

National audit of specialist inpatient healthcare services for people with learning difficulties - table of recommendations

Introduction

The table of recommendations has been produced from the data collected during the Healthcare Commission's audit of services for people with learning difficulties, which began in January 2007.

The audit included all specialist inpatient health services for adults and adolescents with learning difficulties in England. It covered services provided by the NHS and independent healthcare. The audit looked at the provision of care in the following services:

- **acute assessment and treatment centres**
- **short break (or respite) services**
- **individual residential services paid for by the NHS (but not regulated by the Commission for Social Care Inspection)**
- **low secure services**
- **medium secure services**
- **high secure services**
- **'old' long stay services**
- **campus services**
- **specialist adolescent services**

(We did not include those services run by the NHS that were registered with the Commission for Social Care Inspection).

In addition to the recommendations, the table also shows how many visits were undertaken, how many beds the units had and the different types of service delivered within the 68 organisations reviewed.

The audit process

We established external and internal steering groups, which included people with learning difficulties and family carers, clinicians and others with an interest. This ensured their views were heard from the beginning of the process. The membership of the external steering group is shown in **Appendix 3** of the main report.

With the assistance of the external reference group, we designed two questionnaires: a questionnaire for an individual service, and a further questionnaire for an organisation's board.

The external reference group identified 12 areas for the questions to focus on. These were the most critical indicators of the likely safety and quality of a service and were followed up in all organisations selected for a visit. Review teams also selected areas

for additional scrutiny during their visits that were relevant to each service. They used three criteria: potential problems, indications of good practice, and unusual answers given in the questionnaire. This allowed us to react to the information provided and ensure a greater breadth and depth of evidence.

The review teams visited 154 services, providing care to adults and adolescents with learning difficulties. The review team comprised three people: a person with learning difficulties or a family member who cared for a person with learning difficulties, a Healthcare Commission manager and a clinician or manager from the field.

The recommendations

Taking all types of service we made 2,548 recommendations in total for improvements to the 154 services.

Recommendations were coded to nine pre-identified themes:

- choice
- environment
- relationships
- money
- monitoring
- person-centred care
- physical interventions
- safeguarding
- staffing

One recommendation could be coded to more than one theme, if applicable. For example, a recommendation around ensuring staff knew how to make child or adult protection referrals would be coded to both the staffing theme and the safeguarding theme. That recommendation would therefore count as two codes. Consequently it is important when looking at the number of recommendations to note the following four points:

- the number of recommendation codes (which is what is being counted) does not equal the number of recommendations
- there is not necessarily a correlation between the number of recommendation codes and the performance of an organisation
- one recommendation can be coded across more than one theme
- more than one recommendation can be coded at once

The recommendations ranged from fairly minor suggestions to those of a more serious nature (for example, around the safeguarding of children or adults). The quality of a service is dependent on the nature of the recommendations and not the quantity of them. A service with a high number of recommendations does not automatically mean it is a poor service.

The recommendations from the 154 reports were varied. This was because the organisations were providing different services, with different issues, concerns and good practice. Below is a sample of actual recommendations made in each category, which shows the variation.

Choice

- There should be formal arrangements to offer people choice, especially with meals, and these should be documented.
- The trust should review its budget for food to ensure that people using the service have a choice of meals.
- Staff should ensure that the individual preferences and choices of people with learning difficulties are fully reflected in plans for their future living arrangements.
- The service should review the structured weekly activity plans for young people to explore opportunities for greater flexibility, choice and personal responsibility in line with *Valuing People* principles.
- The service should ensure that people with learning difficulties are involved in the decision making process regarding their holidays.
- The restrictions placed on people with learning difficulties, within the building, should be reviewed and assessed to ensure that the service is promoting and supporting their highest possible level of independence.
- People's quality of life needs to be improved and the opportunity for them to exercise choice and control over their own lives should be increased.
- The trust should review the environment and the restrictive practices that control people's lives to ensure that the four principles of *Valuing People* are being met. In addition, consideration should be given to how people with learning difficulties can be supported to take part in meaningful activities whilst staying in the unit.
- Better ways of communicating with service users should be developed to offer them real choices.
- The unit needs to be examined to see if it is suitable for the people living there. Some residents appear to be capable of more independent living whilst others require more intense care and active interventions.
- The unit should make every effort to ensure that residents are supported to make choices, particularly in relation to major issues. This should include the involvement of independent advocates.

Environment

- A deep clean of the unit must be completed and it should be regularly inspected to enable repeat cleaning as appropriate.
- The unit should be refurbished and redecorated to provide a more attractive environment for people who use the service.
- The organisation needs to empower staff to be more actively engaged in creating a personalised and stimulating environment.

- The service provider should develop a maintenance plan for the unit as a matter of urgency to ensure that the building and its surroundings are safe and pleasant for people with learning difficulties, staff and visitors.
- The garden needs to be maintained to an adequate level so residents are able to access all areas of it.
- The cupboard designated for the storage of hazardous substances should be kept locked and the key kept securely.
- Single bedrooms should be made available for all residents, unless they have expressed a wish to share a room.
- The correct use of all fire-resisting doors should be addressed and any remedial action taken without delay.
- The availability of transport for people with learning difficulties should be reviewed to ensure people have access to the community.
- The bath and shower should be repaired without further delay.

Relationships

- The service should develop a strategy to sensitively encourage and support people with learning difficulties and their families to maintain contact.
- The trust should ensure that there is a clear and open pathway for family members to make formal complaints.
- All information about making a complaint should be reviewed and made accessible to people with learning difficulties, staff and visitors.
- The board should implement systems and processes to engage more effectively with people with learning difficulties and staff in the unit.
- The trust should engage and capture the views of people with learning difficulties and their relatives by setting up forums for people who use their services.
- Case review meetings should be arranged at a time when residents and their families are able to attend (if they wish to).

Staffing

- The centre should ensure that all agency and bank staff are adequately trained and undertake full local induction.
- There needs to be a clear commitment to provide cover so that staff can undertake training, when required.
- The trust should ensure that appropriate arrangements are in place for the line management and supervision of staff.
- The staffing of the unit must be reviewed to ensure that the needs of all of the people using the service can be met.

- Steps must be taken to ensure that the team of staff has the appropriate mix of skills, experience and training, and that they attend mandatory training, which is effectively monitored. Action should be taken if staff do not attend.
- The trust should provide ethnicity and diversity training to all staff in the unit.
- The organisation should review staffing levels at weekends, to ensure the safety of staff and people with learning difficulties.
- Training on person-centred planning must be provided as soon as possible to ensure that staff have a good working knowledge of this process, and how to apply this to individual residents. Training should include how to ensure that health action plans are integral to the process.
- The trust should investigate, monitor and manage the present sickness rate amongst staff.
- The trust needs to consider how appropriate leadership, direction and support is given to the staff on the unit.
- The trust should identify a process to ensure the competency of agency staff.

Money

- People with learning difficulties should be allowed to manage their own money, based upon an assessment of their ability. Where necessary, they should be given additional support to address issues around taking other people's property. It is recommended that each resident has a secure lockable space in their room, where they can store money and valuables.
- The provider should review the process for empowering people with learning difficulties to manage their finances.
- The trust should consider whether there are any financial implications for the people using the service who appear to be managed in a hospital setting whilst in receipt of benefits.
- The trust should consider reviewing its financial policies around charging people with learning difficulties, for staff costs in relation to day activities or holidays, to ensure fairness and equality.
- People with learning difficulties should have independent advocacy and support to enable them to make choices about their own money.
- The unit manager should ensure the commissioner of the service agrees that people with learning difficulties should pay for activities.
- The practice of pooling the money, of people who use the service who are deemed to be without capacity, into a single account should be discontinued.
- The trust should facilitate the opening of individual bank accounts for people with learning difficulties who use their services.

Monitoring

- Commissioners should monitor the services that they are commissioning and they should be aware of the needs and requirements of the client group for whom they are commissioning services.
- The board should ensure that people with learning difficulties are effectively safeguarded against abuse, neglect or poor treatment when using services.
- The board should ensure that the voices of people with learning disabilities, their family and carers are heard effectively.
- Medication management practices must be subject to clinical audit and management monitoring.
- A system should be introduced that ensures that the compliments about services are recorded.
- The trust must review its locked door policy.
- The function and admission criteria for this unit should be reviewed and clear criteria and guidelines agreed.
- The service should establish and develop a robust clinical governance system. It should consider awareness training for its non-executive directors, to give them a greater insight into current issues within services for people with learning difficulties and the standards expected.
- The profile of learning difficulties and provision of information regarding learning difficulties should be raised both internally and externally.

Person-centred care

- All people with learning difficulties should be offered access to an independent advocate, especially during the period of uncertainty and service re-provision.
- A GP and dentist should be identified for each resident.
- Commissioners should be proactive in managing the service level agreement and ensuring that they are purchasing the appropriate services, based on relevant information, for example community care assessments, to meet the needs of the people living in the unit.
- Person-centred approaches need to be implemented to ensure that personal choice informs the decision-making processes.
- Senior staff should consider ways to facilitate discharges by working with partner agencies to develop alternatives to hospital care and exerting influence where there are delayed discharges.
- The service should collate data on lengths of stay and causes of delayed discharge, so that this evidence can inform wider strategic planning for young people with this complex set of needs.

- Senior staff and the unit team should review the admission criteria, to ensure an appropriate and safe mix of young people on the unit.
- Systems should be put in place to allow advocacy and patient/carer perspectives to feed into the management structures.
- The level and availability of on unit/on site daily exercise, activities and therapies (both recreational and educational) must be urgently improved.
- The trust should assess the current activity available to patients within the community rather than the campus setting. Taking risk into account, it should introduce more community-based activity.

Physical interventions

- Criteria for the administration of PRN medication need to be developed.
- The frequency and duration of seclusion should be reviewed on a regular basis, to ensure it is appropriate.
- The trust should ensure each person with a learning difficulty has a plan that clearly indicates at what point PRN medication should be administered.
- The service should review the strategies used for the management of difficult and challenging behaviour. This must include an urgent review of all the management guidelines to ensure a more person-centred approach that is not punitive or abusive. Staff should be given the necessary training and support to ensure they are able to manage difficult and challenging behaviour competently and appropriately.
- The de-escalation policy and procedure should be reviewed, to reduce the use of physical interventions.
- Patients should be involved in plans for physical intervention, when appropriate, and documentation should reflect this.
- Staff should not use the seclusion room as a routine way of managing behavioural issues of informal patients. Alternative management should be considered.
- A review of untoward incidents should always take place following an incident so that lessons can be learnt and changes made to proactively reduce the risk behaviours.
- The consistent and frequent use of PRN medication should be reviewed, and consideration given to increasing or changing the existing prescribed medication, and/or reviewing the suitability of the person's continued placement at the unit.
- The trust should undertake urgent reviews at the unit relating to the prescribing and administration of out of license drugs to ensure safe and effective procedures are followed.
- Staff would benefit from training on positive behavioural approaches.

Safeguarding

- Training in relation to adult protection procedures should be provided with immediate effect. The training should be supported by prompt risk-assessment and effective joint working, as set out in *No Secrets* (Department of Health's protection of vulnerable adults policy) between key agencies that safeguard people with learning difficulties from abuse, neglect or poor treatment.
- Training needs to be provided to ensure when and how staff should make protection of vulnerable adults (POVA) referrals.
- Adult protection training for all front-line staff should be implemented immediately.
- The client mix should be reviewed at regular intervals, to ensure the safety and wellbeing of all people who use the service.
- The unit must replace the locking mechanisms to bedroom doors to ensure a person with learning difficulties cannot be purposely or inadvertently locked in their room.
- The trust should ensure the immediate and long-term safety of the people with learning difficulties in this unit.
- The PCT needs to work with colleagues in social services to put mechanisms in place to ensure appropriate action is taken following a POVA referral. This should be addressed with some urgency.
- All incidents of self-harm should be reported to enable effective monitoring and analysis.
- The use of an independent mental capacity advocate should be considered for those people who lack capacity and have no family involvement when developing protective measures following adult protection alerts.
- A lockable medicines cabinet should be purchased, and attached to the wall, so that medication is stored safely and correctly.

Next steps

The Healthcare Commission will work with the healthcare organisations that we visited during the audit to deliver their action plans. We asked each organisation to put monitoring arrangements in place so that their management boards can be assured that actions have been taken. For NHS trusts (except foundation trusts), we have alerted strategic health authorities to monitor the completion of action plans.

The main report contains more detailed information about what we will do and what we expect others to do.