Learning Disability Professional Senate

Key Performance Indicators / Standards for Assessment and Treatment Units for Adults with Learning Disabilities

If I am admitted to an Assessment and Treatment Unit, I can expect the following standards to be met to sure I get the support and treatment I need and that this takes as short a time as possible.

In 75% of times I will be ready to leave within 3 months, and in 90% of times I will be ready to leave within 6 months (irrespective of my gender or ethnic group). This will be monitored by my Commissioner, and should trigger a checkpoint at these timescales as to my progress.

In exceptional circumstances, there may be a valid clinical reason for a standard not to be completed to the specified timescale, but this should be recorded in my notes and completed as soon as possible.

In the first hour of my admission I can expect:	
1.1	Staff make me feel welcome when I arrive on the unit.
1.2	Staff keep me safe, reassure me, and when I am ready, will show me around and introduce me to other people, staff and facilities.
1.3	Staff will know in advance that I am coming to the Unit and will have as much information as possible about my previous support plans, person centred plan, communication plan, risks and admissions.
In the first 4 hours of my admission I can expect:	
2.1	Staff will sit with me, and explain the reason for my admission, including whether my status is informal or detained under the Mental Health Act.
2.2	My capacity to decide on each aspect of my care is considered, formally assessed where needed, or decided in my best interests if I do not have capacity in line with the Mental Capacity Act. Each decision is formally documented in my notes.
2.3	I am given an appropriate 'welcome pack' or introductory information in a format that I understand that contains the following: • A clear description of the aims of the unit; • The current programme and modes of treatment; • Who the staff are on the Unit; • How I will be helped to keep safe on the unit;

	• How I am expected to behave on the unit (The code of conduct); • Unit facilities and the layout of the unit; • What items I can and cannot have in the unit, including use of my mobile phone; • Whether smoking is allowed, and where I can go to smoke if I want to. • How my spiritual, cultural and gender needs will be met; • Visiting arrangements and how I can contact my family and friends; • What I need to do if there is an emergency e.g. fire; • How I will be able to work with staff and be supported to be discharged from the Unit; • Who I go to for support, and who is my named nurse.
2.4	If I am detained under the Mental Health Act, I will be given accessible information on my rights, and this will be documented in my notes. Staff will check that I understand what this means for me.
2.5	I am given individualized accessible information on: • My rights regarding consent to care and treatment; • How to access advocacy services (including independent mental capacity advocate and independent mental health advocate); • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments, and what will happen in response; • How to access my own health records.
2.6	I am supported to decide who I would like to share my information with. This is documented in my notes including who I don't want my information share with and my reasons. If I do not have capacity, then a Best Interests meeting will be held to decide who will have information about me.
2.7	My family or next of kin will be contacted by a staff member (with my consent) to notify them of the admission and to give them the unit contact details. Unless there are good reasons to the contrary, my family will be supported to have an active role through the admission. My family will be helped to ask for a carers assessment.
2.8	I will have a comprehensive physical health review. This will include: • Details of my past medical history; • My current medication, including whether it is helping me, whether I take it regularly, how I take my medication, side effects, future plans for my medications and alternatives to medication; • Other current treatments/ therapy and whether they are working for me; • Physical observations of me including blood pressure, heart rate and respiratory rate; • Any issues that I have with eating, drinking and swallowing. I am told what the results are and what they mean for me, and these are recorded in my notes and in my health action plan.

In the first 24 hours of my admission I can expect:	
3.1	My physical health review will continue. This will include: • Physical examination; • Height, weight, nutritional screening; • Blood tests (can use recent blood tests if appropriate) if needed; • ECG if needed; • Medicines reconciliation. I am told what the results are and what they mean to me, and these are recorded in my notes.
3.2	I have a screening assessment by unit staff using an agreed format to identify my communication needs to ensure that staff know how to communicate with me effectively, including talking to me, my family and other people who know me well. Staff will ask if I have a current communication guideline, profile or passport that describes accurately how best to communicate with me, and will use the information to communicate with me as I need. If I need further assessment I will be referred today to the speech and language therapist, and this assessment will be completed and recommendations received within 2 weeks of my admission.
3.3	I have a screening assessment by unit staff using an agreed format to identify both my sensory and occupational needs to ensure that staff know how to work effectively with me. If I need further assessment I will be referred today to the occupational therapist, and this assessment will be completed and recommendations received within 2 weeks of my admission.
3.4	Staff will consider whether they need to use the Deprivation of Liberty Safeguards to protect me and to make the relevant applications for assessment. My family or those who know me best will be involved in this process.
3.5	I have a comprehensive risk assessment completed that identifies: • My risk to others; • My risk to myself; • Risk to me from others; • I am involved in understanding and describing the risks and in developing the risk management plan. My risk assessment will identify if I am identified as at risk of leaving the building without notifying anyone or without support (particularly when I am here informally, and a plan developed which includes clear instructions for alerting and communicating with my family, people at risk and the relevant authorities.

3.6	I am told about the level of observation that I am under, how it will happen, what it is for, and how it will be reviewed/ revised.
3.7	I have a named nurse from the unit who will act as my discharge facilitator.
3.8	If I was admitted to the unit as an emergency without a Community Care and Treatment Review (CTR), staff at the unit will identify and notify the relevant Clinical Commissioning Group (CCG), Local Authority (LA), GP, and Community Learning Disabilities team (CTPLD) that I have been admitted to the unit, and ask for a post admission CTR to take place within 14 days of admission.
3.9	Staff on the unit will ensure that all relevant information that is known about me is requested from my family, professionals and staff who were supporting me before my admission. This will include: • Any previous assessments; • My Person Centred Plan; • My Health Action Plan; • My Communication Passport / guidelines / profile; • My Positive Behaviour Support Plan / Relapse / Recovery plan; • My current living arrangements and benefits on admission.
3.10	Staff will check if I have an advocate, and if not will make an application to get me an advocate.
Everyday I can expect that:	
4.1	I will be supported by well trained, caring, respectful and sufficient regular staff to ensure my assessment and treatment is completed to agreed timescales.
4.2	The percentage of agency staff does not exceed 10% of the establishment, and that agency staff have an effective local induction to understand my needs and support my care plan.
4.3	My multidisciplinary team as a minimum includes or has dedicated sessional time from: • Psychiatrists; • Registered Nurses; • Healthcare Assistants; • Registered Psychologists; • Occupational Therapists; • Speech and Language Therapists; • Specialist Pharmacist. I will have regular access to my social worker. I will have access to other therapy professionals as needed.
4.4	The staff who support me feel confident to contribute to and safely challenge professional decisions, and are able to raise any concerns they may have about standards of care.

4.5	Staff will fully discuss my needs, risks and management at each handover to ensure consistency of approach.
Within the first 7 days of my admission I can expect:	
5.1	I have an initial statement of need completed within the 1st week of my admission. This will involve: • Myself; • Staff in the unit; • My family; • Staff from where I was living; • My advocate if I have one; • Representative from the Community Team for People with Learning Disabilities; • Anyone else involved in my support or who is important to me. This includes: • Details of my past family medical history; • A full history including all key life events or trauma, and relationships that are important to me and may impact on how I feel and behave; • Factors that lead to my admission; • My physical health and medication / treatments; • My Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use; • My Mental health (including specific diagnoses e.g. mental illnesses, ASD, ADHD) and medication that I take; • My Psychosocial needs; • My Strengths and weaknesses, which must include an adaptive functioning assessment; • My Personal preferences including my likes and dislikes, what is important to me, my coping strategies and challenges, traits and routines.
5.2	My statement of need will lead to the multi-disciplinary team developing an initial written formulation of my needs, including an initial formulation of risk. This will identify further assessments needed and timescale for completion.
5.3	I am supported to help develop my care / treatment plan. This will clearly specify: • A clear, person-centred and recovery based description of what I and everyone is aiming to achieve for me; • Agreed intervention strategies for my physical and mental health; • Measurable goals and outcomes, with timescales; • How I can be supported to manage my own issues; • How I should be supported in a crisis; • How progress will be measured using both measures of clinical outcomes and progress on the goals that I want to achieve.

	I expect it to refer to my previously stated wishes or my advance directives if I have made them clear.
5.4	I have a named CPA co-ordinator from the Community Team for People with Learning Disabilities in the area that I came from before my admission, and a named Social Worker to support my discharge.
5.5	I am supported to attend a multidisciplinary Clinical review / CPA meeting to discuss the initial assessment and formulation, and to agree my care plan. I am given information before the meeting about the purpose of the meeting, who will be there, who I can invite to the meeting. I am supported to prepare for the meeting, including what I want from the meeting and what questions I want to ask. I will be supported after the meeting to check that I have understood what has been said and agreed. If I choose not to attend the meeting, then my named nurse will take my views to the meeting, and feedback to me the results of the meeting and this will be documented in my notes.
5.6	I have a copy of my care plan in a format that has been adapted to my communication needs as appropriate. It will be shared with my family unless I say that I do not want them to have a copy.
5.7	I am offered evidence based pharmacological and psychological interventions (e.g. NICE, National Guidance) and any exceptions are documented in my notes. Medication should only be considered for managing my behaviour if: • Psychology or other therapies do not help within an agreed time; or • Alternative treatment for a mental or physical health problem has not improved the behaviour; or • The risk of harm to me or others is severe; • Psychotropic drugs are only used in combination with psychology or other therapies.
5.8	I am supported to understand the medication that I am taking including: what the medicine is; what it will help with; common side effects; whether the medication is being prescribed off-label, in a high dose; how it works with the other medicines I take; when the medicine will be stepped down or stopped; that I can ask for a review.
5.9	I have people who try to engage me in active support and activities that I enjoy.
5.10	My multidisciplinary team will work with me to develop a leave plan which includes: • A risk assessment and risk management plan that includes a formulation of my risk behaviour, protective factors, what needs to be done to help minimize the risks and an explanation of what to do if problems arise on leave; • Conditions of the leave, escorted, accompanied, unescorted; • Contact details of the ward/unit. My family and I will be supported to have been fully involved in the discussions and

	agreeing to the conditions of the leave.
Within 14 days I can expect:	
6.1	If there has not been Community CTR before my admission, I will be invited to a post admission Care and Treatment Review (CTR): Before the CTR, staff will support me to understand what the CTR is about, provide me with accessible information on the review and help me to prepare. They will also support my family to understand the CTR and support them to attend or to take part via teleconference. I expect that this will be attended by: • My family and /or others who are important to me; • My advocate; • The multi-disciplinary team from the unit including my named nurse and Responsible Clinician/ psychiatrist; • My CPA co-ordinator from the CTPLD; • Manager from my support provider / prospective support provider; • My identified commissioner from the CCG / LA – the responsible commissioner will chair my CTR; • Two Expert advisors who are independent – one being a clinical expert and one an expert by experience.
6.2	My Care and Treatment Review (CTR) meeting will: • Discuss the reason for my admission; • Ask whether my assessment and treatment has to take place in a hospital setting, or whether it could take place at home with the right support; • Discuss whether I could have my assessment and treatment in a unit closer to my home to maintain my community contacts, and if so to facilitate a transfer as soon as possible; • Look at the results of the initial assessments and initial formulation, diagnosis; • Agree the care plan and what outcomes are intended from a period of admission; • Identify which parts of the care plan need to be completed in the unit and which can continue in the community with intensive/ enhanced support; • Set a proposed date for discharge, and agree how any changes to this will be communicated or escalated to commissioners; • Discuss where I will live when the inpatient functions are completed; • Agree what elements need to be included in my future person-centred service specification, how this will be developed and who will lead on this; • Clarify who is responsible for funding my future placement; • Establish the support needs of my family and ensure that they have an up to date carers assessment; • Be clear on all actions and who is responsible for them.
6.3	Following my CTR I will receive a copy of the actions in a format that I can understand. Notes will also be circulated to everyone else involved in my care.

Each following week I can expect:	
7.1	I am invited and supported to attend a multidisciplinary clinical review meeting at least once per week. I will expect that this will be attended by: • The multi-disciplinary team from the unit including my named nurse; • My CPA co-ordinator from the CTPLD; • My family; • My advocate; • Manager from my home / prospective home; • My identified commissioner from the CCG / LA should attend at least monthly.
7.2	My named nurse meets with me before my clinical review to discuss how I think things are going, what else would help and to support me to raise any issues in the meeting, and meets with me after the meeting to check that I have understood.
7.3	My multidisciplinary clinical review meeting will discuss, review, revise and document: • Results from any further assessments; • My care plan; • My medication including whether it is being effective, plans for reductions and alternatives, how it is working for me, and side effects I may be experiencing; • The effects on my physical and mental health of taking mood stabilisers or antipsychotic medications, or any other medicines being taken for managing my behaviour such as anti-depressants or anti-convulsants; • Review whether I still need to take specific medications; • Incidents that I have been involved with; • The use of 'As required' medication including rapid tranquilisation; • Physical Interventions or other restrictive practices including seclusion; • My Communication and how best to give me information and communicate with me; • My sensory needs; • My Positive Behaviour Support plan; • My response to psychological interventions; • My physical health and any follow up investigations or treatments; • My lifestyle choices and supporting me to make healthy choices including smoking cessation; healthy eating; physical exercise; • My risk assessment; • Review my active support plan and my range of activities; • Review my estimated discharge date and the actions needed to support the CCG / LA in finding a placement. At the end of the review the formulation of my needs will be reviewed, revised and documented in light of the discussions. This will be shared with everyone invited to attend to ensure that everyone is working together to prepare for my return to the community. Each clinical review will discuss whether my assessment and treatment needs to continue within the unit, or whether it can be continued in the community with agreed support. At

	this point a discharge ready meeting should take place.
7.4	I am supported to work with my multidisciplinary team to develop a service specification to meet my identified needs for my home /support on discharge. This informs a decision about the environment and support package that is required to support my discharge as soon as possible and to keep me safe and well.
7.5	Once a future package of care is being identified, the multidisciplinary team will support me with visits to look at future housing, advise on any adaptations required, specify care plans that are required to support me, working in partnership with me, my family and my community team.
7.6	I or my family / advocate can ask for a second opinion if there is doubt, uncertainty or disagreement about my formulation or treatment. If I am unhappy about progress being made towards discharge then I (or my family, advocate or commissioner) can ask for a CTR. I have a right to request a CTR.
7.7	My commissioner will be notified each month of my admission about the planned date of discharge - and in particular following the first 28 days of assessment (under Section 3 of the Mental Health Act), at the 3 months and 6 months timescale.
My Discharge Ready Meeting:	
8.1	Having already considered my capacity to make decisions about my future living arrangements, information is available in the right format to enhance and support my ability to make and be involved in my own decisions.
8.2	I am supported to attend my discharge ready meeting. I expect that this will be attended by: • The multi-disciplinary team from the unit including my named nurse; • My CPA co-ordinator from the CTPLD; • My family; • My advocate; • My identified commissioner from the CCG / LA; • Manager from my home / prospective home.
8.3	At my discharge ready meeting, everyone will confirm that my assessment and treatment is at a stage where it can continue safely in the community with the right support and that I am ready for discharge.
8.5	I am supported to help develop an individualised after care plan which clearly specifies: • How my treatment plan / positive behaviour support plan / recovery plan will be implemented; • Transition arrangements from the unit to where I will live; • My risk formulation and the things that need to be done to help minimize the risks; • Who will support me in the community and how often;

	• How my team will work together with me, my family, my GP and CTPLD proactively after my discharge to support me and respond quickly if things change and I need extra support; • What will happen in a crisis; • What treatment and support I will get after discharge including plans for prescribing my medicines, reviewing my medicine and stepping down/terminating my medicines (as medications should only continue as part of a clinically-informed formulation and associated care plan);
8.6	The support needs of my family are established and they are offered a carers assessment.
8.7	The 'Dynamic register' will be explained to me and my family, and why it is important so that it will help me to get the right support and resources after my discharge. I will be asked to give my consent to have my name on the register.
8.8	There will be a discussion about whether a post discharge CTR should take place to check on my progress after I leave the unit.
8.9	The CPA seven day follow-up contact will be planned with me and my family.
What happens if my discharge is delayed	
9.1	I am supported to stay well if my discharge is delayed so that I am ready to leave as soon as the support package is in place.
9.2	Any delays in discharge will be explained to me and my family by my named nurse / CPA care co-ordinator. I will be told what actions are happening to address the delay and how I will be updated. This will be documented in My Discharge planner including who is doing what and by what date.
9.3	My named nurse/discharge facilitator will keep in contact with my commissioner at least twice weekly to ensure pressure to facilitate my discharge and inform me / my family.
9.4	My Commissioner will feedback at least weekly to my clinical review meeting on progress on my discharge, and inform me and my family.

Adapted from:

Quality Network for Inpatient Learning Disability Services (QNLD).

Royal College of Psychiatrists (2016) Quality Standards for adult inpatient learning disability services. Third edition: July 2016. Editors: Renata Souza, Lucy Palmer, Yvonne Amar and Eryna Tarant

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