RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

QNLD
QUALITY NETWORK FOR FOR LEARNING DISABILITY SERVICES

# *Standards for Mental Health Inpatient Rehabilitation Services for Adults with a Learning Disability*

*First Edition*

**Publication Date:** June 2023

**Quality Network for Learning Disability Services (QNLD)**

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Publication number: CCQI 436

Revision date: 2024

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# Foreword

The development of these standards has formed part of a wider quality improvement project targeted at inpatient services who provide care and treatment to people detained beyond the initial acute phase. The inpatient focussed project overall has reviewed relevant literature; analysed data of people who have needed such inpatient services; developed an outcomes framework and commissioning guidance. In addition to the standards and the broader projects being relevant to all four UK countries, this work is to be integrated into a national programme of work for England.

The inpatient project forms part of broader developments in other parts of the system considering those with learning disability whose needs present with particular complexity and the nature of the inpatient and community service offer they require.

The Quality Network for Learning Disability (QNLD) has developed standards for community learning disability teams and for acute inpatient specialist services. These standards are an addition to those.

This development has involved extensive consultation and collaboration with a wide range of stakeholders ranging from family carers and members of various professional groups, NHS England, the Learning Disability Senate, the third sector and the inpatient units themselves. During the course of the development reflection on existing standards for acute inpatient services and for mental health rehabilitation services has informed the final version. New standards have been introduced and some others adopted and modified.

There is a greater number that are Type 1 standards which reflects the drive towards improving quality of care of people with learning disability. Our ambition is that these standards ensure and enable people with learning disability receive evidence-based treatments in environments meeting accepted standards, provided by appropriately trained staff and that services in UK lead the way in high quality care and treatment. Our implementation pilot phases during 2022-2025 involve selected units being supported to work towards accreditation and their feedback will inform future editions.

We would like to thank our consultees for generously giving their time and advice; and to the team from CCQI for their tremendous work.

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# Introduction

These first edition standards have been developed for the purposes of review as part of the Quality Network for Learning Disability Services (QNLD), however, they can also be used as a guide for new or developing services.

The standards cover the follow topics:


Pre-admission and Admission Processes


Care Planning & Treatment


Discharge, Transfer & Referral


Patient & Carer Experience


Staffing & Training


Environment & Facilities


Leadership & Governance

# Who are these standards for?

These standards are designed to be applicable to inpatient learning disability services that work beyond an initial acute assessment and treatment phase and where the key focus is on further treatment and re-integration of people back into the community and can be used within a range of service types by professionals to assess the quality of the team and the unit.

The standards may also be of interest to commissioners, patients, carers, researchers and policy makers.

# Categorisation of standards

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

· **Type 1:** Criteria relating to patient safety, rights, dignity, the law, and fundamentals of care, including the provision of evidence-based care and treatment

· **Type 2:** Criteria that a service would be expected to meet

Whether a standard is categorised as a Type 1 or Type 2 can be identified by the number "1" or "2" located in the "Standard Type" column.

The full set of standards are aspirational, and it is unlikely that any unit would meet them all.

# Terms used in this document

In this document, the inpatient learning disability service is referred to as *'the team'* or *'the unit'*.

People who are cared for by inpatient learning disability services are referred to as *'patients'* and their loved ones are referred to as *'carers'*.

# Key principles of the standards

There are four key principles that run throughout the standards and are crucial to providing good quality care. One or more of the below principles applies to several standards in the document and below icons are used to highlight which principles are particularly relevant to meeting the standard.

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|  | All information provided to patients and carers must be in an **accessible format**, in line with Royal College of Speech & Language Therapists '5 Good Communication Standards' & NHS Accessible Information Standard. |
|  | If patients lack capacity, decisions are made in their **best interests** as per the Mental Capacity Act 2005 or local equivalent. |
|  | When information is given to patients on the unit, staff **check their understanding** of the information, and this is recorded. |
|  | **Reasonable adjustments** are made in line with the Equality Act 2010. |

# Physical Health

Research has shown that on average, people with a learning disability die earlier than the general public, and do not receive the same quality of care as people without a learning disability. Similarly, there is a greater prevalence of certain physical health needs/conditions and sometimes a delay in identifying/diagnosing physical health issues.

Specific physical health matters of greater importance are:

- Identifying and managing deterioration
- Proactive physical health matters such as annual health checks, cancer screening and seasonal vaccinations
- Epilepsy
- Respiratory health
- Cancer, particularly gastric oesophageal
- Diabetes
- Healthy lifestyle including weight management

As such we would expect inpatient services to have a greater depth of consideration of physical health matters in the implementation of the standards and a consideration of these more prevalent matters in relation to each standard where the term 'physical health' is stated.

# References

Please see the list at the end of this document for full references. These are referred to by the number in square brackets in the 'reference' column throughout the document.

The standards are also available to download on our website.

**Any enquiries relating to this publication should be sent to: L.D@rcpsych.ac.uk**

# Sustainability Principles

These have been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee.

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core.

The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run.

In recent years the mounting economic, social, and environmental constraints have put mental healthcare systems under enormous pressure and it is vital to ensure that high-value services continue despite these constraints.

Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost, and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions.

A sustainable mental health service is patient-centred, focused on recovery, self-monitoring, independent living, and actively reduces the need for intervention.

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

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e., the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental, and social domains.

Adoption of these principles across mental healthcare would lead to a less resource intensive and more sustainable service.

**The five Sustainability Principles are as follows:**

**1. Prioritise prevention**

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

**2. Empower individuals and communities**

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

**3. Improve value**

This involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

**4. Consider carbon**

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

**5. Staff sustainability**

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

The green leaf symbol is used throughout this document to indicate standards that are linked to one of the sustainability principles.

**Resources**

A range of guidance, reports and papers have already been developed by the College to help improve the sustainability of mental health care.

Please see the below links for further information:

- Sustainability and Working Sustainably - RCPsych
- Nature and Health Resources
- Centre for Sustainable Healthcare
- Psych Susnet

# Quality Network for Learning Disability Services (QNLD)

# Section 1: Pre-admission & Admission Processes

| Standard No. | Standard Type | Standard | Principle | Reference |
|---|---|---|---|---|
| 1 | 1 | The service provides information to referrers about how to make a referral. | | [1] |
| 2 | 1 | A clear rationale and transition plan is shared with the patient, their carer and named person from the new unit. All core documentation transfers with the patient.<br>*Guidance: This should include why the patient's needs are best met through a transfer/admission. If the patient lacks capacity discussions occur with their carer and advocate.* |  | [2]<br>[3] |
| 3 | 1 | A commissioner led review has taken place to discuss the rationale for a continued stay in hospital including safe and appropriate transfer/admission, treatment, and discharge planning. | | [6] |
| 4 | 1 | Assessments of patients' capacity to consent to care and treatment in the unit are performed in accordance with current legislation and repeated at regular intervals, as appropriate. |  | [1] |
| 5 | 1 | Consent or assessments of capacity are documented and when patients lack capacity to consent to interventions, decisions are made in their best interests as per relevant mental capacity legislation. |  | |
| 6 | 1 | There are systems in place to ensure that the unit takes account of any advance decisions to refuse treatment and advance statements of preferences and wishes that the patient has made. | | [6] |
| 7 | 1 | The unit/staff members engage with the patient's carer and people who know them best (with the patient's consent) to gather information and support with the admission process. |  | [6] |

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| 8 | 2 | Carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns and their own needs. | | [1] |
| 9 | 1 | On transfer/admission the following is checked and given consideration:<br>• The security of the patient's home;<br>• Arrangements for dependants (children, people they are caring for);<br>• Arrangements for pets. | | [1] |
| 10 | 1 | Patients are given accessible information on their rights, which staff members talk through with them and explain how it relates to their care, as soon as practically possible. The information includes:<br>• Their rights regarding admission and consent to treatment;<br>• Rights under the Mental Health Act, Mental Capacity Act, Human Rights Act & Deprivation of Liberty Safeguards (DoLS);<br>• How to access advocacy services;<br>• How to access a second opinion;<br>• Interpreting services;<br>• How to view their records;<br>• How to raise concerns, complaints and give compliments;<br>• Information on restrictive practice;<br>• How to contact their home/lead commissioner.<br>*Guidance: Patients' rights are continuously discussed throughout their time on the unit.* |  <br>  | [1]<br>[2] |
| 11 | 1 | Confidentiality and its limits are explained to the patient and carer on transfer/admission, both verbally and in writing. Patient preferences for sharing information with third parties, including their family or carers, are respected, and reviewed regularly. |  | [1] |
| 12 | 1 | Patients have a screening assessment to identify their communication needs, outlining how to effectively communicate with them, as soon as practically possible.<br>*Guidance: Information on patients preferred communication style is available prior to transfer/admission and this is reviewed within the first week of transfer/admission.* |  | [7] |

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| 13 | 1 | Patients have a comprehensive mental health assessment. This is started within 4 hours of transfer/admission, or as soon as practically possible. This involves the multi-disciplinary team and includes consideration of the patient's:<br>• Mental health and medication;<br>• Psychosocial and psychological needs;<br>• Strengths and areas for development; which includes an adaptive functioning assessment and a sensory assessment.<br><br>*Guidance: Clinicians have access to recent mental health assessments completed by the unit from which they are being transferred. These are then updated by the receiving unit upon transfer/admission. A clear rationale on what is needed in the next phase of treatment is known.*<br><br>Sustainability Principle: Improving Value |  | [1]<br>[2] |
| 14 | 1 | Patients have a comprehensive physical health review. This is started within 4 hours of transfer/admission, or as soon as is practically possible. If all or part of the examination is declined, then the reason is recorded, and repeated attempts are made.<br><br>*Guidance: Clinicians have access to recent physical health assessments by the unit from which they are being transferred. These are then updated by the receiving unit upon transfer/admission. A clear rationale on what is needed in the next phase of treatment is known.*<br><br>Sustainability Principle: Prioritise Prevention |  | [1]<br>[2] |
| 15 | 1 | Patients have follow-up investigations and treatment when concerns about their physical health are identified during their transfer/admission.<br><br>*Guidance: This is undertaken promptly, and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.* |  | [1] |
| 16 | 1 | Patients have a risk assessment and safety plan which is co-produced (where the patient is able to participate), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality).<br><br>*Guidance: This assessment considers risk to self, risk to others, risk from others and safeguarding risk.*<br><br>Sustainability Principle: Prioritise Prevention |  | [1] |

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| 17 | 1 | Patients and carers are given an accessible information pack on or before transfer/admission, which staff talk through with them, that contains the following:<br>• A description of the service;<br>• The therapeutic programme;<br>• Information about the staff team;<br>• The unit code of conduct;<br>• Information on safeguarding;<br>• Key service policies (e.g. permitted items, complaints policy, restrictive practice policy);<br>• Resources to meet spiritual, cultural and gender needs. |  | [1]<br>[2] |
| 18 | 1 | Patients know who the key people are in their team, are supported to understand the role of each person involved in their care and how to contact them if they have any questions.<br>*Guidance: Patients are given the lead/named commissioner's contact details.* |  | [1]<br>[2] |
| 19 | 1 | The patient's GP is informed of the transfer/admission and the rationale for a continued length of stay within the first week of transfer/admission. | | [2] |
| 20 | `1 | There is a documented formalised review of care or patient review meeting within one week of the patient's transfer/admission. Patients are supported to attend this with advanced preparation and feedback. |  | [1] |
| 21 | 1 | When a young person under the age of 18 is admitted:<br>• There is a named CAMHS clinician who is available for consultation and advice;<br>• The local authority or local equivalent is informed of the admission;<br>• The CQC or local equivalent is informed if the patient is detained;<br>• A single room is used;<br>• A risk assessment is completed;<br>• A named buddy or peer worker is provided to support transition. | | [1]<br>[2] |
| 22 | 1 | There is a named worker who has regular contact before the transfer/admission with the person to support with the transition to the unit. | | [3] |

# Section 2: Care Planning and Treatment

| Standard No. | Standard Type | Standard | Principle | Reference |
|---|---|---|---|---|
| 23 | 1 | Progression to this stage of inpatient care is as a result of an acute care episode and not through direct admission from the community. The care plan will clearly indicate that the patient has moved beyond the initial acute care stage and the rationale for this. | | [2] [3] |
| 24 | 1 | Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with the patient's consent) when developing the care plan and they are offered a copy:<br>*Guidance: The care plan clearly outlines (as appropriate):*<br>• *Agreed goals and intervention strategies for physical and mental health;*<br>• *How to build on skills, strengths and experiences to achieve goals and aspirations;*<br>• *Plans to keep well;*<br>• *Any advance decisions or statements that the patient has made;*<br>• *Reducing restrictive practice plan;*<br>• *Crisis and contingency plans;*<br>• *Review dates and discharge plans outlining clear goals for discharge.*<br>*Care plans are adapted to the patients' communication needs.* |  | [1] [2] |
| 25 | 1 | There are pathways in place to support patient's long term physical health needs, including epilepsy.<br>*Guidance: This includes pathways with local hospitals and specialist services with reasonable adjustments in place.* |  | [1] [2] |
| 26 | 2 | There are pathways in place for patients to access genetic screening. |  | [2] |

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| 27 | 1 | The team ensure that patients have access to GP services through the appropriate pathway. |  | [1]<br>[2] |
| 28 | 1 | The unit has a care pathway for patients who are pregnant or in the postpartum period.<br>*Guidance: Patients who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there are exceptional circumstances.* |  | [1] |
| 29 | 1 | The multi-disciplinary team reviews and updates care plans at least every 2 weeks (or when requested and required) and there is a multi-disciplinary patient review meeting monthly. | | [2] |
| 30 | 1 | Patients are supported to prepare for any formal review of their care. During their review they, along with their carer (where consent has been given), are supported to express their views. |  | [5] |
| 31 | 1 | The team knows how to respond to carers when the patient does not consent to their involvement.<br>*Guidance: The unit may receive information from the carer in confidence.* | | [1] |
| 32 | 1 | Patients begin evidence-based interventions, which are appropriate, for their bio-psychosocial needs, as per individual clinical need. Any exceptions and delays are documented in the case notes.<br>*Guidance: Interventions are adapted as per individual need.* |  | [1]<br>[2] |
| 33 | 1 | Patients have a formal assessment of their daily living skills including personal care, meal planning and preparation, laundry, bed making, money handling, household skills, budgeting, social skills and road safety, where appropriate.<br>*Guidance: This is reassessed at an interval as appropriate for each patient and the patient's carer is involved in this assessment,* where possible. |  | [4] |

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| 34 | 2 | Staff members review patients' progress against patient-defined goals in collaboration with the patient and their carer at the start of treatment, during clinical review meetings and at discharge. | | [1]<br>[2] |
| 35 | 1 | The team and patient jointly develop a leave plan, which is shared with the patient, their carer and other people involved in their care (with the patient's consent), that includes:<br>• A risk assessment and risk management plan that includes protective factors and an explanation of what to do if problems arise on leave;<br>• Conditions of the leave;<br>• Information on medication;<br>• Contact details of the unit and crisis numbers;<br>• Ability to access bed on return. |  | [1]<br>[2] |
| 36 | 1 | Staff agree leave plans with the patient's carer where appropriate, allowing carers sufficient time to prepare. | | [1] |
| 37 | 1 | When patients are absent without leave, the team (in accordance with local policy):<br>• Activates a risk management plan;<br>• Makes efforts to locate the patient;<br>• Alerts carers, people at risk and the relevant authorities;<br>• Escalates as appropriate. | | [1] |
| 38 | 1 | Each patient is offered a one-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns. |  | [1] |
| 39 | 1 | Actions from reviews are fed back to the patient and carer (with the patient's consent) and this is documented. |  | [5] |
| 40 | 1 | Patients are involved (wherever possible) in decisions about their level of therapeutic observation by staff.<br>*Guidance: Patients are also supported to understand how the level can be reduced.* |  | [1] |
| 41 | 2 | Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them. | | [1] |

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| 42 | 2 | Patients, according to risk assessment, have access to regular 'green' walking sessions.<br><br>*Guidance: Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rain wear.*<br><br>Sustainability Principle: Consider Carbon | | [1] |
| 43 | 1 | When medication is prescribed, patients are supported to understand:<br><br>• What medication they are taking;<br>• What the benefits are;<br>• What the common side effects are;<br>• Whether the medication is being prescribed off label or in high dose;<br>• How it will work with other medicines;<br>• A timescale for medicine to be stepped down or stopped.<br><br>*Guidance: Medication is prescribed in line with the principles of STOMP, where appropriate and information is available in an accessible format.* |  | [1]<br><br>[2] |
| 44 | 1 | Patients have their medications reviewed at least every 2 weeks. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.<br><br>*Guidance: Side effect monitoring tools can be used to support reviews and there are processes in place to ensure medication can be discussed outside of medication reviews when needed and requested.*<br><br>Sustainability Principle: Consider Carbon | | [1]<br><br>[2] |
| 45 | 1 | Every patient's PRN medication is reviewed at least every 2 weeks: frequency, dose, and indication. | | [1]<br><br>[2] |
| 46 | 1 | The indication(s) and rationale for prescribing psychotropic medication is clearly stated and documented including whether the medication is being used off label, polypharmacy or high dose; how long the medication should be taken for; the strategy for reviewing the prescription and stopping the medication.<br><br>*Guidance: In line with STOMP guidance in prescribing psychotropic medication.* | | [8] |
| 47 | 1 | Review and evaluation of the need for continuation or discontinuation of the psychotropic drug should be undertaken in line with diagnostic review or whenever there is a request from patients, carers or other professionals. | | [8] |

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| 48 | 1 | Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon. | | [1] |
| 49 | 2 | The unit enables the patient to work towards managing their own medication as independently as possible, including self-administration and self-monitoring of the desired effects and side effects.<br>*Guidance: This is completed where possible in line with relevant risk assessment. The team provides education and support to carers to help facilitate this.* | | [4] |
| 50 | 2 | Patients, carers, and prescribers are able to meet with a pharmacist to discuss medications. | | [1] |

# Section 3: Discharge, Transfer and Referral



| Standard No. | Standard Type | Standard | Principle | Reference |
|---|---|---|---|---|
| 51 | 2 | The team invites a community team representative, social worker, and commissioners to attend and contribute to patient review meetings and discharge planning meetings, as well as CPAs (or their equivalent).<br>*Guidance: Feedback is given to the host commissioner.* | | [10] |
| 52 | 2 | Discharge planning is initiated at the first multi-disciplinary team review and a provisional duration of admission is set.<br>*Guidance: Goals for discharge are set and reviewed regularly.* | | [5] |

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| 53 | 1 | Patients have a discharge plan, which reflects their individual needs. Staff members collaborate with patients, their carers, all relevant staff and commissioners (with the patient's consent) when developing the discharge plan and they are offered a copy:<br><br>*Guidance: The plan includes details of:*<br><br>• *Goals set to be discharge ready;*<br>• *Transition arrangements from the unit;*<br>• *Current care plan;*<br>• *How services will proactively work together (and carers, with the patient's consent) to support the transition;*<br>• *What to do in a crisis;*<br>• *Medication including monitoring arrangements;*<br>• *Details of when, where and who will follow up with the patient.* |  | [5] |
| 54 | 1 | The service will work to identify and resolve barriers to discharge early. Where there are delayed transfers/discharges:<br><br>• The team can easily identify delayed discharges;<br>• The team has a system to recognise and monitor delays to transfers and discharge;<br>• Concerns are escalated to senior staff, commissioners, or additional systems of support. | | [5]<br>[10] |
| 55 | 1 | A thorough assessment of the patient's personal, social, safety and practical needs is undertaken to reduce the risk of suicide on discharge.<br><br>*Guidance: Where possible, this should be completed in partnership with carers.* | | [1] |
| 56 | 1 | Patients and their carer (with the patient's consent) are supported to attend a discharge meeting and are involved in decisions about discharge plans.<br><br>*Guidance: A care coordinator is allocated to support the discharge process.* |  | [5] |
| 57<br>  | 1 | The team sends a copy of the patient's care plan or interim discharge summary to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge.<br><br>*Guidance: The plan includes details of:*<br>• *Care in the community/aftercare arrangements;*<br>• *Crisis and contingency arrangements including details of who to contact;*<br>• *Medication including monitoring arrangements;*<br>• *Details of when, where and who will follow up with the patient.*<br><br>Sustainability Principle: Prioritise Prevention | | [1] |

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| 58 | 2 | A discharge summary is sent, within a week, to the patient's GP and others concerned (with the patient's consent). The summary includes why the patient was admitted and how their condition has changed, and their diagnosis, medication and formulation. | | [1] |
| 59 | 1 | The team makes sure that patients who are discharged from the unit have arrangements in place to be followed up within 72 hours of discharge. | | [1] |
| 60 | 1 | Patients admitted to a unit outside the area in which they live have a review of their placement, in line with national timeframes.<br>*Guidance: This will occur at a minimum every 3 months, in line with national guidelines. The team are responsible for following up on any actions from the review.* | | [1]<br>[2] |
| 61 | 1 | When patients are placed in out of area services, there has been written communication from the commissioner to the patient, their carer and other relevant contacts, on why the person has been placed out of area and what steps will be taken so they can return to their local area.<br>*Guidance: This may be done via a Care & Treatment Review (CTR) or equivalent system.* | | [2]<br>[4] |
| 62 | 1 | Teams provide support to patients when their care is being transferred to another unit, to community teams for people with learning disabilities, or back to the care of their GP. | | [1] |
| 63 | 2 | Patients are able to visit new accommodation placements and have leave to enable overnight stays, where appropriate before discharge. |  | [4] |
| 64 | 2 | Training is provided to all those who will be involved in supporting the patient in their new placement once discharged from the unit, including but not limited to:<br>• Community teams for people with learning disabilities;<br>• Other community teams;<br>• Supported housing project staff. | | [2]<br>[4] |
| 65 | 1 | When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, taking their wishes into account as far as possible. | | [1] |

# Section 4: Patient & Carer Experience

| Standard No. | Standard Type | Standard | Principle | Reference |
|---|---|---|---|---|
| 66 | 1 | On transfer/admission to the unit, patients feel welcomed by staff members who explain why they are on the unit.<br>*Guidance: Staff make use of the patient's hospital passport/communication profile where available to establish correct communication strategies. Staff members show patients around and introduce them to other patients, offer them refreshments and address them using their preferred name and correct pronouns. Staff should enquire as relevant how they would like to be supported in regard to their gender.* | | [1]<br>[2] |
| 67 | 1 | Patients are supported to access advocacy services including Independent Mental Health Advocates (IMHA) and Independent Mental Capacity Advocates (IMCA).<br>*Guidance: Staff members check if patients have an advocate and support in the application process.* | | [1]<br>[2] |
| 68 | 1 | The unit uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. | | [1] |
| 69 | 1 | Staff members are easily identifiable, photographs of staff with their names and role are visible on the unit. | | [7] |
| 70 | 1 | Staff members treat all patients and carers with compassion, dignity, and respect. | | [1] |
| 71 | 1 | Patients feel listened to and understood by staff members. | | [1] |

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| 72 | 1 | The unit can demonstrate that it promotes culturally and spiritually sensitive practice.<br>*Guidance: This is taken into consideration within care planning and treatment and the unit links in with external agencies to meet any unmet needs.* | | [5] |
| 73 | 1 | Patients and staff members feel safe on the unit. | | [1] |
| 74 | 1 | For physical examinations, all patients are given the option to have a chaperone.<br>*Guidance: The patient has the option to select a chaperone of their choice.* | | [5] |
| 75 | 1 | To reduce the use of restrictive interventions, patients who present with behaviours that communicate distress are supported to identify:<br>• What causes distress, triggers and early warning signs (through the use of alternative and augmentative communication when necessary);<br>• Make advance statements about the use of restrictive interventions through positive behaviour support plans.<br>*Guidance: Patients have an accessible one-page profile outlining how to best support them.* |  <br>  | [1]<br>[2] |
| 76 | 1 | Staff members respect the patient's personal space, e.g., by knocking and waiting before entering their bedroom. | | [1] |
| 77 | 1 | Patients and (carers, with patient consent) are provided with accessible information about the patient's mental illness, behaviours that communicate distress, autism, sensory and physical health needs.<br>*Guidance: Information could be provided in a 1:1 meeting with a staff member, a patient review meeting or in a psycho-education group.* |  | [1]<br>[2] |
| 78 | 1 | Information provided to patients and carers is available in an accessible format.<br>*Guidance: Information can be provided in languages other than English and in formats that are accessible for people with sight/hearing/ cognitive difficulties and learning disabilities. This could include easy read, audio and video materials, using symbols and pictures, communication passports and signers. This information is in line with national accessible information standards.* |  | [7] |

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| 79 | 1 | There are processes in place to facilitate the understanding of information given to patients throughout their time on the unit.<br><br>*Guidance: Staff routinely check patients' understanding of information provided.* |  | [7] |
| 80  | 1 | Patients have access to safe outdoor space every day.<br><br>Sustainability Principle: Consider Carbon | | [1] |
| 81 | 1 | Every patient has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with.<br><br>*Guidance: This includes activities of daily living, education, employment, volunteering, and other occupations such as leisure activities and caring for dependants. As a minimum, activities should be provided in accordance with the teams contracted hours.* |  | [1]<br>[2] |
| 82 | 2 | Patients are supported to engage in psychoeducation on topics about activities of daily living, and any specific topic that would support a person to discharge.<br><br>*Guidance: Groups are adapted to suit individual communication needs.* |  | [1]<br>[2] |
| 83 | 2 | There is a minuted community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patients on the unit.<br><br>*Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the unit and to review the quality and provision of activities with staff members. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.* |  | [1] |
| 84 | 2 | Patients are consulted about changes to the unit environment. | | [1] |
| 85  | 1 | Patients and carers are regularly asked for their feedback about their experiences of using the service and this is used to improve the unit.<br><br>*Guidance: Patients are supported to express their views, through communication adjustments and support that meets their individual needs.*<br><br>Sustainability Principle: Empowering Individuals |  | [1]<br>[2] |

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| 86 | 1 | Patients use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the unit, subject to risk assessment and in line with local policy.<br><br>*Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.* | | [1] |
| 87 | 2 | Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues and learning disabilities.<br><br>*Guidance: Patients are supported to maintain pre-existing links with their faith community where possible.* | | [1] |
| 88 | 1 | The team supports patients to access support with finances, benefits, debt management and housing needs. | | [1] |
| 89 | 2 | The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and may include access to:<br><br>• Voluntary organisations;<br>• Community centres;<br>• Local religious/cultural groups;<br>• Peer support networks;<br>• Recovery Colleges. |  | [1] |
| 90 | 2 | Patients are able to maintain friendships and social networks outside of the hospital environment and have the resources and support to do this remotely when they are unable to leave the unit. | | [2]<br>[4] |
| 91<br>  | 1 | Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, weight management, physical activity, and access to smoking cessation services. This is documented in the patient's care plan.<br><br>*Guidance: All patients have a health action plan that includes information regarding their most recent annual health check.*<br><br>Sustainability Principle: Consider Carbon |  | [1]<br>[2] |
| 92 | 2 | Health promotion principles are embedded on the unit and education is offered to patients on the importance of keeping healthy and remaining active.<br><br>*Guidance: Patients have access to a range of physical activities based on individual needs and interests.* | | [5] |

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| 93 | 1 | Carers are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at patient review meetings, where the patient consents.<br><br>Sustainability Principle: Empowering Individuals | | [1] |
| 94 | 2 | The team provides each carer with accessible carer's information.<br><br>*Guidance: Information is provided verbally and in writing (e.g., in a carers' pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops, and relevant charities.* | | [1] |
| 95 | 1 | Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. | | [1] |
| 96 | 2 | Carers have access to a carer support network or group. This could be provided by the unit, or the team could signpost carers to an existing network.<br><br>*Guidance: This could be a group or network which meets face-to-face or communicates online.* | | [5] |
| 97 | 2 | Carers feel supported by staff members. | | [1] |
| 98 | 2 | The unit has a staff member designated as the carer lead or champion. | | [5] |
| 99 | 2 | The service has a strategy for carer engagement. The strategy describes measures taken to proactively support:<br><br>• A carer's own needs around information and support;<br>• How they can be involved in the care of their loved one;<br>• Opportunities to be involved in service developments, training and improvements. | | [5] |

# Section 4: Environment & Facilities

| Standard No. | Standard Type | Standard | Principle | Reference |
|---|---|---|---|---|
| 100 | 1 | The unit has clear and accessible signage. |  | [7] |
| 101 | 1 | Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety.<br><br>*Guidance: This includes avoiding the use of blanket rules and assessing risk on an individual basis.* |  | [1] |
| 102 | 1 | Reasonable adjustments are clearly detailed in care plans, where the environment is not deemed to be most appropriate this is escalated to commissioners and the appropriate staff/individuals to ensure either environmental adjustments or a more appropriate placement is sourced.<br><br>*Guidance: The unit is not overly clinical and has a therapeutic feel.* |  | [2]<br>[3] |
| 103 | 1 | Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms. There is an agreed response when the alarm is raised.<br><br>*Guidance: Patients are supported to understand how to raise an alarm via different means.* | | [1]<br>[2] |
| 104 | 1 | A collective response to alarm calls is rehearsed at least 6 monthly. | | [5] |
| 105 | 1 | Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use. | | [1] |
| 106 | 1 | A risk assessment of all ligature points on the unit is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management. | | [1] |

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| 107 | 1 | Laundry facilities are available to all patients and their clothes are washed separately.<br><br>*Guidance: Patients are supported to use laundry facilities independently, where appropriate.* | | [5] |
| 108 | 1 | Male and female patients have separate bedrooms, toilets and washing facilities. Room allocation should accommodate a spectrum of gender and patient gender self-identification should be supported wherever possible.<br><br>*Guidance: Self-identification as male or female should be accepted, and allocation to a gendered room done with patients' agreement. Where this allocation could present risks to the patient or to vulnerable others, this is risk assessed and all practical steps taken to accommodate patient preference. If patient preference cannot be safely accommodated, this is discussed between the patient and clinical team and agreement made on the most appropriate environment for care.* | | [1] |
| 109 | 1 | The unit has at least one bathroom/shower room for every three patients. | | [1] |
| 110 | 2 | Every patient has an en-suite bathroom. | | [1] |
| 111 | 2 | All patients have single bedrooms. | | [1] |
| 112 | 2 | Units are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment. | | [1] |
| 113 | 2 | Patients are able to personalise their bedroom spaces.<br><br>*Guidance: Patients are able to put up their own photos, pictures and posters reflecting their likes and interests.* | | [1] |
| 114 | 2 | All patients can access a charge point for electronic devices such as mobile phones. | | [1] |
| 115 | 2 | Staff members and patients can control heating, ventilation and light.<br><br>*Guidance: For example, patients are able ventilate their rooms through the use of windows, they have access to light switches, and they can request adjustments to control heating.* | | [1] |

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| 116 | 1 | Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g., covered copies of faith books, access to a multi-faith room, access to groups. | | [1] |
| 117 | 2 | All patients can access a range of current culturally specific resources for entertainment, which reflect the unit's population.<br><br>*Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.* | | [1] |
| 118 | 2 | The unit has a designated room for physical examination and minor medical procedures. | | [1] |
| 119 | 1 | There is a separable gender-specific space which can be used as required. | | [1] |
| 120 | 1 | There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day.<br><br>*Guidance: Patients have lockers available to store personal food and drink, based on risk and individual plans.* | | [1]<br>[2] |
| 121 | 1 | Patients are provided with meals which offer choice, ensure a nutritional and 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. | | [1] |
| 122 | 2 | Staff members ask patients for feedback about the food, and this is acted upon. | | [5] |
| 123 | 1 | The unit has at least one quiet room or de-escalation space other than patient bedrooms. | | [1] |

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| 124 | 1 | In units where seclusion is used, there is a designated room that meets the following requirements:<br>• It allows clear observation;<br>• It is well insulated and ventilated;<br>• It has adequate lighting, including a window(s) that provides natural light;<br>• It has direct access to toilet/washing facilities;<br>• It has limited furnishings (which includes a bed, pillow, mattress and blanket or covering);<br>• It is safe and secure – it does not contain anything that could be potentially harmful;<br>• It includes a means of two-way communication with the team;<br>• It has a clock that patients can see;<br>• Therapeutic and meaningful activities are available in line with individualised risk assessment. |  | [1]<br>[2] |
| 125 | 1 | In units where long-term segregation is used, the area used conforms to standards as prescribed by the Mental Health Act Code of Practice.<br><br>*Guidance: This includes patients having access to meaningful and therapeutic activity and outdoor space. Other country specific reporting requirements to regulators and national best practice guidance should be followed.* |  | [1]<br>[2] |
| 126 | 1 | When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives. | | [1] |
| 127 | 2 | Equipment for physical activity is available to meet patient's physical needs. | | [2] |
| 128 | 2 | Patients have access to a sensory room. | | [2] |

# Section 6: Staffing and Training

| Standard No. | Standard Type | Standard | Principle | Reference |
|---|---|---|---|---|
| The multi-disciplinary team consists of staff from a number of different professional backgrounds that enables them to deliver a full range of treatment and therapies appropriate to the individual needs of patients on the unit. The team includes: | | | | |
| 129 | 1 | Consultant psychiatrist(s) | | [5] |
| 130 | 1 | Registered learning disability nurses form the majority of the team which may also include registered mental health nurses. | | [11] |
| 131 | 2 | Specialist pharmacist(s)<br><br>*Guidance: This role includes medicine management, medicine supply, prescribing support/advice within the MDT, medication education support with discharge to community supply and shared care principles.* | | [5] |
| 132 | 1 | Healthcare assistant(s)<br><br>*Guidance: This includes support workers, occupational therapist assistants, and psychology assistants.* | | [5] |
| 133 | 1 | There is a psychologist who is part of the MDT. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions.<br><br>*Guidance: Psychologists are HCPC registered.* | | [1] |
| 134 | 1 | There is an occupational therapist who is part of the MDT. They work with patients requiring an occupational & sensory assessment and ensure the safe and effective provision of evidence based occupational interventions.<br><br>*Guidance: Occupational therapists are HCPC registered.* | | [1] |

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| 135 | 1 | There is a speech and language therapist who is part of the MDT. They work with patients requiring communication and/or dysphagia assessment and intervention and ensure safe and effective provision of evidence-based interventions.<br><br>*Guidance: Speech & language therapists are HCPC registered.* | | [5] |
| 136 | 2 | Arts or creative therapist(s). | | [1] |
| 137 | 2 | The unit has access to other specific allied health professionals (AHPs) who are able to assess and support the individual needs of patients.<br><br>*Guidance: This may include, but is not limited to, dietitians, physiotherapists, chiropodists & podiatrists.* | | [10] |
| 138 | 2 | The unit has access to peer support workers or local equivalent. | | [10] |
| 139 | 1 | The unit has access to social workers who attend regular meetings/reviews throughout the patient's admission and are part of the discharge planning process. | | [2] |
| 140  | 1 | The unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:<br>• A method for the team to report concerns about staffing levels;<br>• Access to additional staff members;<br>• An agreed contingency plan, such as the minor and temporary reduction of non-essential services.<br><br>Sustainability Principle: Empowering Staff | | [1] |
| 141 | 2 | The unit uses a tool to determine optimal staffing levels helping measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. | | [9] |
| 142 | 1 | The unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g., in response to additional clinical need or short-term absence of permanent staff. | | [1] |
| 143  | 1 | The team, including bank and agency staff, are able to identify and manage an acute physical health emergency.<br><br>Sustainability Principle: Prioritise Prevention | | [1] |

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| 144 | 1 | There is an identified duty doctor available at all times to attend the unit, including out of hours. The doctor can attend the unit within 30 minutes in the event of an emergency. | | [1] |
| 145  | 2 | Patient or carer representatives are involved in the interview process for recruiting potential staff members.<br><br>*Guidance: The representatives should have experience of the relevant service.*<br><br>Sustainability Principle: Empowering Individuals | | [1] |
| 146 | 1 | New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes:<br>• Arrangements for shadowing colleagues on the team;<br>• Jointly working with a more experienced colleague;<br>• Being observed;<br>• Receiving enhanced supervision until core competencies have been assessed as met. | | [1] |
| 147 | 1 | All clinical staff members receive clinical supervision at least monthly or as otherwise specified by their professional body.<br><br>*Guidance: Supervision should be profession specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.* | | [1] |
| 148 | 2 | All staff members receive line management supervision at least monthly. | | [1] |
| 149  | 2 | Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice.<br><br>Sustainability Principle: Empowering Staff | | [1] |
| 150 | 1 | Staff members are able to take breaks during their shift that comply with the European Working Time Directive.<br><br>*Guidance: They have the right to one uninterrupted 20-minute rest break during their working day if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.* | | [1] |
| 151 | 1 | When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans. | | [1] |

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| 152  | 1 | The unit actively supports staff health and wellbeing.<br><br>*Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports, and taking action where needed.*<br><br>Sustainability Principle: Empowering Staff | | [1] |
| 153  | 1 | Unit-based staff members have access to a dedicated staff room.<br><br>Sustainability Principle: Empowering Staff | | [1] |
| 154  | 1 | Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.<br><br>Sustainability Principle: Empowering Staff | | [1] |
| Staff receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. The training includes: | | | | |
| 155 | 1 | The use of legal frameworks, such as the Mental Health Act, the Mental Capacity Act, and the Human Rights Act (or equivalents). | | [1] |
| 156 | 1 | Physical health assessment and management.<br><br>*Guidance: This could include training in understanding physical health problems, undertaking physical observations, basic life support, and Early Warning Signs.* | | [1] |
| 157  | 1 | Safeguarding vulnerable adults and children.<br><br>*Guidance: This includes recognising and responding to the signs of abuse, exploitation, or neglect.*<br><br>Sustainability Principle: Prioritise Prevention | | [1] |
| 158  | 1 | Risk assessment and risk management.<br><br>*Guidance: This includes assessing and managing suicide risk and self-harm; prevention and management of behaviour that communicates distress.*<br><br>Sustainability Principle: Prioritise Prevention | | [1] |

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| 159 | 1 | Recognising and communicating with patients with cognitive impairment, communication difficulties and learning disabilities within the context of person-centred care. | | [1]<br>[2] |
| 160 | 1 | Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care. | | [1] |
| 161 | 1 | Autism awareness training.<br>*Guidance: This may be through mandated Oliver McGowan Training in England or equivalent UK country offer.* | | [5] |
| 162 | 2 | A minimum of 80% of the staff team receive additional specialist autism training.<br>*Guidance: Specialist autism training can include training in autism interventions and in autism diagnostics.* | | [2] |
| 163 | 1 | Restrictive practice training.<br>*Guidance: Staff are trained in preventative and reactive approaches. This training is certified as complying with the Restraint Reduction Network training standards.* | | [5] |
| 164 | 1 | Trauma-informed approaches to care. | | [5] |
| 165 | 2 | Epilepsy training. | | [5] |
| 166 | 2 | Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality. | | [1] |
| 167 | 1 | Staff know how to prevent and respond to sexual exploitation, coercion, intimidation, and abuse. | | [1] |
| 168 | 1 | The team are knowledgeable about, and sensitive to, the needs of patients from minority groups. This may include:<br>• Black, Asian and minority ethnic groups;<br>• People with physical disabilities;<br>• Asylum seekers or refugees;<br>• LGBTQ+ community;<br>• Travellers. | | [5] |

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| 169 | 1 | The team effectively manages behaviours that communicate distress on the unit:<br>• Staff members can evidence that if restrictive interventions are used then they represent the least restrictive option to meet the need;<br>• Individualised support plans, incorporating positive behaviour support plans, are implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions;<br>• Providers report on the use of restrictive interventions;<br>• Advance statements are used to identify the patient's wishes and feelings;<br>• During and after the use of physical restraint, the patient's physical condition (including vital signs and airway status) should be monitored and recorded and any deterioration is responded to.<br><br>*Guidance: Interventions and procedures used align with the Mental Health Act Code of Practice (2015), Towards Safer Services (RRN, 2019) and Positive and Proactive Care (DoH, 2014).* |  | [5] |
| 170 | 1 | When restraint is used staff members restrain in adherence with accredited restraint techniques. | | [1] |
| 171 | 1 | The team uses seclusion only as a last resort and for brief periods only. | | [1] |
| 172 | 1 | All staff members who administer medications have been assessed as competent to do so. The assessment is completed at least once every three years using a competency-based tool. | | [1] |
| 173 | 1 | All staff involved in administering or prescribing rapid tranquillisation, or monitoring patients to whom parenteral rapid tranquillisation has been administered, have received training in immediate life support. | | |
| 174 | 1 | All staff undergo specific training in therapeutic observation, as part of their induction on the unit. This training includes:<br>• Principles around positive engagement with patients;<br>• When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this;<br>• Actions to take if the patient absconds. | | [1] |
| 175 | 1 | Staff are knowledgeable and understand the basic principles of complex continuing care, rehabilitation, habilitation and recovery. | | [4] |

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| 176 | 1 | All staff members who deliver therapies and activities are appropriately trained and supervised.<br><br>Sustainability Principle: Staff Empowerment | | [1] |
| 177 | 2 | Patient and/or carer representatives are involved in delivering and developing staff training. | | [1] |
| 178 | 1 | Staff members follow a protocol when conducting searches of patients and their personal property. | | [5] |
| 179 | 1 | Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral. | | [5] |

# Section 7: Governance & Leadership



| Standard No. | Standard Type | Standard | Principle | Reference |
|---|---|---|---|---|
| 180 | 1 | All staff members are consulted on matters that effect patient safety and quality of service. | | [5] |
| 181 | 2 | Services are developed in partnership with appropriately experienced patients and carers and have an active role in decision making. | | [1] |
| 182 | 1 | All patient information is kept in accordance with current legislation.<br><br>*Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards, and having password protected computer access.* | | [1] |

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| 183 | 1 | The environment complies with current legislation on disabled access.<br><br>*Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.* |  | [1] |
| 184 | 1 | There is a system in place to respond to themes and trends in safeguarding alerts/referrals and there are mechanisms to share learning.<br><br>*Guidance: An organisational action plan is in place to address any issues raised, including where training needs are identified.* | | [5] |
| 185 | 2 | Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics. | | [1] |
| 186 | 1 | The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment.<br><br>*Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.* | | [1] |
| 187 | 1 | The multi-disciplinary team collects audit data on the use of restrictive interventions, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and/or quality improvement methodology.<br><br>*Guidance: Audit data are used to compare the service to national benchmarks where possible.* | | [1] |
| 188 | 1 | If long term segregation is used on the unit, mechanisms are in place for regular monitoring.<br><br>*Guidance: The use is monitored in weekly multi-disciplinary team meetings or at external reviews.* | | [12] |
| 189 | 1 | Any use of force (e.g., physical, restraint, chemical restraint, seclusion and long term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018. | | [1] |

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| 190 | 2 | The unit reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, patient empowerment, maximising value/ minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team. | | [1]<br>[2] |
| 191 | 1 | Clinical outcome measurement is collected at two time points (at assessment and discharge).<br>*Guidance: This includes clinical outcomes measurements as recommended in the complex continuing care outcomes framework including patient-reported outcome measurements where possible.* | | [1]<br>[2] |
| 192 | 1 | Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this. | | [1] |
| 193<br>  | 1 | Staff members, patients and carers who are affected by a serious incident including restrictive practice and rapid tranquilisation are offered post incident support.<br>*Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection.*<br>Sustainability Principle: Empowering Individuals | | [1] |
| 194 | 1 | When serious mistakes are made in care, this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement. | | [1] |
| 195 | 1 | Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons. | | [1] |
| 196 | 2 | The team use quality improvement methods to implement service improvements. | | [1] |
| 197 | 2 | The team actively encourages patients and carers to be involved in quality improvement initiatives. | | [1] |

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# Acknowledgements

The Quality Network for Learning Disability Services (QNLD) is extremely grateful to the following people for their time and expert advice in the development and revision of these standards:

- Members of the Quality Network for Learning Disability Services (QNLD) Advisory Group who contributed to this work;
- Experts by experience that contributed their views and opinions;
- Individuals who attended the virtual standards consultation workshop;
- Individuals who contributed feedback via the e-consultation process.

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