QNLD
QUALITY NETWORK FOR INPATIENT LEARNING DISABILITY SERVICES
CCQI

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ROYAL COLLEGE OF PSYCHIATRISTS

Quality Network for Learning Disability Services (QNLD)

Standards for Inpatient Learning Disability Services
Fourth Edition

Editors: Amy Colwill & Leyla Golparvar

March 2021
Publication number: CCQI 358

Quality Network for Learning Disability Services (QNLD)

Royal College of Psychiatrists' Centre for Quality Improvement
21 Prescot Street
London
E1 8BB

www.rcpsych.ac.uk/QNLD

L.D@rcpsych.ac.uk

Publication number: CCQI 358

Revision date: 2023

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Artwork provided by Louise Lane on Byron Court, Essex.

Foreword

Since publication of the 3rd edition of the Quality Network for Learning Disability (QNLD) standards for Accreditation of Inpatient Assessment and Treatment units for adults with Intellectual Disability, there have been significant national policy initiatives, including STOMP, and guidance from various statutory bodies in the UK. The CCQI has worked hard to ensure that this, the 4th edition reflects the changes in legislation, practice and the evolving ethos in inpatient services since the publication of the last edition.

This revision has involved extensive consultation and collaboration with a wide range of stakeholders ranging from representatives of carer groups, members of various professional Colleges, NHS England, the Intellectual Disability Senate, the third sector and the inpatient units themselves. During the course of this exercise, many new standards have been introduced and some old ones modified or removed following guidance from our stakeholders. There has been a consensus among them towards moving to more Type 1 standards in keeping with the prevailing drive towards improving quality of care of people with intellectual disability. Other changes are as a result of a desire to make the standards as user friendly as possible.

On behalf of the Advisory Committee, I would like to thank our consultees for generously giving their time and advice; and to the team from CCQI for their tremendous work. We sincerely hope these standards ultimately help the people with intellectual disability receive evidence-based treatments, in environments meeting international standards, provided by appropriately trained staff.

It is my pleasure to commend to you, on behalf of the CCQI, the 4th Edition of the QNLD standards for inpatient units for people with an intellectual disability.

Dr Kiran Purandare

Chair of QNLD Accreditation Committee & Advisory Group

February 2021

Introduction

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation by the Quality Network for Learning Disability Services (QNLD) standards development group, which includes carers and professional groups involved in the provision of inpatient learning disability services. They incorporate the College Centre for Quality Improvement (CCQI) Core Inpatient Standards, as well as specialist standards relating specifically to inpatient learning disability services.

The standards cover the follow topics:

- Admission and assessment
- Care Planning & Treatment
- Referral, Transfer & Discharge
- Patient & Carer Experience
- Environment & Facilities
- Staffing & Training
- Governance

Who are these standards for?

These standards are designed to be applicable to inpatient learning disability services for working age adults and can be used by professionals to assess the quality of the team. The standards will also be of interest to commissioners, patients, carers, researchers and policy makers.

Since inpatient learning disability units differ widely in their configuration and the models used, these standards focus on the function of a team in order to make them as widely accessible as possible.

Categorisation of standards

To support in their use during the 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;

Notation

College Centre for Quality Improvement (CCQI) Core Inpatient Standards are marked with [1] in the reference column throughout the document. Several College Core Standards have been modified to become more in line with the speciality of inpatient learning disability services; those College Core Standards that have been modified have [1] and [2] within the reference column. The remaining standards are not included in the College Core set and relate specifically to inpatient learning disability services.

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 the inpatient learning disability services are referred to as '*patients*' and their loved ones are referred to as '*carers*'.

Key principles of the standards

A new edition to this set of standards is the introduction of four key principles that run throughout the standards, which are crucial to providing high quality care. One or more of the principles applies to several standards within the document and below icons are used throughout the document when the principle is key to meeting the standard.

	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.
	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.

References

Please see the list at the end of this document for full references.
The standards are also available to download on our website: www.rcpsych.ac.uk/QNLD

Standards for Inpatient Learning Disability Services

Section 1: Admission & Assessment

No.	Type	Standard	Principle	Ref
1	1	Accessible information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on: • How to make a referral; • A description of the unit and its purpose; • Admission criteria; • Clinical pathways describing access, discharge, timescales and treatment pathways; • Main interventions and treatments available; • Contact details for the unit.		[1] [2]
2	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.		[1] [2]
3	1	Consent-to-treatment procedures (or best interest decision-making processes) should be followed and documented, as per Mental Capacity Act 2005.		[3]
4	1	When patients lack capacity to consent to interventions, decisions are made in their best interests.		[3]
5	1	There are systems in place to ensure that the unit takes account of any advance decisions and statements that the patient has made.		[1] [2]
6	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.		[2] [16]
7	1	On admission the following is given consideration: • The security of the patient's home; • Arrangements for dependants (children, people they are caring for); • Arrangements for pets; • Essential maintenance of home and garden.		[1]

8	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: • Their rights regarding admission and consent to treatment; • Rights under the Mental Health Act, Mental Capacity Act, Human Rights Act & Deprivation of Liberty Safeguards (DoLS); • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments; • Information on restrictive practice. *Guidance: Patients' rights are continuously discussed throughout their time on the unit.*		[1] [2]
9	1	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.		[1]
10	1	Patients begin a screening assessment to identify their communication needs, outlining how to effectively communicate with them, within 4 hours of admission or as soon as practically possible. *Guidance: The team utilise the patients' current communication passport/profile during this assessment, where available.*		[2] [8]
11	1	Patients begin a comprehensive mental health assessment within 4 hours of admission, or as soon as practically possible. This involves the multi-disciplinary team and includes consideration of the patient's: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; which includes an adaptive functioning assessment and an assessment of sensory needs.		[1] [2]
12	1	Patients have a comprehensive physical health review. This is started within 4 hours of admission, or as soon as is practically possible. The assessment is completed within 1 week, or prior to discharge.		[1]
13	1	Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Patients have a health action plan and advice may be sought from primary or secondary physical healthcare services.*		[1] [9]

14	1	Patients and carers are given an accessible information pack on admission, which staff talk through with them, that contains the following: • A description of the service; • The therapeutic programme; • Information about the staff team; • The unit code of conduct; • Information on safeguarding; • Key service policies (e.g. permitted items, complaints policy, restrictive practice policy); • Resources to meet spiritual, cultural or gender needs.		[1] [2]
15	2	The community team (including the social worker) and the GP are informed about the patient's admission within one working day.		[2]
16	1	When patients are 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, Local Authority, GP, and Community Team for People with Learning Disabilities.		[2] [16]
17	1	There is a documented Care Programme Approach (or equivalent) or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this and express their views with advanced preparation and feedback.		[1] [2]
18	1	When a young person under the age of 18 is admitted: • There is a named CAMHS clinician who is available for consultation and advice; • The local authority or local equivalent is informed of the admission; • The CQC or local equivalent is informed if the patient is detained; • A single room is used; • A risk assessment is completed.		[1] [2]

Section 2: Care Planning and Treatment

No.	Type	Standard	Principle	Ref
19	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: *Guidance: The care plan clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *How to build on skills, strengths and experiences to achieve goals and aspirations;* • *Plans to keep well;* • *Any advance decisions or statements that the patient has made;* • *Reducing restrictive practice plan;* • *Crisis and contingency plans;* • *Review dates and discharge plans.* *Care plans are adapted to the patients' communication needs.*		[1] [2]
20	1	The multi-disciplinary team reviews and updates care plans at least weekly.		[19]
21	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.		[19]
22	1	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others, risk from others and safeguarding risk.		[1] [2]
23	1	The team knows how to respond to carers when the patient does not consent to their involvement.		[1]
24	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.		[1] [2]

25	2	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.		[1]
26	1	The team and patient jointly develop a leave plan, which is shared with the patient and their carer (with the patient's consent), that includes: • A risk assessment and risk management plan that includes protective factors and an explanation of what to do if problems arise on leave; • Conditions of the leave; • Information on medication; • Contact details of the unit and crisis numbers.		[1] [2]
27	1	Staff agree leave plans with the patient's carer where appropriate, allowing carers sufficient time to prepare.		[1]
28	1	When patients are absent without leave, the team (in accordance with local policy): • Activate a risk management plan; • Make efforts to locate the patient; • Alert carers, people of concern and the relevant authorities; • Complete an incident form.		[1] [2]
29	1	Patients are offered a pre-arranged 1-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.		[1]
30	1	Actions from reviews are fed back to the patient and carer (with the patient's consent) and this is documented.		[1]
31	1	Patients are involved in decisions about their level of observation by staff, where appropriate. *Guidance: Patients are supported to understand why they are under the level of observation and how it can be reduced.*		[1] [2]
32	1	When medication is prescribed, patients are supported to understand: • What medication they are taking; • What the benefits are; • What the common side effects are; • Whether the medication is being prescribed off label or in high dose; • How it will work with other medicines; • A timescale for medicine to be stepped down or stopped. *Guidance: Medication is prescribed in line with the principles of STOMP, where appropriate.*	 	[1] [2] [11]
33	1	Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*		[1]

34	1	Patients have their PRN medication reviewed weekly, with consideration of the frequency dose and reasons.		[1]
35	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. *Guidance: In line with STOMP guidance in prescribing psychotropic medication.*		[11]
36	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.		[11]
37	1	Patients who are on units for long periods of time, who are prescribed mood stabilisers or antipsychotics, have the appropriate physical health assessments at the start of treatment (baseline), at 6 weeks, at 3 months and then annually unless a physical health abnormality arises.		[1] [2]

Section 3: Referral, Transfer and Discharge

No.	Type	Standard	Principle	Ref
38	2	The team invites a community team representative and commissioners to attend and contribute to ward rounds and discharge planning, where appropriate.		[2]
39	2	Discharge planning is initiated at the first multi-disciplinary team review and a provisional duration of admission is set.		[1] [2]
40	1	Patients have a discharge plan, which reflects their individual needs. Staff members collaborate with patients and their carers (with the patient's consent) when developing the discharge plan and they are offered a copy: *Guidance: The plan includes details of:* • *Transition arrangements from the unit;* • *Current care plan;* • *How services will proactively work together (and carers, with the patient's consent) to support the transition;* • *What to do in a crisis;* • *Medication including monitoring arrangements;* • *Details of when, where and who will follow up with the patient.*		[1] [2]

41	1	Where there are delayed transfers/discharges: • The team can easily raise concerns about delays to senior management; • Local information systems produce accurate and reliable data about delays; • Action is taken to address any identified problems.		[10]
42	1	Mental health and learning disability practitioners engage in a thorough assessment of the patient's personal, social, safety and practical needs, in collaboration with the patient, to reduce the risk of suicide on discharge.		[1] [2]
43	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. *Guidance: A named nurse is allocated to support the discharge process.*		[2] [10]
44	2	A discharge summary is sent within a week to the patient's GP and others concerned (with the patient's consent), including why the patient was admitted and how their condition has changed, diagnosis, medication and formulation.		[1]
45	1	The team makes sure that patients who are discharged from the unit have arrangements in place to be followed up within 3 days of discharge.		[1]
46	1	Patients admitted to a unit outside the area in which they live have a review of their placement, in line with national timeframes. *Guidance: This will occur at a minimum every 3 months, in line with national guidelines.*		[1] [2]
47	1	When patients are transferred between units there is a handover which ensures that the new team have an up-to-date care plan and risk assessment.		[19]
48	1	Teams provide specific transition support to patients when their care is being transferred to another unit, to a community team for people with learning disabilities, or back to the care of their GP. *Guidance: The team provides transition mentors, transition support packs or training for patients, carers and staff on how to manage transitions.*		[1] [2]
49	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]
50	1	The team follows a joint working protocol with primary health care teams. *Guidance: This includes the team informing the patient's GP:* • *If an annual health check is overdue;* • *If there are significant changes in the patient's mental health or medication;* • *If the patient has been referred to another team.*		[12] [16]

51	2	There are care pathways in place to support patients when attending local generic health services. *Guidance: This includes joint working with liaison nurses within hospitals.*		[12] [16]
52	1	There are care pathways in place to support patients to access other mental health services. *Guidance: This includes inviting the mental health service to attend ward rounds and take part in joint care planning.*		[12] [16]
53	2	The team follows a joint working protocol with social care services.		[12] [16]
54	1	The service has a care pathway for women who are pregnant or in the postpartum period. *Guidance: Women who are over 32 weeks pregnant or up to 12 months postpartum period should not be admitted to the unit unless there are exceptional circumstances.*		[1]
55	2	The team supports patients to attend appointments with their community GP whilst on the unit if they are admitted in the local area.		[1] [2]

Section 4: Patient and Carer Experience

No.	Type	Standard	Principle	Ref
56	1	On admission to the unit, patients feel welcomed by staff members who explain why they are on the unit. *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 the name they prefer.*		[1] [2]
57	1	Patients are supported to access advocacy services including Independent Mental Health Advocates (IMHA) and Independent Mental Capacity Advocates (IMCA). *Guidance: Staff members check if patients have an advocate and support in the application process.*		[1] [2]
58	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]

59	1	Staff members are easily identifiable, photographs of staff with their names and role are visible on the unit.		[2]
60	1	Patients know who the key people are in their team and how to contact them if they have any questions. *Guidance: Patients are supported to understand the role of each person involved in their care.*		[1] [2]
61	1	Staff members treat all patients and carers with compassion, dignity and respect.		[1]
62	1	Patients feel listened to and understood by staff members.		[1]
63	1	The unit can demonstrate that it promotes culturally and spiritually sensitive practice. *Guidance: This is taken into consideration within care planning and treatment and the unit links in with external agencies to meet any unmet needs.*		[12]
64	1	Patients and staff members feel safe on the unit.		[1]
65	1	For physical examinations, all patients are given the option to have an impartial observer to act as a chaperone. *Guidance: A chaperone should usually be a health professional who is familiar with the examination procedure. Any appropriate requests for a specific gender of healthcare professional should be accommodated as far as possible.*		[14]
66	1	To reduce the use of restrictive interventions, patients who present with behaviours that challenge are supported to identify: • What causes distress, triggers and early warning signs (through the use of alternative and augmentative communication when necessary) • Make advance statements about the use of restrictive interventions through positive behaviour support plans.	 	[1] [2] [18]
67	1	Staff members respect the patient's personal space, e.g. by knocking and waiting before entering their bedroom except in emergencies or where there are concerns about the patient's wellbeing.		[1]
68	1	Patients and carers are provided with accessible information about the patient's mental illness, behaviours that challenge, autism, sensory needs and physical health needs. *Guidance: Information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.*		[8] [16]

69	1	Information provided to patients is available in an accessible format. *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.*		[8]
70	1	There are processes in place to facilitate the understanding of information given to patients throughout their time on the unit. *Guidance: Staff routinely check patients' understanding of information provided.*		[8]
71	1	Patients have access to safe outdoor space every day.		[1]
72	1	Every patient has a 7-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. *Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*		[1]
73	2	Patients are supported to engage in psychoeducation on topics about activities of daily living, for example interpersonal communication, relationships, coping with stigma, stress management and anger management.		[1] [2]
74	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. *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. The meeting should be facilitated by a professional who understands group dynamics.*		[1]
75	2	Patients are consulted about changes to the unit environment.		[1]
76	1	Patients and carers are asked for their feedback about their experiences of using the service and this is used to improve the unit. *Guidance: Patients are supported to express their views, through communication adjustments and support that meets their individual need.*		[1] [2]

77	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. *Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone on the unit and know how to manage situations when this is breached.*		[1]
78	2	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health and learning disabilities. *Guidance: Patients are supported to maintain pre-existing links with their faith community where possible.*		[1] [2]
79	1	The team supports patients to access support with finances, benefits, debt management and housing.		[1]
80	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: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery Colleges.		[1]
81	1	Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan.		[1]
82	2	Health promotion principles are embedded on the unit and education is offered to patients on the importance of keeping healthy and remaining active. *Guidance: Patients have access to a range of physical activities based on individual needs and interests.*		[2] [9]
83	1	Carers (with the patient's consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.		[1]
84	2	The team provides each carer with carer's information. *Guidance: This may be in the form of a carers pack and includes:* • *Names of key staff members and who to contact for questions, concerns or in an emergency;* • *How to stay in contact with their loved one whilst they are on the unit;* • *Information on sharing information with carers;* • *Information on family advocacy;* • *Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*		[1] [2]

85	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.		[1]
86	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. *Guidance: This could be a group or network which meets face-to-face or communicates online.*		[15]
87	2	Carers are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns, family history and their own needs.		[2]
88	2	Carers feel supported by staff members.		[1]
89	2	The unit has a staff member designated as the carer lead or champion.		[15]
90	2	The service has a strategy for carer engagement. The strategy describes measures taken to proactively support: • A carer's own needs around information and support; • How they can be involved in the care of their loved one; • Opportunities to be involved in service developments, training and improvements.		[20]

Section 5: Environment and Facilities

No.	Type	Standard	Principle	Ref
91	1	The unit has clear and accessible signage.		[2]
92	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety.		[1]
93	1	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms and there is an agreed response when an alarm is used.		[1]
94	1	A collective response to alarm calls is rehearsed at least 6 monthly.		[1]
95	1	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.		[1]

96	1	The unit is a safe environment with no ligature points, clear sightlines (e.g. with use of mirrors) and safe external spaces.		[1]
97	1	An audit of environmental risk is conducted annually, and a risk management strategy is agreed. *Guidance: This includes an audit of ligature points.*		[1]
98	1	Laundry facilities are available to all patients and their clothes are washed separately.		[2]
99	1	Male and female patients have separate bedrooms, toilets and washing facilities.		[1]
100	1	The unit has at least one bathroom/shower room for every three patients.		[1]
101	2	Every patient has an en-suite bathroom.		[1] [2]
102	2	All patients have single bedrooms.		[1]
103	2	Patients are able to personalise their bedroom spaces. *Guidance: Patients are able to put up their own photos, pictures and posters reflecting their likes and interests.*		[1]
104	2	All patients can access a charge point for electronic devices such as mobile phones.		[1] [2]
105	2	Staff members and patients can control heating, ventilation and light. *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]
106	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]
107	2	All patients can access a range of current culturally specific resources for entertainment, which reflect the unit's population. *Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.*		[1]
108	2	The unit has a designated room for physical examination and minor medical procedures.		[1]
109	1	There is a separable gender-specific space which can be used as required.		[1]

110	2	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. *Guidance: Patients have lockers available to store personal food and drinks, based on risk and individual plans.*		[1] [2]
111	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]
112	2	Staff members ask patients for feedback about the food and this is acted upon.		[1]
113	2	The unit has at least one quiet room or de-escalation space other than patient bedrooms.		[1]
114	1	In units where seclusion is used, there is a designated room that meets the following requirements: • It allows clear observation; • It is well insulated and ventilated; • It has adequate lighting, including a window(s) that provides natural light; • It has direct access to toilet/washing facilities; • It has limited furnishings (which includes a bed, pillow, mattress and blanket or covering); • It is safe and secure – it does not contain anything that could be potentially harmful; • It includes a means of two-way communication with the team; • It has a clock that patients can see; • Therapeutic and meaningful activities are available in line with individualised risk assessment.		[1] [6]
115	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. *Guidance: This includes patients having access to meaningful and therapeutic activity and outdoor space.*		[6]
116	2	There is a designated space for patients to receive visits from children, with appropriate facilities such as toys and books.		[19]

Section 6: Staffing and Training

No.	Type	Standard	Principle	Ref
	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 bio-psychosocial needs of patients on the unit. The team includes:			
117	1	Consultant psychiatrist(s)		[16]
118	1	Registered specialist learning disability and/or mental health nurse(s)		[16]
119	1	Specialist pharmacist(s)		[1]
120	1	Healthcare assistant(s) *Guidance: This includes support workers, occupational therapist assistants, and psychology assistants.*		[16]
121	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. *Guidance: Psychologists are HCPC registered.*		[1]
122	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. *Guidance: Occupational Therapists are HCPC registered.*		[1] [2]
123	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. *Guidance: Speech & Language Therapists are HCPC registered.*		[2]
124	2	Social worker(s)		[16] [10]
125	2	Dietician(s)		[2]
126	2	Arts therapist(s)		[1] [2]

127	1	The unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.		[1]
128	2	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.		[1] [5]
129	1	The team including bank and agency staff are able to identify and manage an acute physical health emergency.		[1]
130	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]
131	2	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting potential staff members.		[1]
132	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes: • Arrangements for shadowing colleagues on the team; • Jointly working with a more experienced colleague; • Being observed; • Receiving enhanced supervision until core competencies have been assessed as met.		[1]
133	1	All clinical staff members receive clinical supervision at least monthly or as otherwise specified by their professional body. *Guidance: Supervision should be profession specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*		[1]
134	2	All staff members receive line management supervision at least monthly.		[1]
135	1	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*		[1]
136	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.		[1] [2]
137	1	The unit actively supports staff health and well-being. This includes: • 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.		[1]

138	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *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]
139	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.		[1]
140	2	Unit-based staff members have access to a dedicated staff room.		[1]
141	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.		[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 (standards 142 – 152):			
142	1	The use of legal frameworks, such as the Mental Health Act, the Mental Capacity Act and the Human Rights Act (or equivalents).		[1] [2]
143	1	Physical health assessment. *Guidance: This could include training in understanding physical health problems, undertaking physical observations and when to refer the patient for specialist input.*		[1]
144	1	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*		[1]
145	1	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm; prevention and management of behaviour that challenges.*		[1]
146	1	Recognising and communicating with patients with cognitive impairment, communication difficulties or learning disabilities within the context of person-centred care.		[1] [2]
147	1	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance and basic life support.*		[1]
148	1	Autism awareness training.		[6]

149	1	Restrictive practice training. *Guidance: Staff are trained in preventative and reactive approaches. This training is certified as complying with the Restraint Reduction Network training standards.*		[17]
150	2	Trauma-informed approaches to care.		[6]
151	2	Epilepsy training.		[2]
152	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.		[1]
153	1	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the unit.		[1]
154	1	The team are knowledgeable about, and sensitive to, the needs of patients from minority groups. This may include: • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • LGBTQ+ community; • Travellers.		[16]
155	1	The team effectively manages behaviours that challenge on the unit: • Staff members can evidence that if restrictive interventions are used then they represent the least restrictive option to meet the need; • 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; • Providers report on the use of restrictive interventions; • Advance statements are used to identify the patient's wishes and feelings; • 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. *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] [18] [20]
156	1	Staff members do not restrain patients in a way that affects their airway, breathing or circulation.		[1]
157	1	The team uses seclusion or segregation only as a last resort and for brief periods only.		[1]

158	1	All staff members who administer medications have been assessed as competent to do so. Assessment is done using a competency-based tool. This assessment is repeated at least once every three years.		[1]
159	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.		[2]
160	1	All staff undergo specific training in therapeutic observation, as part of their induction on the unit. This training includes: • Principles around positive engagement with patients; • When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this; • Actions to take if the patient absconds.		[1]
161	1	All staff members who deliver therapies and activities are appropriately trained and supervised.		[1]
162	2	Experts by experience are involved in delivering and developing staff training.		[1]
163	1	Staff members follow a protocol when conducting searches of patients and their personal property.		[19]
164	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

No.	Type	Standard	Principle	Ref
165	2	Services are developed in partnership with appropriately experienced patient and carers who have an active role in decision making.		[1]
166	1	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*		[1]
167	1	There is a system in place to respond to themes and trends in safeguarding alerts/referrals and there are mechanisms to share learning. *Guidance: An organisational action plan is in place to address any issues raised, including where training needs are identified.*		[5]

168	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. *Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.*		[6] [13]
169	1	The multi-disciplinary team collects audit data on the use of restrictive interventions and actively works to reduce its use year on year. *Guidance: Audit data are used to compare the unit to national benchmarks where possible.*		[1]
170	1	If long term segregation is used on the unit, mechanisms are in place for regular monitoring. *Guidance: The use is monitored in weekly multi-disciplinary team meetings or at external reviews.*		[6]
171	1	The safe use of high-risk medication is audited at a unit level, at least annually. *Guidance: This includes audit of the use of medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines.*		[1]
172	2	A range of local and multi-centre clinical audits is conducted, which include the use of evidence-based treatments, as a minimum.		[10]
173	1	Clinical outcome measurement, and progress against user defined goals is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.		[1]
174	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.		[1]
175	1	Staff members, patients and carers who are affected by a serious incident including restrictive practice and rapid tranquilisation are offered post incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection and learning review.*		[1] [18]
176	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]
177	1	When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.		[1]
178	1	There is a visiting policy which includes procedures to follow for specific groups including: • Children; • Unwanted visitors (i.e. those who pose a threat to patients, or to staff members).		[19]

179	2	The team use quality improvement methods to implement service improvements.		[1]
180	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;
- 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.

Quality Network for Learning Disability Services (QNLD)
Royal College of Psychiatrists' Centre for Quality Improvement
21 Prescot Street
London
E1 8BB

L.D@rcpsych.ac.uk

www.rcpsych.ac.uk/QNLD