gender, for physicalexaminations.	

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10	Patients have their physical healthcare needs assessed within 72 hours of admission and reviewed every six monthsor more frequently if required. Patients are informed of theoutcome of their physical health assessment and this is recorded in their notes. *Guidance: This includes past medical history and family medical history, current medication, physical observations, physical examination, blood tests, physical symptoms, lifestyle factors and lifestyle advice. A monitoring plan is in place for patients who decline an initial assessment, until an assessment can be completed.*	
11	Care plans consider physical health outcomes andinterventions in the following areas: • Health awareness; • Weight management; • Smoking; • Diet and nutrition; • Exercise; • Dental and optical needs; • Any patient specific items. *Guidance: For patients who have not successfully reached their physical health targets after three months of followinglifestyle advice, the team discusses further intervention.*	
12	Patients are informed of and supported to access screeningprogrammers available in line with those available to the general population with the aim of ensuring early diagnosisand prevention of further ill health. *Guidance: Patients are informed of the higher physical health risks for patients in secure mental health, such as diabetes, dyslipidaemia, hypertension, epilepsy, asthma etc. and gender-specific needs.*	
13	Emergency medical resuscitation equipment (crash bag) isavailable within three minutes. The crash bag is maintainedand checked weekly, and after each use.	

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Treatment and Recovery		
14	Every patient has a written care plan reflecting theirindividual needs, including: • Any agreed treatment for physical and mental health; • Positive behavioural support plans; • Advance directives; • Specific personal care arrangements; • Reducing risk and risk of reoffending; • Specific safety and security arrangements; • Medication management; • Management of physical health conditions.	
15	The multi-disciplinary team develops the care plancollaboratively with the patient and their carer. *Guidance: The patient is actively involved in the decisions, goals and timescales of their care plan, developed with theMDT in an open and transparent manner.*	
16	The multi-disciplinary team reviews and updates care plansat least monthly, or more frequently according to clinical need.	
17	The patient and their carer are involved in discussions about the patient's care and treatment planning and they are offered a copy of the care plan and the opportunity to reviewthis.	
18	Patients have a pathway of care planned that is realistic andtakes account of their aspirations. The plan identifies services the patient is likely to need through their pathway to the community or to the last realistic point of care.	
19	Patients are offered evidence based pharmacological interventions and any exceptions are documented in thecase notes.	
20	Patients are offered evidence based psychological interventions to promote mental health recovery andoffending/risk behaviour, and any exceptions are documented in the case notes. *Guidance: This is likely to include interventions to address mental health recovery, insight, drug and alcohol, offending/risk behaviour and family relations. The number, type and frequency of psychological interventions offered are informed by the evidence base.*	

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21	Patients have clear personalised outcomes identified in key recovery areas (if relevant) and understand which outcomes are pathway critical i.e. what they must achieve to progress to the next level of care. *Guidance: Recovery areas may include:* • *Mental health recovery;* • *Insight;* • *Problem behaviours and risk;* • *Drugs and alcohol;* • *Independent living skills;* • *Physical health.*	
22	Patients have a personalised plan of therapeutic and skill- developing activity that is directly correlated to their outcomes plan. Activities and therapy are planned over seven days and not limited to conventional working hours.Patients can see the connection between activities they areundertaking and the achievement of their recovery goals.	
23	Patients have a formalised review of their care (such as CareProgramme Approach or equivalent) within the first three months and as a minimum every six months thereafter to review ongoing outcomes work and progress. *Guidance: There is evidence that patients are encouraged and supported to play a key participating role in their formal review meeting and the patient's views are clearly documented.*	
24	The team provides information, signposting and encouragement to patients where relevant to access localorganisations for peer support, social engagement and meaningful occupation such as: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	

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25	The team develops a leave plan jointly with the patient thatincludes: • The aim and purpose of section 17 leave; • Conditions of the leave and the therapeutic purpose; • A risk assessment and risk management plan that includes an explanation of what to do if problemsarise on leave; • Contact details of the service; • Expectations on return from leave e.g. searching; • MAPPA requirements and victim issues, whererelevant.	
26	The service identifies and addresses the immediate needs and concerns of the patient in relation to transitions to otherservices or to the community. *Guidance: This is likely to include practical issues such as:* • *Housing support;* • *Support with finances, benefits and debtmanagement;* • *Advice and support on disclosure;* • *Medication and access to primary healthcareservices;* • *Clothing;* • *Transfer of personal items;* • *Personal care;* • *Use of electronic devices, such as mobile phones.*	
27	Patients and their carer are invited to a discharge meeting and are involved in decisions about discharge plans.	
28	The service works proactively with the home area care coordinator and next point of care (including other inpatient services, forensic outreach teams, community mental healthteams or prison) to develop robust discharge/transfer arrangements and minimise delay in accessing crisis support. *Guidance: Patient discharge plans feature triggers and arrangements for 'recall' to the service if the patient relapses. When patients are transferred between services there is a handover which ensures that the new team have an up-to-date care plan and risk assessment.*	

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29	There is a system in place for all permanent and agencynursing staff to be assessed as competent to administermedications.	
30	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded. *Guidance: Patients are helped to understand the functions, expected outcomes, limitations and side effects of their medications and to self-manage as far as possible.*	
31	Patients prescribed mood stabilisers or antipsychotics arereviewed at the start of treatment (baseline), at three months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the patient: • A personal/family history (at baseline and annualreview); • Lifestyle review (at every review); • Weight (every week for the first six weeks); • Waist circumference (at baseline and annual review); • Blood pressure (at every review); • Fasting plasma glucose/ HbA1c (glycatedhaemoglobin) (at every review); • Lipid profile (at every review).	
32	The safe use of psychotropic medication is audited andreviewed, at least annually and at a service level. *Guidance: This includes medications such as lithium, valproate, high dose antipsychotic drugs, antipsychotics incombination and benzodiazepines.*	
33	Evidence-based clinical and patient reported outcome measurement data is collected post-admission and routinelyreviewed by the team and patient at clinical reviews.	

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Patient Experience		
34	Individual staff members are easily identifiable. *Guidance: For example, by wearing or displaying appropriate photo identification.*	
35	Patients and their carers are offered written and verbal information about the patient's mental health condition and any physical health conditions.	
36	Confidentiality and its limits are explained to the patient andtheir carers on admission, both verbally and in writing. *Guidance: For carers, this includes confidentiality in relation to third party information.*	
37	The patient's consent to the sharing of clinical informationoutside the clinical team is recorded and there is a systemfor review. If this is not obtained the reasons for this are recorded.	
38	The advocate is independent, known by name to the patientgroup and where requested raises issues on behalf of the patients and feeds back any actions or outcomes.	
39	Patients are treated with compassion, dignity and respect. *Guidance: This includes respect of a patient's race, age, expressed social gender, marital status, sexual orientation,maternity, disability, social and cultural background.*	
40	Patients feel listened to and understood by staff members.	
41	Patients' preferences are **taken into account** during the selection of medication, therapies and activities, and areacted upon as far as possible.	

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42	Patients' preferences/views are **taken into account** whenallocating staff members undertaking overnight observations in bedroom areas.	
43	There is a clear and well understood route for patient communication to the organisation's board, and from the board back to patients on the wards. Patients are given theopportunity to communicate their feedback and experiences of using the service in a variety of forms, including feedback surveys, focus groups, community meetings and patient representatives.	
44	There is a minimum of two community meetings a monthon each ward that are attended by patients and staff members. • The meeting is chaired or co-chaired by a patient; • Discussions are recorded with written minutes; • There is a clear process for the discussions from this meeting to be fed through management and governance routes to the board, and a clear process through which the board feeds back to patients at the ward-based community meeting.	
45	The service has a user involvement and co-productionstrategy covering all aspects of service delivery. *Guidance: The strategy defines patient and carer involvement as an equal partnership between people who design and deliver services, people who use the services and people in the community.*	
46	There is a designated lead for patient and carer involvement.*Guidance: This individual is part of the executive management team and attends each ward-based community meeting a minimum of once a year.*	

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47	The service facilitates access to a peer support service.	
48	Patients are provided with meals which offer choice, addressnutritional/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.	
49	The service enables patients to make healthy diet choices atmeal and non-meal times. *Guidance: Policies and practices around access to non- hospital food and drink, including patient shop items, take- aways and use of patient leave are in place. The provision ofinformation and support for carers regarding appropriate choices around food and drink they may bring to the unit and provide on home visits is documented.*	
50	Education is offered to patients on the importance of maintaining a healthy lifestyle and the service encouragespatients to remain active. *Guidance: Patients have access to a range of physical activities and appropriate physical health monitoringmeasures are in place.*	
Family, Friends and Visitors		
51	The team provides each carer with a carers' information pack. *Guidance: This includes the names and contact details of key staff members at the service. It also includes other localsources of advice and support such as local carers' groups, carers' workshops, advocacy services and relevant charities.*	
52	Carers are advised on how to access a statutory carers' assessment provided by an appropriate agency. *Guidance: This is an opportunity for carers to discuss what support or services they need, including physical, mental and emotional needs. Arrangements should be made through the carer's local council.*	

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53	Carers have access to a carer support network or group. Thiscould be provided by the service, or the team could signpostcarers to an existing network. *Guidance: This could be a group/network which meets face- to-face or communicates electronically.*	
54	Carers are supported to engage in meetings, events andservice initiatives. *Guidance: This includes organising transport and facilitating video-conferencing calls.*	
55	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	
56	When a patient withdraws consent, general information about the hospital, its service provision, as well as educationabout mental ill-health and recovery is still available to carers.	
57	The service has a strategy for carer engagement developedthrough use of the 'Carer support and involvement in securemental health services toolkit' (NHS England, 2018). The strategy describes measures taken to proactively support: • A carer's own needs around information and support; • How they can be involved in the care of their lovedone; • Opportunities to be involved in service developments, training and improvements.	

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58	Visitors are made to feel welcome and the service provides apositive first impression.	
59	There is a designated visitors' room within the secure perimeter. The space must meet the following requirements: • Suitable to maintain privacy and confidentiality; • Provide a homely environment; • Observations are not overly intrusive; • Accessible by patients and visitors.	
60	The service can safely facilitate child visits and is equipped with a range of child-appropriate facilities such as toys, games and books. *Guidance: The children should only visit if they are the offspring of or have a close relationship with the patient andit is in the child's best interest to visit. Sufficient staff should be made available to enable children to visit during evenings and weekends.*	
61	The pathway of care considers victim issues and is developed in liaison with relevant supervisory agencies e.g.the responsible local authority, offender manager and/or **MAPPA.**	
Ward Environment		
62	Call button/personal alarms are available to all staff, patients and visitors within the secure perimeter.	
63	Lockable facilities are provided for: • Patients for their personal possessions (with staff override feature) with maintained records of access; • Staff away from the patient area for the storage of anyitems not allowed within patient areas (which are locally determined); • Visitors away from patient areas to store prohibited or restricted items whilst they are in the service.	

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64	Staff members ensure that no confidential data is visible oraccessible beyond the team. *Guidance: This might be by locking cabinets and offices, using swipe cards and having password protected computer access, and ensuring computer screens are notvisible through reflection or direct sight.*	
65	The environment meets the needs of individuals withphysical disabilities. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	
66	Patients can adjust or request changes to the environmentto maintain thermal comfort. *Guidance: This includes adjustments to heating, ventilation through the use of windows and support to add/removeclothing.*	
67	Patients can personalise the ward environment and theirbedroom spaces, in conjunction with staff members andwhere appropriate.	
68	There are clear lines of sight to enable staff members to viewpatients. Measures are taken to address blind spots and ensure sightlines are not impeded. *Guidance: Measures may include staff placement, the use of mirrors or CCTV.*	
69	Furnishings minimise the potential for fixtures and fittings tobe used as weapons, barriers or ligature points.	
70	Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking. Bedrooms have patientoperated privacy locks that staff can override from the outside.	
71	Doors in rooms used by patients have observation panels with integrated blinds/obscuring mechanisms. These can beoperated by patients with an external override feature for staff.	

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72	The service has designated and fit for purpose facilities forpatients within the secure perimeter for: • Education; • Therapies; • Tribunals; • Quiet space; • Physical exercise; • Primary health provision; • Self-catering/cooking; • Dining; • Shop/café; • Video-conferencing; • Laundry.	
73	There is a designated multi-faith room within the secureperimeter which provides patients with access to faith- specific materials and facilities that are associated with cultural or spiritual practices. *Guidance: This space should be private and quiet.*	
74	There is a secure treatment and dispensary room.	
75	The service has at least one bathroom/shower room for everythree patients. *Guidance: Services built after 2011 should provide en-suite facilities as specified in the Environmental Design Guide. Older buildings should have an established maintenance programme working towards this.*	
76	Patients can wash and use the toilet in private.	
77	Patients can access safe outdoor space when requested, atleast daily and when it is safe to do so. *Guidance: Unless individual risk assessments dictate otherwise. Any exceptions should be documented in casenotes.*	

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78	Patients can make and receive calls in private.	
79	All patients have access to facilities to make their own hotand cold drinks and snacks. *Guidance: Facilities are accessible at all times unless individual risk assessments dictate otherwise.*	
80	All patients can access a range of current resources for entertainment, which reflect the service's population. *Guidance: This may include recent magazines, daily newspapers, books, board games, a TV and DVD player withDVDs, computers and internet access (where risk assessment allows).*	
81	There is a dedicated de-escalation space that is furnished for the purpose of de-escalation.	
82	Any designated seclusion room meets the requirements ofthe Mental Health Act Code of Practice. *Guidance: The room:* • *Allows for communication with the patient when thepatient is in the room and the door is locked, e.g. via an intercom;* • *Includes limited furnishings which should include a bed, pillow, mattress and blanket or covering;* • *Has no apparent safety hazards;* • *Has robust, reinforced window(s) that provide naturallight (where possible the window should be positioned to enable a view outside);* • *Has externally controlled lighting, including a mainlight and subdued lighting for night time;* • *Has robust door(s) which open outwards;* • *Has externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature;* • *Does not have blind spots, and alternate viewing panels are available where required;* • *Has a clock visible to the patient from within theroom;* • *Has access to toilet and washing facilities.*	

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Physical Security		
83	The service manages physical security according to the standards stated in the QNFMHS Physical Security in SecureCare guidance.	
Procedural Security		
For standards 84-92, there are formalised policies, procedures and guidance, which have been co-produced where possible, on:		
84	Anti-bullying. *Guidance: Policies and procedures include information for staff and patients, for those who are bullying, and those who are being bullied.*	
85	Conducting searches of patients and their personal property,staff members, visitors and the environment.	
86	Effective liaison with local police on incidents of criminalactivity/harassment/violence and other criminal justice agencies, where relevant. *Guidance: A memorandum of understanding is in place with local police on reporting crime.*	
87	Supporting patients' use of electronic equipment and safe access to the internet, including specific advice around theappropriate use of social networking sites, confidentiality and risk.	
88	Managing situations where patients are absent withoutleave.	

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89	Patient observation.	
90	Prevention of suicide and management of self-harm.	
91	Minimising restrictive practices. *Guidance: Policies and procedures include a formalised strategy for minimising restrictive practices that is proportionate to the possible risks identified. A process for reviewing restrictive practices is documented with specified timescales. Individual care plans focus on minimisation and restrictive practices.*	
92	Visiting, including procedures for children and unwantedvisitors (i.e. those who pose a threat to patients, or to staffmembers).	
93	A contingency plan addresses: • The chain of operational control; • Communications; • Patient and staff safety and security; • Maintaining continuity in treatment; • Accommodation; • Testing by live and desktop exercises, including a collective response to rehearsing alarm calls at leastsix-monthly.	
94	The service's policies and procedures are developed, implemented and reviewed in consultation with patients, their carers and staff members. There is a process in place toenable patients and their representatives to view policies critical to their care.	
95	Policies, procedures and contingency plans are reviewed, and updated where required, at the point of material changeto the service, in the event of an incident, and every three years as a minimum.	

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96	Policies, procedures and guidelines are formatted, disseminated and stored in ways that staff, patients andcarers find accessible and easy to use.	
97	There are systems in place to assess staff knowledge ofpolicies critical to their role.	
	Relational Security	
98	There is a relational security component to the inductionprogramme for all staff that is informed by See Think Actand as a minimum covers: • The context of risk and consequence in secure care; • An explanation of the definition of relational security; • An explanation of the relational security model; • How to manage boundaries effectively.	
99	There is a structure in place for direct care staff that supportsongoing skill development in the eight areas of relational security.	
100	There are clear and effective systems for communicationand handover within and between staff teams. *Guidance: Relevant issues are identified using the relational security explorer wheel, are noted in handovers and audited.*	
	Safeguarding	
101	Inter-agency protocols for the safeguarding of adults and children are easily accessible on the ward. This includes local safeguarding responsibilities and functions, and escalating concerns if an inadequate response is received to a safeguarding alert or referral. *Guidance: On admission, a record is made for each patient of any children known to be in their social network, their relationship to those children and any known risks whether or not reflected in convictions.*	
102	There is a local designated safeguarding lead who can give advice and ensure that all safeguarding issues are raised and resolved, in line with local policy and external requirements of the Safeguarding Adults and Children Board.	

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103	There is a system in place to respond to themes and trends in safeguarding alerts/referrals and there are mechanisms toshare learning. *Guidance: An action plan is in place to address any issues raised, including where training needs are identified.*	
104	Staff members feel able to raise any concerns they may haveabout standards of care. *Guidance: There is an active system in place for whistleblowing and raising concerns regarding standards of care.*	
Workforce		
105	The multi-disciplinary team consists of or has access to stafffrom a number of different professional backgrounds that enables them to deliver a full range of treatments/therapiesappropriate to the patient population. *Guidance: The team includes psychiatrists, nurses (including primary care), healthcare assistants, registered psychologists, allied healthcare professionals, social workers and educational professionals.*	
106	The service has a mechanism for responding to saferstaffing, including: • A method for the team to report concerns aboutstaffing; • Access to additional staff members; • An agreed contingency plan, such as the minor andtemporary reduction of non-essential services; • An overdependence on bank and agency staff members results in action being taken.	
107	There is a medical on-call arrangement in place whichenables the service to: • Respond within 30 minutes to psychiatricemergencies; • Fulfil the requirements of the Mental Health Act Codeof Practice. *Guidance: An identified doctor should be available at all times to attend the service, including out of hours. They should be able to attend the ward within one hour during normal working hours and within four hours outside of this.*	

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108	All clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified bytheir professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	
109	All staff members receive individual monthly linemanagement supervision. *Guidance: Supervisors should be appropriately trained to deliver supervision.*	
110	All staff members receive an annual appraisal and personaldevelopment planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	
111	All staff members have access to monthly formal reflectivepractice sessions. *Guidance: This forum provides staff members with the opportunity to reflect on their own actions and the actions of others. It can also be used to discuss concerns and issues of relational security. Reflection is a conscious effort to thinkabout an activity or incident that allows the individual and/or group to consider what was positive or challenging, and if appropriate, plan how it might be enhanced, improved or done differently in the future.*	

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112	There are processes and initiatives in place to support staffhealth and well-being. *Guidance: This includes:* • *Providing access to support services;* • *Monitoring staff sickness and burnout;* • *Encouraging staff to take scheduled breaks;* • *Assessing and improving morale;* • *Providing wellbeing programmes;* • *Monitoring turnover;* • *Reviewing feedback from exit reports and taking action where needed.*	
113	New staff members, including bank and agency staff, receivean induction based on an agreed list of core competencies. *Guidance: This includes arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced and weekly supervision until core competencieshave been assessed as met.*	
114	Staff members receive training consistent with their role and in line with their professional body. This is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: • Statutory and mandatory training; • The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act(or equivalent); • Physical health assessment; • Drug and illicit substance awareness; • Immediate Life Support.	
115	Staff members receive training on: • Recognising and communicating with patients, e.g. cognitive impairment or learning disabilities; • Recovery and outcomes approaches; • A patient's perspective; • Carer awareness, family inclusive practice and socialsystems, including carers' rights in relation to confidentiality.	

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116	The team receives training on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression andviolence.	
117	The team effectively manages violence and aggression inthe service. *Guidance*: • *Staff are appropriately trained and confident in managing violence and aggression*; • *Education is offered to patients on least restrictivepractices;* • *Staff members do not deliberately restrain patients ina way that affects their airway, breathing or circulation*; • *Restrictive intervention always represents the leastrestrictive option to meet the immediate need*; • *The team works to reduce the amount of restrictivepractice used*; • *Providers report on the use of restrictive interventions to service commissioners, who monitor and act in the event of concerns.*	
118	Patients and carers are involved in the design and delivery offace-to-face training.	
Governance		
119	Service quality improvement is supported by a formalprogramme of involvement: • There is a co-produced local quality improvementstrategy linked to the needs of patients and the workforce; • Models of care within the service are routinely subjectto evaluation and review; • There is a mechanism in place for staff and patients to influence and contribute to quality improvement projects.	

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120	The service supports research and the implementation of evidence-based interventions: • There is a local research strategy linked to the needs of patients and workforce; • Research includes projects co-produced with patients and carers and collaboratively engages with other services and stakeholders; • Assessment and treatment models of care within theservice are routinely subject to evaluation; • There is a mechanism in place for staff and patients to influence and contribute to research projects; • The service shares the outcomes of their research withpatients, carers, staff and other stakeholders by means such as plain language summaries, research papers, posters and presentations.	
121	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service?	
122	The ward/unit has a strategic managerial meeting, at least annually, with all stakeholders to consider topics such as referrals, the clinical model, service developments, issues ofconcern and to re-affirm good practice. *Guidance: Stakeholders should include staff member representatives from across the care pathway, as well as patient and carer representatives.*	
123	There is a widely accessible complaints procedure, for staff, patients and visitors, that clearly sets out the ways in which a complaint can be made, the process for investigation and how communication is managed throughout.	
124	Complaints are reviewed on a quarterly basis to identifythemes, trends and learning.	
125	Staff members and patients feel confident to contribute toand safely challenge decisions. *Guidance: This includes decisions about care, treatment and how the service operates.*	

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126	Systems are in place to enable staff members to quickly andeffectively report incidents and managers encourage staff members to do this. Staff members are provided with feedback following the reporting of an incident.	
127	Staff members share information about any serious incidents involving a patient with the patient themselves and their carer, in line with the Statutory Duty of Candour (orequivalent).	
128	Staff members, patients and carers who are affected by a serious or distressing incident are offered post incidentsupport.	
129	Findings from investigations, recommendations, and implementation reports are routinely shared between theteam and the board, and vice versa, so that lessons can be learned.	
130	An audit of environmental risk is conducted annually, and arisk management strategy is agreed. *Guidance: This includes an audit of ligature points.*	

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