Inpatient Services for People with Learning Disabilities

Standards for Healthcare Professionals
Pilot Edition

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A manual of standards written primarily for:
Inpatient services for adults with learning disabilities

Also of interest to:
People with learning disabilities
Carers
Commissioners
Policy makers
Researchers

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A full copy of this document is available on our website at:
www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/ldaccreditation.aspx

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Foreword

We are pleased to introduce the first edition of the standards for the National Accreditation Programme for Inpatient Learning Disability Units. This development coincides with the recent national drive to improve the standards of care in NHS health campuses following the publication of the Healthcare Commission audit report.

The standards mentioned here are applicable to any Inpatient Unit for Adults with Learning Disability. A similar document on standards already exists for Children with Learning Disability.

We welcome the collaborative effort to improve the quality of Inpatient Units and these standards have been developed from a literature review and consultation with stakeholder groups including the Healthcare Commission, User/Carer groups and professional bodies. We hope the standards will provide staff with a clear and comprehensive description of best practice within inpatient units.

These standards will be audited annually through self and external peer-review by member wards. Feedback will be sought from participating Units to allow us to review the standards from time to time.

Please join us in promoting high-quality care environments for people with Learning Disability in all Inpatient Care settings.

Sabyasachi Bhaumik
Chair of Learning Disabilities Faculty
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Introduction

The need for a quality improvement programme

The NHS funds a range of residential provision for people with a learning disability (LD). This includes:

- NHS-managed admission and assessment units;
- NHS-managed long-stay/rehabilitation units (although there are plans to close those that remain);
- NHS-managed forensic/secure units;
- Units managed by the independent sector the care of whose residents is funded by the NHS.

These vary greatly in terms of size (in terms of numbers of resident), staffing levels, level of security, length of stay, case mix of resident group and philosophy of care. They range from therapeutic communities to secure units and from short-stay admission units to "homes for life".

Consistent with this diversity, LD services are managed by a range of organisations. Within the NHS, the commonest configuration is for them to be a small part of an NHS Trust that manages mental health services. Organisations that manage independent sector units vary greatly in size. Commissioning of LD residential care is poorly developed and haphazard. One result of this diversity, and of the marginalisation of LD services, is that LD Units tend to be isolated from one another both geographically and in organisational terms.

In England, NHS-managed long-stay LD units have attracted the attention of the media and of the Healthcare Commission because of poor standards of care and of institutionalised practices that create a culture where abuse was more likely to occur. This recent, high profile press coverage of poor quality care has dented public confidence about learning disability inpatient units. The Learning Disability Faculty discussed at length what the College could do both to improve the quality of care and to demonstrate that care practices in these units are generally sound. As a result, it asked the College Centre for Quality Improvement (CCQI) to establish a new quality improvement network for inpatient units for people with learning disabilities and mental health needs. The Royal College of Psychiatrists' CCQI currently manages a range of programmes of work in mental health services, each tailored to meet the needs of the specialty. As well as identifying and acknowledging services that have high standards, these support and enable services to achieve higher standards of organisation and care; as a result, quality in services is driven up.

Key Principles for a quality improvement initiative in LD

These are the same as those that underpin the other quality networks managed by the College Centre for Quality Improvement (CCQI), namely:

- ***Local ownership and trust***: the process has to be owned by front-line staff and will incorporate true peer-review.
- ***Engagement***: the system engages all relevant groups, including all staff who work on the unit, senior service managers, people with learning disabilities, and carers.
- ***Credibility***: the standards on which the programme is based are explicit and the process of applying them will be transparent. We are seeking recognition and engagement from the professional bodies of those working in learning disability services, national organisations representing the service user perspective, the Healthcare Commission, NIMHE, NICE and the National Patient Safety Agency.
- ***Responsiveness***: feedback to participating units will be prompt and will include advice and support about how to meet standards. Networking will be encouraged through newsletters and an e-mail discussion group.
- ***A focus on development***: although the process of review will be rigorous, and the feedback honest, the purpose of the process is to support and help units to improve in line with the standards.

An overview of the programme

Membership

Membership is open to LD units managed by both the NHS and independent sector. The common criterion is that the care received by the residents of the unit is funded by the NHS.

The standards

This manual of standards has been produced to underwrite the accreditation processes. They have been developed from a literature review and in consultation with stakeholder groups. Care has been taken to include information from a wide range of sources and to take into account the views of staff, people with learning disabilities, and carers. The standards will be subject to annual review.

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 safety, rights or dignity and/or would breach the law;

- **Type 2:** standards that an accredited service would be expected to meet;

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

The standards are also available on our website:
http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/ldaccreditation.aspx

The audit tools

A series of audit tools is being developed to support the measurement of adherence to the standards. These will include:

A patient questionnaire: a series of questions about the person's experiences of different aspects of the services provided by the unit e.g. the assessment process, the environment, the provision of information and choice.

A carer questionnaire: a series of questions about carers' experiences of different aspects of the services provided by the unit e.g. the assessment process, the environment, the provision of information and choice.

A staff questionnaire: a series of questions about unit staff's experiences of different aspects of the service e.g. staff support and training, etc.

A referrer questionnaire: a brief series of questions for referrers about different aspects of the outcome of the referral.

Patient tracer: an audit of a sample of case notes against a detailed checklist of standards.

Checklist: a checklist of policies, protocols and procedures that govern service provision.

Staff training matrix: a checklist of training attended by each member of unit staff.

Staff levels matrix: a series of questions regarding each member of staff e.g. hours worked, supervision received.

Environmental Audit

Stages of the accreditation process

Stage 1: **the unit undertakes a self-review** using a range of audit tools (as described above).

Stage 2: **the unit hosts a peer-review visit** by a multi-professional team that includes a person with learning disabilities or carer.

Stage 3: **staff from the unit peer-review another service** that is participating in the programme.

Stage 4: **the unit receives a written local report**, which will include a statement about performance against the standards, highlight issues that need attention, and include advice and comments from the review team. Subsequent feedback will also include the decision about accreditation status.

Stage 5: **the unit begins action planning and implementation of improvements.**

The award of accreditation will be for a set period of time (probably three years) but will be subject to regular (probably annual) self-review and affirmation that standards necessary for accreditation have been maintained. It would be expected that units that are accredited would demonstrate engagement in an ongoing process of improvement to meet those standards.

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Glossary of Terms and Abbreviations

- **BILD.** The British Institute of Learning Disabilities
- **Capacity.** The ability to understand and give legal consent to an action or arrangement.
- **Care plans.** A care plan will say in writing what help a person needs and who will be providing this.
- **Carers.** Where we have used the term 'carers', we mean 'people who care for or support the person with learning disabilities'. This includes family carers, advocates, befrienders, associates, paid staff (see also **Family carer**).
- **Clinical governance.** A systematic approach to maintaining and improving the quality of patient care
- **Consent.** Agreement to an action or arrangement
- **CPA**. Care Programme Approach: The process mental health service providers use to coordinate care for mental health patients.
- **CRB**. Criminal Records Bureau.
- **Family carer:** this term is used to refer specifically to non-professional and unpaid carers.
- **Health Action Plans.** A Health Action Plan is a personal plan about what a person with a learning disability can do to be healthier
- **Knowledge and Skills Framework.** The Knowledge and Skills Framework process involves managers working with individual members of staff to plan their training and development.
- **MDT**. Multi disciplinary team
- **Mental Health Act Section 117** Under section 117, health authorities and local social services have a legal duty to provide aftercare for patients who have been on sections 3, 37, 47 or 48, but who have left hospital
- **Named nurse –** This is a ward nurse who will have a special responsibility for a patient while they are in hospital.
- **Person-centred planning.** A process of life planning for individuals based on the principles of inclusion and the social model of disability.
- **Person/People**. Where we have used the terms 'person' or 'people', we mean 'people with learning disabilities/difficulties'
- **POVA.** The Protection of Vulnerable adults scheme
- **PRN.** 'Pro re nata' (as required). It refers to being prescribed medication to take when it's needed, rather than regularly at the same time each day.

No.	Standard	Type
Section 1: Patient Journey		
Pre-admission		
Standard 1: A person who requires inpatient care is referred to the appropriate services, without unnecessary delay		
1.1	Written referral criteria clearly specify the function of the inpatient service, and the age groups and problems that the unit does and does not cater for	2
1.2	There are documented, up-to-date referral procedures for routine referrals, which are agreed with other agencies and services	2
1.3	Inpatient staff are involved in pre-admission discussions to determine whether or not the unit is suitable for the individual's needs, taking into account the remit of the unit and the needs of the resident population	3
1.4	Pre-admission assessments are attended by a member of the inpatient unit team	3
1.5	For routine admissions, the inpatient team makes efforts to access all of the recent community paperwork that is available on the person, e.g.: • mental health and risk assessments; • details of current medication; • physical health assessments, and a copy of any Health Action Plans; • existing care plans/person-centred plans/CPAs; • details of daily living routines and preferences; • the role of family and carers; • communication needs and use of communication methods.	1
1.6	There are documented, up-to-date referral procedures for emergency referrals (i.e. people being admitted within 24 hours), which are agreed with other agencies and services	2
1.7	For emergency admissions, where the person arrives out of hours, there is evidence that community assessment paperwork was actively sought the next working day"	2
1.8	The admission proceeds without unnecessary delay	2

Admission and Initial Assessment		
Standard 2. Throughout the admission process, the person is reassured, welcomed and given the information they require		
2.1	Before a routine admission, the person (and their carer) is given an accessible information/welcome pack that describes: • the purpose of the unit; • methods of treatment; • unit facilities, daily life and programme of activities; choice of food; • personal safety on the unit; • visiting arrangements; • what practical items people need to bring in; • the rights of people who are staying there and what is expected of them, including levels of freedom and restriction; • sleeping arrangements (e.g. shared or single bedrooms).	2
2.2	After an emergency admission, as soon as they are well enough, the person and their carer are given an accessible information/ welcome pack that describes: • the purpose of the unit; • methods of treatment; • unit facilities, daily life and programme of activities; choice of food; • personal safety on the unit; • visiting arrangements; • what practical items people need to bring in; • the rights of people who are staying there and what is expected of them, including levels of freedom and restriction; • sleeping arrangements (e.g. shared or single bedrooms).	2
2.3	Before admission, or as soon as they arrive, a member of staff checks that the person has any aids or equipment that they need e.g. walking frame, hearing aid	1
2.4	The person (and their carer) is met on arrival, shown to an appropriate area, and offered refreshments	2
2.5	The person (and their carer) is introduced to a member of staff who will be their point of contact for the first few hours of admission	2
2.6	On the day of their admission, or as soon as they are well enough, the person (and their carer) is shown around the unit at a steady pace	2
2.7	On the day of their admission, or as soon as they are well enough, the person (and their carer) is given accessible information on: • their rights; • rights to advocacy and second opinion; • right of access to interpreting services; • professional roles and responsibilities; • the complaints procedure.	1
2.8	On the day of their admission, or as soon as they are well enough, any person who is detained under the Mental Health Act is given a user-	1

	friendly description of what their 'section' means to them, and their right to appeal	
2.9	On the day of their admission, or as soon as they are well enough, the person (and their carer) is told the name of their named nurse/care team and how to arrange to meet with them	2
2.10	If the person is having difficulty settling and would benefit from extra contact with their carer, staff make efforts to facilitate this, e.g.: • by showing flexibility around visiting times, telephone contact; • by allowing carers to stay overnight.	2
Standard 3: A comprehensive initial assessment takes place		
3.1	A physical examination is conducted within 24 hours of admission and this is recorded Note: If the examination does not occur (because the person refuses, or because a risk assessment confirms that examination is not possible within this time frame), this is recorded and all possible relevant observations are documented	1
3.2	A comprehensive physical health review takes place on admission or as soon as possible, including: • details of past medical history (or request made for information from relevant agencies); • a comprehensive review of symptoms; • current medication, including side effects; • lifestyle factors such as sleeping, diet, smoking, exercise, sexual activity, alcohol and drugs.	1
3.3	If the person has epilepsy, information is gathered and recorded on: • seizure type, frequency and stability; • managing prolonged or serial seizures; • arrangements for use of rescue medication.	1
3.4	The person's needs are assessed in relation to mobility e.g aids and adaptations, exercises etc. and these are recorded	1
3.5	Within one week of admission, additional information is obtained and recorded in relation to: • health promotion history; • family history; • details of health screening and vaccinations.	2
3.6	Needs are assessed and recorded and there is ongoing recorded monitoring in relation to • help with taking medication; • dental care arrangements; • advice on sexual health and contraception.	2
3.7	A documented CPA review/admission meeting is held within one week of admission	2

Further Assessment and Planning		
Standard 4: A process of continual multi-factorial assessment and care planning takes place		
4.1	The assessment takes into account existing information and covers *mental and physical health well-being*, including: • past and present mental health problems; • mental capacity; • consent or refusal of consent to treatment; • notable life events (loss, trauma, major changes); • developmental history; • a physical health check and history taking.	1
4.2	The assessment takes into account existing information and covers *social and personal well-being*, including: • the person's wishes and expectations regarding their admission; • communication needs; • family/social network/social needs; • the role of carers, supporters and advocates; • individual needs relating to gender, ethnicity, culture or spirituality; • pattern of daily life and activities/ability to carry out activities; • food preferences, including special dietary requirements; • any concerns over living situation/financial worries/employment status.	1
4.3	The assessment takes into account existing information and covers *risk and safety issues*, including: • risk; • risk of absconding; • risk of harm to self or others; • risk of vulnerability, exploitation or abuse; • examples of situations under which any behaviour that challenges are most likely to occur/historical factors that have contributed to behaviour and any relevant environmental/social/health factors; • any forensic history.	1
4.4	The assessment takes into account existing information and covers *the person's sensory processing profile and the environments they typically function within*, including: • sensory based assessment of any challenging or self-injurious behaviours; • sensory based assessment of the events leading to or maintaining the hospital admission; • the use of sensory approaches and environments to help manage challenging and self-injurious behaviours, and promote development of positive regulation and self-management strategies.	2
Standard 5: The person's care and support needs are assessed and planned using person-centred approaches		
5.1	Care plans build on strengths and are focussed on clear and attainable goals, which are recorded	2
5.2	Care plans reflect all of the needs identified in the assessment	1

5.3	If a person arrives with a person-centred plan, staff ensure that it is upheld within the inpatient unit	3
5.4	Where used, behavioural support plans are individualised and consist of ways of avoiding the need for the behaviour to occur. These include prevention and secondary prevention strategies and clear interventions for all to follow	2
5.5	Appropriate physical investigations are carried out and recorded in accordance with the request of the assessing clinician	2
Intervention - Review / Monitoring		
Standard 6. Interventions, outcomes and support are monitored and reviewed in accordance with individual needs		
6.1	Staff monitor and record clinical outcomes and risk at regular intervals, using validated tools	1
6.2	Each person has a minimum of weekly documented sessions with their named worker to review their progress	2
6.3	The person's care is reviewed and recorded by the multi-disciplinary team at the agreed frequency	2
6.4	Review notes record any progress made against the aims of the care plan	2
6.5	Review notes demonstrate that care plans are adapted where necessary, in response to a person's individual needs	2
6.6	Results of physical investigations are reviewed, signed and filed in the notes	2
6.7	Each person is given the opportunity to develop a Health Action Plan, (or review their existing one) and this is recorded	2
6.8	Each person is given the opportunity to have access to a health facilitator and this is recorded	3
6.9	Details of the Health Action Plan are incorporated in the care plan	2
6.10	People have their weight and blood pressure recorded at least monthly	2
6.11	Physical health review examination and investigations are repeated at least once a year and this is recorded	2
6.12	People on antipsychotic medication are offered screening for side effects (such as movement disorders) after one month and three months of treatment, and thereafter every six months and this is recorded	2

6.13	People taking certain groups of medication (clozapine, anticonvulsant agents, lithium etc) have regular blood tests in accordance with therapeutic guidelines and this is recorded	1
6.14	People with epilepsy have descriptions of their seizures and frequency recorded on standardised charts	2
6.15	The symptoms, progress and treatment of long-term physical disorders is reviewed and documented at least monthly by medical staff	1
6.16	Unit staff facilitate the person's access to health services, for example by assisting with transport arrangements, or accompanying the person if required	1
6.17	If the person takes medication, the person's allocated nurse monitors the tolerability and side-effects on an appropriately frequent basis	2
6.18	If the person takes medication, the medical team monitors and records the therapeutic response of medication on a weekly basis	2
Standard 7: A person-centred range of activities is available and made use of		
7.1	Each person has a programme of weekend and evening leisure and exercise activities which are relevant to their needs. This is recorded in their care plan and regularly monitored and reviewed	2
7.2	Group activities are protected and not interrupted	2
7.3	The person is able to access community-based activities, such as eating out, trips to the cinema, playing sport and going on day trips (and holidays for those in longer-stay units) and are enabled to continue with community activities they were involved in (subject to risk assessment where appropriate)	2
Discharge		
Standard 8: The person is discharged from the unit when they are ready to do so		
8.1	A discharge plan is initiated and documented on or before admission	2
8.2	The place of discharge is known before admission and this is recorded	3
8.3	The discharge plan includes expected length of stay and a provisional/anticipated discharge date	2
8.4	The person (and their carer) are fully involved in decisions about the stage at which they will move on from the service and this is recorded	2
8.5	The person (and their carer) are given timely notification of transfer or discharge and this is documented in their notes	1

8.6	Local information systems are capable of producing accurate and reliable data about delayed transfers of care	2
8.7	Delayed discharges are routinely reviewed and action is taken to address any identified problems	2
Standard 9: The person experiences continuity of care when moving between services		
9.1	The person's allocated care co-ordinator visits the person on the unit during the two weeks prior to discharge and this is recorded	2
9.2	There is evidence that inpatient staff make every effort to ensure a smooth transition, for example by: • helping to arrange for people, carers or staff to visit the new setting, to check its suitability; • finding out about statutory and voluntary services that might be helpful to the person (and their carer) once they leave the unit.	2
9.3	A documented discharge meeting/review (e.g. CPA/Mental Health Act Section 117) is held prior to discharge	1
9.4	Inpatient staff provide other community services (including out of area services) with timely notice of discharge planning meetings	2
9.5	In addition to the needs identified through the care planning processes, discharge/aftercare plans record: • the person's preferences for their future living arrangements including social, educational and employment factors; • the care and rehabilitation to be provided; • the name of the care co-ordinator (if further care is required); • the action to be taken if relapse or crises occur; • specific action to take in the first week.	2
9.6	The person (and their carer) are given a copy of the written discharge/aftercare plan and this is recorded	2
9.7	Within seven days of discharge, plans are sent to all relevant service providers, including the referring agent	2
9.8	Prior to discharge, the date of the follow-up review is recorded in the notes and communicated to the person (and their carer) and relevant services	2

Section 2: Structure

Policies, Protocols and Strategy

Standard 10: there is a range of appropriate protocols in place to cover clinical, management and interagency working

Clinical protocols/procedures/strategies are in place for the following:

10.1	The use of person-centred planning tools and systems	2
10.2	Reviewing whether the person and their named worker are getting on	2
10.3	Informal patients discharging themselves against medical advice	1
10.4	Obtaining consent (which includes a list of activities for which specific written consent is required)	1
10.5	The use of mobile phones, including camera phones	2
10.6	The use of observation in the context of the prevention and management of violence	1
10.7	The use of seclusion (which complies with the Mental Health Act)	1
10.8	The administration of PRN medication	1
10.9	The use of physical restraint, including where a person has a physical condition which might increase the risk to them of collapse or injury during restraint	1
10.10	Recording/reporting of any incident requiring rapid tranquillisation, physical intervention or seclusion.	1
10.11	Recording/reporting of physical and non-physical incidents	1
10.12	Reviewing incidents of severely challenging/violent behaviour, to include: • a clear description of the behavioural sequence(s); • a measure of the frequency, intensity and duration of the behaviour; • a conclusion about why the behaviour occurred.	2
10.13	Ensuring that post-incident support is available for anyone involved in an incident or anyone who witnessed it, including people and their carers	2

Management protocols/procedures/strategies are in place for the following:		
10.14	Bed occupancy (including what to do when levels are exceeded)	1
10.15	Planning menus (in accordance with the good practice guidelines)	2
10.16	Monitoring staff morale e.g. sickness levels and reasons for leaving	2
10.17	Communication between the nursing staff, doctors and other relevant members of the MDT e.g. handover protocols	2
10.18	The investigation of complaints, adverse incidents, and near-misses	1
10.19	Confidential reporting or 'whistleblowing' on abuse or inappropriate care	1
10.20	Promoting positive sexuality and relationships	1
10.21	The use of bank and agency staff	1
10.22	The use of volunteers	1
10.23	Staff appraisal and supervision	2
Interagency protocols are in place for the following:		
10.25	Liaison with general practitioners to investigate non-urgent physical health issues	2
10.26	The sharing of information between identified personnel and agencies in accordance with public protection and the Data Protection Act	1
10.27	Safeguarding adults	1
10.28	Emergencies requiring Emergency Services intervention	1
10.29	Access to support after people have been discharged	3
10.30	Transfer or shared care between LD and generic mental health services	2
10.31	Transfer or shared care between LD and social care services	2
10.32	Access to primary and secondary health services	2
10.33	Access to emergency medical care	1

Standard 11: The service is developing and implementing key strategic initiatives		
11.1	The service has a strategy for improving its service in line with relevant key national policy and guidance[1]	2
11.2	The service has a strategy for reviewing and monitoring the action plans that arose from the Healthcare Commission audit (England only)	2
Environment and Equipment		
S*tandard 12: The service provides an accessible, safe, and comfortable environment*		
12.1	The external sign-posting to the unit is clear	2
12.2	The internal sign-posting is clear and appropriate to the needs of the people who reside there	2
12.3	A smoke free environment is provided	2
12.4	The unit has access to aids and equipment to allow the person to do as much for themselves as they wish, subject to risk assessment	2
12.5	Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence in self-care needs	2
12.6	All confidential case material is kept in locked cabinets, locked offices or securely password-protected on IT systems	2
12.7	There is a regular and comprehensive general risk assessment to ensure the safety of the clinical environment, including potential ligature points	1
12.8	There is a management plan based around the annual risk assessment to address any shortfalls in the safety of the clinical environment	1

[1] *Valuing People: a New Strategy for Learning Disability for the 21st Century* (England only) Department of Health (2001)
Valuing People Now: be a 3 year strategy and delivery plan building on Valuing People (England only) Department of Health (2009)
Putting people first: a shared vision and commitment to the transformation of adult social care Department of Health (2007)
Independent Living Strategy Office for Disability Issues
Healthcare for All An Independent Inquiry into access to healthcare for people with learning disabilities , Healthcare Commission (2008)
A Life like Any Other? Human Rights of Adults with Learning Disabilities Joint Committee on Human Rights (2008)

12.9	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 e.g. mirrors, staffing levels adjusted.	2
12.10	There is secure, lockable access to a person's room, with external staff override	2
12.11	The unit is not accommodated on more than two floors	3
12.12	Entrances and exits enable staff to see who is entering or leaving	2
12.13	Whilst ensuring appropriate levels of security, the environment is open and does not unnecessarily restrict people	2
12.14	In any area where rapid tranquillisation, physical intervention and seclusion are used, 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.	1
12.15	The crash bag is maintained and checked weekly or after use	1
12.16	An adequately stocked First Aid kit is available on each unit	1
12.17	An effective system is in place to ensure that people who are staying there, visitors and staff are able to summon help in an emergency e.g. alarm systems, call buttons, personal alarms, staff observations, two-way radios	1
12.18	Alarm systems/call buttons/personal alarms are checked and serviced regularly	1
12.19	There is a collective and rehearsed response to alarm calls	1
12.20	The unit is in a good state of repair	2
12.21	The unit is welcoming and comfortable	2
12.22	The unit is managed to allow optimum use of available space and rooms	2
12.23	The unit has adjustable light	2
12.24	The unit has adjustable temperature	2

12.25	The unit has adjustable ventilation	2
12.26	Areas which need to be quiet are located as far away as possible from any sources of unavoidable noise	2
12.27	There is a quiet room with a variety of comfortable chairs	2
12.28	The unit offers a range of semi-private and public spaces outside the private bedroom	2
12.29	There is direct access to a safe outside space which has seating available for relaxation	2
12.30	The outside space has a garden area with pleasant and stimulating features such as a herb garden, flowerbeds, greenhouse and scented flowers	2
12.31	People have access to the following: • exercise facilities; • reading facilities; • music facilities; • multi-faith prayer/worship facilities; • catering facilities; • art and craft facilities.	3
12.32	Entertainment facilities suit a range of personal and culturally-specific tastes[2], such as: • daily newspapers and good quality magazines; • board games; • cards; • TV and VCR/DVD with videos/DVDs; • computers and internet access (with supervised, risk-assessed access if necessary).	2
12.33	People can sleep in privacy and separate from the opposite sex	2
12.34	Bedrooms are fitted with dimmer switches, one located inside and the other outside the room, to control bedroom lights	2
12.35	People have access to lockable storage	2
12.36	There are private, designated spaces for people to receive visitors	2
12.37	People can make and receive telephone calls in private where appropriate	2
12.38	In spaces where personal and confidential discussions are held, such as interview rooms and consulting/examination/treatment spaces, conversations cannot be heard outside of the room	2

[2] Subject to documented risk assessment where appropriate

12.39	There is at least one room for interviewing and meeting with individual people and carers, which is furnished with comfortable seating	2
12.40	The unit has access to a specific room for physical examination and minor medical procedures	2
12.41	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.	2
12.42	The unit is able to meet the individual sensory needs of the people resident there e.g. sensory rooms, portable sensory trolleys/ equipment	2
12.43	The unit environment complies with current legislation on disabled access	1
12.44	Staff have access to a separate staff room with tea/coffee making facilities, away from the main area of the unit	2
12.45	All staff are able to take regular allocated breaks in a separate area	2
12.46	All staff have access to lockable storage	2
12.47	There is a dining area big enough for staff, people who are staying there and visitors to sit together for the purpose of social interaction and observation	2
12.48	Water and soft drinks are available 24 hours a day	1
12.49	Hot drinks are available to people who are staying there 24 hours a day	2
12.50	The unit has adequate access to suitable vehicles that it can use to transport people who are residing there e.g. to activities	2
12.51	Any vehicle that is used by the unit to transport people who are residing there is subject to regular MOT checks and services and a record is kept of this.	1
12.52	There is a record that all vehicle drivers are compliant with statutory requirements[3]	1
12.53	Where risk assessment indicates, there is an established, reliable and effective means of communication during escorted leave such as two-way radios or mobile phones.	0

[3] For mini-buses an internal driving test is appropriate. Car drivers should have a full driving licence and be insured for business

Staffing: Staffing levels, management, organisation and communication		
Standard 13: Staffing levels are appropriate to the overall situation and to specific situations		
13.1	Staffing levels are reviewed on a daily basis, taking into consideration: • levels of observation; • sickness and absence; • therapeutic engagement; • escorts; • the need to promote people's independence; • training, supervision, mentoring and their requirements for continuing professional development; consultation, outreach and liaison functions.	1
13.2	Extra cover can be arranged, e.g. additional on-call staff in an emergency	2
13.3	In the event of vacancies, long term sickness or maternity leave, prompt arrangements are made for staff cover	2
13.4	The unit comprises a core multi-disciplinary team, which is able to meet the needs specified in peoples' individual care plans, and includes representatives from the following professions: Psychiatry; Occupational therapy; Speech and language therapy; Psychology; Physiotherapy; Pharmacy; Social work.	2
13.5	There are sufficient administrative and secretarial skills available to meet the needs of the unit	2
13.6	All staff have time to engage in clinical governance activity relevant to their work	2
Standard 14: Operational management supports effective care		
14.1	Each person has a named member of staff who co-ordinates their care and this is recorded	2
14.2	The unit manager has evidence that all staff have up-to-date CRB and POVA checks	1
14.3	The organisation supports team-building activities, such as an annual team-building session	3
14.4	The unit manager has control over the unit budget	2

14.5	Staff have access to a clear, up-to-date line management structure	2
Standard 15: There are effective systems of communication between staff		
15.1	The nurse in charge of the shift is the point of contact for consultation, negotiation and decision-making for all unit operational matters	2
15.2	Each shift handover contains a discussion of risk factors and individual needs resulting in an action plan for the shift, with individual and group responsibilities	1
15.3	MDT staff are consulted in the development of policies, procedures and guidelines that relate to their practice	2
15.4	Policies, protocols and guidelines are written and formatted in ways MDT staff find accessible and easy to use	2
15.5	Policies, protocols and guidelines are disseminated and stored in ways MDT staff find accessible and easy to use	2
Staffing: MDT and Therapeutic Provision		
Standard 16: Therapeutic interventions are available and are provided by appropriately trained/qualified people		
The service is <u>able to access</u> a range of therapies and activities that includes the following:		
16.1	Behavioural therapy	2
16.2	Cognitive therapy	2
16.3	Communication and social skills	2
16.4	Complementary therapies (e.g. aromatherapy, reflexology)	2
16.5	Creative Therapies (e.g. Art, Music, Drama, Dance)	2
16.6	Dietetic advice	2
16.7	Family therapy	2
16.8	Group therapy	2
16.9	Medication	2
16.10	Occupational therapy	2
16.11	Physiotherapy	2

16.12	Social skills training	2
16.13	Speech and language therapy	2
16.14	Sports and exercise	2
16.15	Activities and opportunities to meet individual's sensory needs	2
16.16	Therapeutic interventions are provided by staff who are appropriately qualified to do so	2
Staffing: Knowledge and Training		
Standard 17: The unit provides support, training and supervision for staff		
New staff / induction		
17.1	All new staff are allocated a mentor/preceptor who oversees their induction	1
17.2	Before being asked to carry out any clinical work, all new staff receive mandatory training in fire, manual handling and basic life support	1
17.3	All new staff are given an induction handbook	2
17.4	All new staff are given information on trust/organisational policies, in accordance with their level of responsibility, as part of the induction process	2
All staff receive up-to-date training and development consistent with their role in the following:		
17.5	The principles of person-centred working	2
17.6	Communicating effectively with people with, e.g.: • understanding the person's preferred means of communicating; • the use of different communication methods and visual aids; • the importance of tone of voice; • non-verbal communication; • the use of appropriate language; • active listening techniques; • recognising when people might be suggestible/acquiescing; • recognising when people are communicating distress, and responding to it; • the link between communication and challenging behaviour; • the appropriate use of interpreters.	1
17.7	Understanding learning disability	2
17.8	Understanding mental health	2

17.9	Engaging and working with carers, families and advocates	2
17.10	Empowerment and encouraging independence	2
17.11	Working in a respectful and dignified way	2
17.12	Understanding the barriers often faced by people with learning disabilities and how to help people overcome them, including access to services, personal rights, and relationships	2
17.13	The legal rights of people with learning disabilities, according to: • the Mental Health Act 1983 (amended 2007) • the Mental Capacity Act 2005/Adults with Incapacity Act 2000; • the Disability Discrimination Act 2005; • the Human Rights Act 1998; • the UN Convention on the Rights of Persons with Disabilities.	2
17.14	The limits of information-sharing, according to: • Data protection; • Freedom of information; • Confidentiality.	2
17.15	Assessing capacity and gaining consent from people with learning disabilities	2
17.16	Medicines management	2
17.17	Recognising and managing swallowing difficulties	1
17.18	Understanding the mental health problems sometimes associated with learning disability	2
17.19	A range of a pharmacological interventions	2
17.20	A basic understanding of medical conditions sometimes associated with learning disability	2
17.21	Recognising the signs of symptoms associated with: • physical abuse; • sexual abuse; • emotional abuse; • financial abuse; • institutional abuse; • self-neglect; • neglect by others.	2
17.22	Helping people with learning disability recognise potentially or actually abusive behaviour in any of their relationships	1
17.23	The protection of people with learning disabilities, including protection of vulnerable adults (POVA) arrangements	1

17.24	Culturally sensitive practice, disability awareness, and other diversity and equality issues	2
17.25	The use of outcome measures	2
17.26	Providing basic psychological and psychosocial interventions (including, but not limited to, conflict resolution/de-escalation, engagement activity scheduling, group facilitation)	2
17.27	BILD-approved training (or the equivalent) on the prevention and management of violence	1
17.28	Teams working together have undertaken the same accredited prevention and management of violence training	2
17.29	The unit has access to advice on tailor-made hold/technique by accredited instructors	1
Unqualified staff		
17.30	Unqualified staff are encouraged and enabled to develop additional skills, for example through the Learning Disability Awards Framework/Learning Disability Qualifications/NVQ level 2 and 3 (RJ)	2
General		
17.31	Clinical staff are aware of the evidence base behind the interventions they practice (in research, audit etc)	3
17.32	Qualified staff from nursing, occupational therapy, psychiatry and clinical psychology professions are developing the necessary skills to provide a repertoire of *basic* psychological interventions in line with NICE guidance	2
17.33	Qualified staff from nursing, occupational therapy, psychiatry and clinical psychology professions receive ongoing training and supervision to provide a repertoire of *complex* psychological therapies, as defined by NICE guidance	2
17.34	At least one of the MDT is developing at least one complex psychological therapy, as defined by NICE guidance	2
17.35	There is clinical leadership training for registered nurses, psychiatrists and other members of the MDT	3
Supervision and Appraisal		
17.36	All staff receive annual appraisal and annual review of their job plan	1
17.37	All MDT staff receive managerial supervision on an agreed basis from a person with appropriate experience and qualifications, according to the	2

	guidelines of their respective professional body	
17.38	All MDT staff receive clinical supervision on an agreed basis from a person with appropriate experience and qualifications, according to the guidelines of their respective professional body	2
17.39	Supervision is linked to personal development plans	2
17.40	All staff have access to work-related counselling	2
17.41	All staff have access to a unit-based reflective practice/staff support group to discuss clinical work	3
17.42	All staff are able to contact a senior colleague as necessary, 24 hours a day	2
Budget		
Standard 18: The unit budgets for training, activities and outings		
18.1	Training budgets enable all staff to meet requirements for their continuing professional development and the 'Knowledge and Skills Framework'	2
18.2	The inpatient unit has an identified budget for activities and outings	2

Section 3:Process		
Involvement		
Standard 19: Peoples' opinions and preferences are taken into account in the running of the service		
19.1	The person's individual preferences are taken into account in the initial selection of their named worker e.g. gender	3
19.2	The person has a choice of who comes to any meetings where their care is being assessed, planned or reviewed, including whether their carer attends[4]	2
19.3	The views, wishes and feelings of the person (and their carer) are recorded by the assessing practitioner	2
19.4	The person (and their carer) are encouraged to be active partners in developing all aspects of the care plan, including agreeing aims and interventions	2
19.5	The person is able to be actively involved in choosing and planning the activities they take part in (for example, planning a day trip)	2
19.6	The person (and their carer) play a key role in monitoring, evaluating and reporting the effects of interventions	2
19.7	The person (and their carer) are comfortable with the way that review meetings/ward rounds are conducted	2
19.8	Action from reviews is fed back to the person (and their carer) and this is documented	2
19.9	The person is supported and encouraged to manage their own affairs (e.g. their personal finances) as far as is possible	3
19.10	The person can be involved in the day-to-day running of the unit if they wish to, e.g.: planning social events; menu planning, shopping and food preparation; laying tables, clearing away and washing up; helping to maintain the unit; laundry and housework; gardening.	2
19.11	Information produced by the unit is designed in consultation with people and carers	3
19.12	There are formal, documented arrangements that provide people with as much choice and control over their life as possible; including bedtimes	2

4 Except in cases where the person's care is subject to the Care Programme Approach, Offender Management and Ministry of Justice requirements

	and bathtimes, eating and drinking, and how the person spends their time	
19.13	The person is able to control light and ventilation in their bedroom	2
19.14	The person is able to personalise their bedroom e.g. with prints, photographs etc	2
19.15	There is access to the day room at night if the person is unable to sleep at night	2
19.16	Choice is only restricted for significant clinical or safety reasons, which are explained to the person and recorded in their care plan	2
19.17	People can ask to see a staff member on their own e.g. without other staff or carer present, subject to risk assessment	1
19.18	Efforts are made to ensure that people can see a staff member of the gender of their choice subject to documented risk assessment where appropriate	2
19.19	The person (and their carer) are actively encouraged to give feedback on the service throughout their admission, and on leaving the service, (e.g. via consultation groups, a 'compliments and suggestions' box, discharge questionnaires, satisfaction surveys, follow-up letters etc)	2
19.20	The person (and their carer) are assured that any complaint would be taken seriously and that they would not be discriminated against	1
19.21	If a person makes a complaint, they are given regular progress reports from a named contact person	2
19.22	Staff make efforts to find out individual preferences for types of food and style of preparation, including food allergies	2
19.23	People with learning disabilities are involved and supported in interviewing potential members of the MDT during the recruitment process	2
Communication		
Standard 20: Staff communicate respectfully and make sure they are understood		
20.1	Staff make sure that they are understood, for example, by: using communication methods that are consistent with the person's usual and preferred means of communication; avoiding the use of clinical language/jargon and abbreviations; avoiding having too much new information in one sentence; checking that the person has understood the information by asking them to explain it back, in their own words.	1
20.2	Staff make sure that they communicate respectfully, for example, by: being patient and encouraging; allowing enough time; avoiding using	2

	language that is patronising, infantilising or negative; speaking to the person first, and only checking with the carer if something is not clear.	
20.3	The unit has access to professional interpreters who have received training or guidance about learning disability and mental health and recognise the importance of full and accurate translation	3
Information		
Standard 21: Clear and accessible information relevant to the person is available		
21.1	The person (and their carer) are provided with enough information to make informed choices about care and treatment (e.g. information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention)	2
21.2	A copy of the care plan is given to the person (and their carer) in an accessible format and this is recorded	2
21.3	The person has access to health promotion advice in an accessible format, including advice on diet and exercise, oral health, smoking cessation, and sexual health	2
21.4	Information is available about a range of mental health conditions	3
21.5	Information is available about local mental health and learning disability services	2
21.6	Information provided is culturally relevant and sensitive	1
21.7	Information is clear, up-to-date and available in sufficient quantity	2
21.8	There is a board on display showing the photographs, names and roles of staff	3
21.9	Information is available for people and carers about: • how to make a verbal complaint; • how to make a written complaint.	1
21.20	Information is available for people and carers about: • how to suggest service improvements and enhancements; • how to make a written compliment; • how to make a donation.	2
21.21	Complaints procedures are well-publicised and user-friendly and help is given on how to follow them	1
21.22	The person (and their carer) are informed of the procedures that would be followed if a disclosure of abuse were made, and they are reassured that they would be taken seriously	1

21.23	The person is informed of the level of observation that they are under	2
21.24	Telephone messages are passed on to people	2
Dignity and Ethics		
Standard 22: The unit applies good practice in regard to consent, capacity, confidentiality and respect		
Consent – where people are assessed as having capacity		
22.1	People are informed by staff of their right to agree to or refuse intervention and the limits of this and this is recorded	1
22.2	Where people are assessed as having capacity, consent is obtained and recorded	1
22.3	Careful procedures are used to establish that a person has given informed consent; for example, staff check the person's broad understanding of what they are consenting to by asking them to communicate this back to them	2
22.4	Staff make efforts to establish a person's capacity on an ongoing basis, including seeking advice from the person's carer and this is recorded	2
22.5	There is evidence that interventions are only conducted without the person's consent if: • it has been established that the person lacks the current capacity to consent to the treatment; • all other options have been exhausted; • the treatment is deemed to be in their best interests.	2
22.6	Where necessary, documented 'best interest' meetings are held for carers, professionals, advocates and relevant others to discuss the situation and support healthcare professionals to reach a decision about how to proceed	1
22.7	When a person who is assessed as lacking capacity is treated against their will, this is conducted within the appropriate legal framework and is noted in the person's file and this is recorded	1
22.8	If a person who lacks capacity is treated against their will, staff still provide the person (and their carer) with as much information about the intervention as possible and this is recorded	2

Confidentiality		
22.9	People who are assessed as having capacity are asked to give or withhold consent before case material is shared with others, including carers and external agencies/services[5]	2
22.10	People are aware of their rights to access records held by the service	2
Respect		
22.11	During the administration or supply of medicines, the person's privacy, dignity and confidentiality are respected	2
22.12	Staff are friendly and approachable	2
22.13	Staff and people who are staying there treat one another with mutual respect	1
22.14	The person's privacy and dignity is ensured when receiving intimate care	1
22.15	People are able to use the toilet safely and in privacy	1
22.16	Assistance with eating food is given individually and discreetly and with care and sensitivity e.g. staff sit with the person they are assisting	2
22.17	Where necessary, staff provide sensitive advice on clothing, hygiene and personal presentation	2
22.18	Gender-sensitive groups are provided	2
22.19	When any physical examinations are carried out, staff ensure that the person is comfortable with the staff member who is doing it, or their chosen chaperone	2
22.20	Staff respect people's personal space, e.g. by knocking and waiting before entering bedrooms	2
22.21	The person is supported to practice/follow their own cultural or religious beliefs e.g. by having access to associated items, such as a copy of the Koran, Bible or similar, support to attend services, respecting festivals	2
External Relationships		
Standard 23: Staff liaise with carers and other agencies		
Carers / Families		

5 Except in cases where information relates to safety, risk and public protection and is subject to legislative requirements to notify victims of certain offences. Refusal to consent must be documented but may be over-ridden with clear explanations of the reason to disclose

23.1	Inpatient staff advise the principal family carer on how to have access to an assessment of their own needs	3
23.2	Staff support the psychological and emotional needs of family carers by signposting them to local carers' support groups, or counselling services, as required	3
23.3	Staff explain how carers can contact the unit for extra information, advice or support as needed, including outside of planned meetings	2
23.4	**With the consent of the person**, staff and carers meet to update each other on any significant information about the person's care, before and after any leave of absence	2
23.5	Prior to any leave of absence, staff offer the person and their carer advice on coping techniques and behaviour management techniques, if required	2
23.6	During any leave of absence, carers can contact unit staff for support	2
23.7	Unit staff provide carers with advice on using different methods of communication, if required	2
23.8	Family carers are involved in the recruitment process	2
23.9	Visits from friends, family and others are encouraged and facilitated	2
Other Agencies		
23.10	The assessment identifies the other agencies involved in the person's care and communicates effectively with the referrer throughout the person's stay and following discharge	1
23.11	There is access to relevant faith-specific support, preferably through someone with an understanding of mental health issues	3
23.12	The unit has a formal link with a range of advocacy services	2
23.13	The person (and their carer) have easy access to independent advocacy services and staff explain the benefits of using these services	2
23.14	The unit can access an independent mental capacity advocate if required	2
23.15	Where clinically appropriate, staff enable people to continue with community activities they were involved in (e.g. by arranging for the community LD team to support the person)	3

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