

A hospital or a home?

Findings from themed
visits to NHS and private
sector wards for people
with learning disabilities

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Who we are

We are an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We're made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- be treated with dignity and respect;
- have the right to treatment that's allowed by law and fully meets professional standards;
- have the right to live free from abuse, neglect or discrimination;
- get the care and treatment that best suits his or her needs; and
- be enabled to lead as fulfilling a life as possible.

Our visits

In recent years the Commission's role has been significantly extended. The introduction of the Adults with Incapacity Act and the Mental Health (Care & Treatment) (Scotland) Act gave us a range of duties in relation to monitoring and promoting best practice in the operation of legislation. Effective monitoring of the care, treatment and support people receive is very much dependent on the direct contact we have with individuals.

Seeing where a person lives, where he or she receives care and treatment, and hearing how he or she feels about that care and treatment, gives us an important insight into how law and policy impact on individual experience.

We visit people in a range of settings throughout Scotland; at home, in hospital, or in any other setting where care and treatment is being delivered. As part of our programme we visit people in learning disability hospitals. This report reflects our findings from a special programme of visits to learning disability hospitals, which took place across Scotland between 25 October and 7 November 2007.

Policy context

National policy for the provision and development of services to people with learning disabilities has been driven for the last 8 years by 'The same as you?'. This review, published in May 2000, provided the first in-depth analysis of services for people with learning disabilities for over 20 years. The report set out 29 recommendations to improve services and support for people, and for family and carers. The focus of recommendations was very much on people being included, living in the community, and having far greater access to mainstream services. As a means to achieve this, the report said that all long-stay hospitals for people with learning disabilities should close by 2005 and that people should not have a hospital as their home.

To assist with the implementation of 'The same as you?' and to advise on progress, a national implementation group was set up

in June 2001. A report, 'Home at last?', was published by the implementation group in 2004. This report assessed progress in hospital closure and provision of appropriate services to support people living outwith hospital. It said progress had clearly been made, but that there were still significant issues to address. The report highlighted a cohort of people across the country who were still living in hospital, even though the main hospitals they had been living in had closed. An update to this report, 'Progress with learning disability hospital closure in Scotland', was published in February 2005. While this document confirmed that hospital closures were still taking place, it said there were still significant barriers that were preventing substantial numbers of people moving to non-hospital accommodation.

How we carried out the visits

The Commission decided to undertake a themed visit to all learning disability in-patient units during our 2007-08 visiting programme. We were aware that real progress had been made towards closing all learning disability hospitals by the 2005 deadline, set out in 'The same as you?'. We also recognised the need, highlighted in that report, for a small number of in-patient places. We felt it was important to get more accurate information about current hospital services, levels of in-patient need and about the experiences of people living in in-patient wards.

We visited 39 facilities across Scotland from 25 October to 7 November 2007. Prior to the visits, we had asked health boards to provide us with some information about the wards in their areas. Each facility was visited by two or three Commission staff. We asked staff a series of questions about the people living in the ward on the day of the visit and about how care and treatment was provided. We met with individual patients and some relatives and carers who were either in the ward at the time, or had requested a meeting with us. We took time to look around the wards and gain an impression of the environment. We also examined two sets of patient notes in each ward. We were particularly interested in seeing how assessment of individual need was taking place and the ways identified needs were being met. We also looked for evidence within files that would indicate how individual people and carers were being involved in decisions about current and future care. By looking at these different sources of information we were able to get a broad picture of care in the wards we visited.

Wards visited and number of patients

Health Board	Hospital	Ward	Beds	Male	Female
Grampian	Elmwood	Fern	12	5	4
		Bracken	12	12	–
Highland	New Craigs	Rowans	17	9	8
		Beeches	6	4	2
		Willows	8	4	3
Fife	Lynebank	Ward 3	13	6	–
		Ward 4	10	3	5
		Levendale	8	8	–
Tayside	Carseview	LD assessment unit	13	9	3
		Strathmartine	Craigowl	10	10
	Bridgefoot – Flat 1		8	8	–
	– Flat 2		8	3	3
	– Flat 3		8	4	3
	Monroe House	Anoach	12	6	6
		Etive Ward	14	10	2
Lothian		Greenbank Centre	12	12	1
		William Fraser Centre	12	13	–
		Carnethy	8	7	–
		Dunedin	5	5	–
		Glenlomond	6	6	–
	Camus-Tigh	8	8	–	
	Primrose Lodge	8	–	8	
	Murray Park	Tay	6	4	2
Forth Valley	Lochview	House 2	6	4	1
		House 3	6	3	3
Dumfries & Galloway		Darataigh	5	3	2
		Holly Cottage/ Heather Lodge	7	5	2
Ayrshire	Arrol Park	Houses 4,5 and 6	17	9	2
Lanarkshire	Kirklands	Kylepark Ward	9	1	8
		Fairview	9	7	2

Wards visited and number of patients (continued)

Health Board	Hospital	Ward	Beds	Male	Female
Greater Glasgow & Clyde		Pineview	4	–	4
		Blytheswood	11	2	2
		Netherton	8	8	–
		Overtoun Court	16	14	2
		Waterloo Close	8	5	3
		Dykebar Leverndale	Bute Campsie, Whitehouse	8 8	8 7
Totals			346	232	81

Out of the 313 people who were in-patients on the visits, 176 were subject to compulsory measures under the Mental Health (Care & Treatment) (Scotland) Act 2003.

Age range and length of stay

During the visits we asked about the ages of the people in the wards. We are pleased that at the time of the visits only one young person, under 18, was an in-patient, and that a considerable amount of work had been done to provide an age-appropriate service to that person. 11 people were aged over 65, with 129 people aged between 18 and 40, and 172 aged between 41 and 65.

We also asked staff on the wards to tell us how long people had been in-patients for. The figures provided are in the table below:

No of People	Length of Stay
76	<1 year
50	1-3 years
39	4-5 years
148	Over 5 years

These figures show that, across Scotland, just under 50% of people with learning disabilities who are in hospital have been there for over five years. Some will have been in-patients for many more years than this. This number will include people who have been on resettlement lists, or have moved into different facilities as the main hospitals they lived in have closed and they still have no home to move to. There are some variations in local figures. In NHS Highland, for example, about 80% of people had been in hospital for over five years when we visited. Many of this group were, however, due to be resettled very soon after our visit.

Ready for discharge?

To facilitate the move from hospital to home, 'The same as you?' recommended the development of robust and flexible community-based services to accompany a programme of long-stay hospital closure.

According to the report, only a very small number of in-patient beds should be retained for the small number of people who might require them. 'Home at Last?' and 'Progress with Learning Disability Hospital Closure in Scotland (Update Report February 2006)', identified a number of barriers to closure. 'Home at Last?', for example, described delays in agreeing plans and funding arrangements as well as difficulties meeting timescales. The 2006 report concluded that there were still difficulties "agreeing financial frameworks [and] delays in commissioning housing" (page 14). Of the 440 people still in NHS accommodation at this point, 312 had discharge plans, while 128 presumably had no plans relating to their discharge in place. This report also acknowledged that it was difficult to get accurate information on the number of people who are long-stay in hospital.

Different areas have different definitions of 'long-stay', but there were clearly people admitted to assessment beds who "ended up becoming long-stay because of difficulties in agreeing and funding discharge arrangements" (page 5). It also clearly said that, in a number of identified areas, there are rehabilitation units "where most residents are long-stay and do not have a home in the community" (page 5). Differences in definition of 'delayed discharge' continue. The 'Survey of Learning Disability In-Patient Services in Scotland' gathered information on bed occupancy on 1 May 2007. This survey had a 100% response rate from health boards, and found that there were 388 in-patients (297 non-forensic and 91 forensic). 68 people were also identified by clinicians as being 'delayed discharges'. On our visits, we asked

ward staff on the wards how many people they felt were ready for discharge. We were informed that 119 individuals were ready to leave hospital. This accounts for almost 40% of the total number of people who were in-patients in the wards we visited.

We acknowledge that it is difficult to make a direct comparison between the cases we identified from our visit and the numbers identified in the 2007 survey. While we gathered information from nursing staff in the wards, the survey was completed by psychiatrists. We were also asking a different question – not who was formally defined as being subject to delayed discharge, but who did nurses think was ready for discharge. In particular units we visited, most people who were identified as ready for discharge were also people who may not appear on formal delayed discharge lists. Some of these individuals would have been on 'resettlement' lists – i.e. people who should have moved on from hospital during a closure programme.

Whatever the definitional problems are – and accepting that there are discrepancies when comparing our visit information to the survey results – it is still clear that a significant number of people throughout Scotland are in hospital unnecessarily, because homes with support are not yet available. There are clearly particular problems in certain geographical areas. For example, 80% of people with a learning disability in hospital Grampian & Tayside are considered 'ready for discharge'.

Individual and carer/family involvement

'The same as you?' set out seven principles which should underpin the development of services for people with learning disabilities. This included the principle that people "should be asked about the services they need and be involved in making choices..." (page 11). It also recommended that everyone who wants to, should have a personal life plan. This plan should ensure a better assessment of needs and the active involvement of the person and any family/carers in recording and describing "how the person, his or her family and professionals, will work together..." (page 21). This theme has been picked up in the Mental Health (Care & Treatment) Act 2003. The principles of the Act require anyone providing care and treatment to take account of the views of the individual and his or her carers. The person should also be supported to participate as much as possible in decisions about his or her care and treatment.

During our service visits we asked specific questions about personal life histories. We wanted to see how the involvement of individual people and of carers/family members was being promoted and documented. We also wanted to assess whether in-patient services were being provided in a way which was consistent with the principles of 'The same as you?' and mental health law. We knew that the latest statistics release, relating to the implementation of 'The same as you?', had shown that over the past five years there had been a steady increase in the number of people with a personal life plan. We wanted to see if this trend was being reflected in in-patient facilities.

Although not many of the people we visited had personal life plans, it was clear that the practice of preparing life plans is becoming more common. Some units did have plans in place. In some units, for example Elmwood, plans were in the process of being completed.

We also noted, however, that many people did not have a life history in their records. We believe a personal life history is essential for person-centred care. Staff need to know the person they are caring for, their likes and dislikes, what is and has been important in their life. Life histories enhance communication with the person and can also provide key information for assessments. The process of creating a life history can be used to engage individuals and carers in assessment and planning processes. Some files we looked at did have a life history and some were very detailed. Many files however, only had partial histories, or no history at all. This did vary from unit to unit, suggesting that the task of preparing a life history is given a higher priority in some areas. We think that all people should have life histories and some form of personal life plan in place.

We looked at the information recorded in individual files that might tell us how involved carers were in discussions about current and future care and treatment plans. From those files we examined, the information was generally positive. In some areas the files indicated that all carers seemed to be fully involved in each case. In all areas, carers seem to be involved in the majority of cases. A number of carers confirmed this impression with us during our visits. In a small proportion of files, however, there was no evidence of carer involvement.

Participation of individuals with learning disabilities was less consistent than for carers. There were a number of people with profound disabilities who clearly had no meaningful involvement. There was another group of people who, from the evidence on file, seem to be fully and actively involved in discussions, in review meetings, and in future care planning. Others were involved with advocacy support, and the information available suggests that advocacy services are readily available across the country. (In Elmwood, for example, everyone who was seen or whose file was examined has an advocate. Staff in other units spoke about access to advocacy being good and often having increased over the past two years.) However, in some files there was no evidence of how the person was involved, or of reasons why they were not involved. We will continue to monitor this issue, as part of our general duty to promote best practice in the application of the principles of mental health law.

Assessment, reviews and multi-disciplinary input

There is a specific chapter in 'The same as you?' called 'Working Well Together' which emphasises that good partnerships are essential, and that professionals should be "working better together to help people through the many different stages in their lives..." (page 74).

We believe that it is very important that professionals work well together and work with the individual and his/her carer, to ensure that broad and specific care and treatment needs are properly assessed. We also feel that it is very important that the care and treatment provided in a hospital setting is reviewed regularly, to make sure that needs continue to be met appropriately. We therefore asked staff a number of questions about how care was reviewed and who was involved in the processes of assessment and review. We also looked for evidence recorded in individual case records.

Overall we are satisfied with how care and treatment needs were being assessed and reviewed, as well as with the level of multi-disciplinary input we saw. All units have review meetings involving clinicians and ward staff, with variable input from other health professionals, at least fortnightly. In the majority of units this happens on a weekly basis. All the units we visited also had more formal, multi-disciplinary meetings, with a wider range of professionals present. The frequency of these meetings varied. Almost half of all units had formal multi-disciplinary review meetings every three to four months, a small proportion every six months. A few units had annual meetings. Where reviews

are scheduled annually, staff generally reported they could be more frequent if necessary. It did appear that there was a link between the reason for someone being admitted to hospital and the frequency of formal reviews. Where a person had been admitted for assessment, reviews appeared to be held more frequently. It was also clear that in areas where people are due to be discharged from hospital soon, as in NHS Highland, the reviews were being held more frequently and were being co-ordinated appropriately through the Care Planning Approach.

We looked at case files in wards to find out how records of assessments and reviews were kept. We saw that, in a large majority of cases, assessments were seen to have been completed with extended multi-disciplinary involvement (i.e. with professionals other than the doctor and nurse involved). Those care plans we saw almost always addressed identified needs. In Lothian, for example, we looked at 16 files. In 14 of these, plans were in place relating to all identified needs, with plans being prepared for the other two individuals. Unmet needs, however, were rarely recorded. This does raise the question of the extent to which needs assessments may be driven by service rather than individual needs. Where unmet need is not recorded, we are concerned that this may be because professionals are aware that there is no service available. We also noted several cases where multi-disciplinary input into care provision was happening, but was not well evidenced on paper. Some files had no care plan which pulled together input from different disciplines. This means professionals have to review nursing and medical files to get a

complete picture of the care plan. We think a summary of the overall care plan provides a useful overview for all staff involved in an individual's care and treatment.

We found that, in almost all files examined, multi-disciplinary review meetings were minuted with copies on file. Some of these minutes were of a very good standard, with clear agreed action points. There was evidence of good multi-disciplinary involvement in minuted meetings, from health and social work and from advocacy services. The NHSQIS national overview report did say that "the provision of specialist services is a challenge for all NHS Boards" (page 51) but we did not pick up any significant issue with regard to the non-availability of specialists at multi-disciplinary meetings. Given the communication needs which many people with learning disabilities may have, we were particularly pleased to see that speech and language therapy seemed to be widely involved. Our examination of files was restricted, however, so that we would not draw any firm conclusions about the availability of specialist input across the country. We are aware from other visits about the difficulties in ensuring dietetic and clinical psychology input, often because of recruitment problems.

Staffing in wards

During the visits we asked specific questions about the number of registered and unregistered nursing staff employed. It is noticeable from the information we gathered that staff levels and ratios can vary widely across Scotland, even when comparing units that have a similar number of in-patient beds. This may well be appropriate, if variable staffing ratios

reflect the variable needs of individuals living in the wards. We would expect that staffing levels would probably be higher where people have more complex needs.

We did notice that, in a small number of units, there seemed to be a very heavy reliance on the use of bank and agency staff to cover shifts. This is particularly evident, for example, in NHS Highland. We understand that there may well be specific local factors which may account for this. Where wards are due to close in the near future, as part of a planned hospital closure programme, there will be issues about staff re-deployment and it may be difficult to fill vacant posts on a permanent basis. There are also well recognised issues about the availability of training courses in the learning disability nursing field and about the difficulty recruiting qualified staff in some areas. Nonetheless, we believe that issues can arise if significant numbers of bank or agency staff are employed. It may be difficult to ensure continuity of care, or consistency of assessment, for example. There could also be situations where staff on duty may not be knowledgeable about relevant policies or procedures applicable in the wards (or may not have undertaken appropriate training). We think that NHS boards need to be aware of this and should monitor the use of bank/agency staff.

Physical health care needs

In February 2004 the 'Health Needs Assessment Report' was published.

The report presented a detailed review of the available evidence regarding the types and extent of health needs experienced by persons with learning disabilities. The report stated very clearly that people with learning disabilities have more complex health needs, when compared with the general population and that often health needs are unrecognised and therefore unmet. It also highlighted considerable variation in the quantity and scope of services provided to meet health needs across Scotland. The report said that there has often been insufficient attention paid to identifying and treating health needs specific to people with learning disabilities.

Much of the 'Health Needs Assessment Report' focused on the provision of services within the community, but regular physical health checks are essential for people with learning disabilities within in-patient facilities, particularly since almost 75% of in-patients have been in hospital for over a year. When we visited, we gathered information from nursing staff about how general health care needs were assessed and met. When we examined individual files, attention was paid to records relating to the individual's physical health care needs; how these had been assessed and treated.

Completing physical health checks when someone is admitted to hospital appeared to be standard practice across all units we visited. The large majority of units also have policies which state that annual physical health checks will be done when someone is in hospital for this length of time. Two units

arranged health checks on a more frequent basis, either four or six monthly. Three units did not arrange any routine health checks. When we explored this, there seemed to be very regular GP input to these units, with individual people being seen quickly if any physical health problems were identified. This could obviously create problems if symptoms of physical ill health are not identified in the wards and does mean that people with learning disabilities may not access screening opportunities. Several wards did link older women in to breast cancer screening programmes, but there was no evidence of people being able to access other screening programmes which are available within community settings.

File information about physical health checks was generally available. In most cases we saw that checks had been carried out as per local policies. In Fife and Lothian, for example, 75% of people whose files we looked at had attended a physical health check within the previous six months. In one unit though, where the policy is to provide annual checks, no information could be found on file and nursing staff could not locate it. In other units there was often a small number of individuals for whom there was no record to show that a health check had been completed within the previous year. This suggests to us that there is a need for local arrangements to audit whether health checks are being completed regularly.

Medication

We were pleased with the evidence we saw during the visits about the appropriate administration of medication. We asked specific questions about this issue when speaking to staff and looked closely at the information in records.

All units appeared to be complying with the requirements of the mental health Act in relation to people who were detained and relevant T2 or T3 forms appeared to be in place. In a couple of units, these forms were not in the medication kardex. We would recommend that forms or copies are in the kardex, so that the person responsible for administration can be clear about what is authorised. In two units we also noted that old forms 9 and 10 were in place. We have said that these forms should be replaced with new T2 or T3 forms by the end of March 2008.

We looked at the use of S47 certificates, which provide authority for any medical treatment where an adult is incapable in relation to a decision. Visitors noted that there seems to be a widespread use of S47 certificates, which is welcome. We asked staff if S47 certificates were being completed where this seemed necessary and we looked at whether certificates were in place in selected files. From this small sample, necessary certificates did seem to be in place. Where no certificates were in place, the evidence we saw was that this was because appropriate consideration had been given as to whether the person was capable in relation to decisions about treatment.

We asked staff about whether policies were in place with regard to medication in the units. We also asked about the use of covert

medication. Only a very small number of units were administering any medication covertly, including one unit providing care and treatment to people with very profound and complex health care needs. What we observed was that, where medication was administered covertly there were very obvious reasons for this, but that there was rarely an explicit care plan documenting the reasons why. We have published guidance on the use of covert medication which looks at taking decisions in this area and includes a Covert Medication Care Pathway. We recommend that services refer to this in their own policy and practice. The use of covert medication is controversial and in order to best safeguard the individual concerned, a range of issues should be fully considered prior to any decision being made. Our guidance sets out a framework for documentation which we would expect services to apply and keep on file.

With regard to general policies about medication, very few units had policies and procedures in place. Where specific policies were in place, almost all related to the administration of medication for emergency sedation, or on an 'as required' basis. Some units also had general policies or protocols available which applied across various service areas and were not learning disability specific. We would suggest that in this area there is scope to use good practice guidance which is available nationally, such as that published by Birmingham University, 'Using medication to manage behaviour problems among adults with a learning disability', to help develop more local guidance for staff.

Behaviour management

A significant number of people being provided with care and treatment in hospital settings will present behavioural challenges, will be vulnerable and may be a risk to themselves or to others around them. We therefore looked at whether policies on the use of restraint were in place, what training staff receive and at the information in individual files about how risks had been assessed and were being managed.

Our 'Older and wiser' report, while looking at provision of continuing care for people with dementia, addressed behaviour management and made recommendations. Many of our recommendations are equally applicable in learning disability settings. We said that the effective management of some behaviours 'requires very careful assessment, to understand why the person is behaving in a risky manner and to determine how best to help reduce these risks. Sometimes risk reduction might involve care interventions that constitute restraint on the person's movement. The use of restraint in any setting requires careful control. Staff using any form of restraint should have clear guidance and local policies and procedures in place...'

All except three units had policies in place regarding the use of restraint and management of aggressive behaviour. Considerable training seemed to have been undertaken by staff, with only one unit commenting that no training had been provided. In a significant number of units we were advised that 100% of staff had been trained, with other units saying that targets had been set. For example at Netherton all staff were to have undertaken training by the

end of March 2008. Training provision varied across the country, but it seems common for three to five day courses to be completed by staff, with annual update refresher training. At Lochview, for example, we were told that all staff complete a five-day course with one further day annually. Housekeeping staff also received training in breakaway techniques. In some units, however, staff identified the need for refresher training, or were concerned that training had not been specific enough for learning disability settings. Problems ensuring that new staff had access to training were also reported to us. Overall though, the commitment to providing staff training was heartening.

Of all the wards visited, only eight had open doors, with two other units saying that they had an open door policy. However, in these units the door had been locked as long as staff could recollect. Virtually every unit had a policy on locking the door.

When we looked at individual files we wanted to see if the assessment and management of risk was an integral part of any interventions and behavioural management plans. We saw that a significant number of people had behaviour management care plans in place. Some of the plans were of a very good standard, with clear, pro-active strategies. In several areas, the clinical psychology service had responsibility for co-ordinating risk assessments and management plans. In some cases, however, we didn't think that plans accurately reflected what staff were doing. A number of plans did not address all the behavioural issues which were documented on file. This highlights the importance of risk assessments and

management plans being living documents which are regularly reviewed. In one of the units we visited we saw a risk assessment which had been prepared several years ago, with no evidence of whether a review or re-assessment had ever taken place.

A considerable amount of guidance is now available for staff considering behaviour management issues. The recently published 'Challenging behaviour: a unified approach', prepared jointly by the Royal College of Psychiatrists, British Psychological Society, and Royal College of Speech and Language Therapists says clearly that it is intended to provoke action as much as to inform. We would suggest that the publication of this report, with clinical and service guidelines, provides an opportunity for local policies and procedures to be reviewed.

Activities

In our 'Older and wiser' report we commented that "keeping physically and mentally active is very important for people with dementia in continuing care" (page 13). This is equally relevant in learning disability units. Stimulating activities can improve physical and mental health, help people develop new skills and interests and improve social skills and daily functioning. Structured activity can have a positive effect on behaviour.

Unfortunately, there is often very little emphasis in hospitals on making sure that activities are provided. 'Home at Last' commented on the "lack of day and social and recreational opportunities in hospital". NHSQIS has looked at this issue specifically in learning disability in-patient services. In its overview report it says that "despite the

dedicated efforts of many staff, a significant number of in-patient services are challenged to provide a suitable and responsive range of vocational, educational and leisure opportunities for their residents. Additionally, in the majority of services where these opportunities are available, the frequency of opportunity is limited by staffing availability” (page 58).

During our visits we looked at around 70 case files to see whether the person’s involvement in activities was recorded. There were very few explicit assessments, or care plans, relating to involvement in activities. We were pleased to see, however, that case files generally did record the activities that people were involved in. It was generally possible for us to get a picture of what people were doing within and outwith wards. Some people were obviously involved in a wide range of structured activities, often in day units or in the wider community. Some units had art therapy involvement and the activities mentioned in files were very varied, from forms of physical exercise to shopping, fishing, going to the cinema, or participating in creative or craft orientated activities. Some people had activity programmes which were clearly very personalised, reflecting individual interests and needs. Some people seemed able to access a range of opportunities in the wider community, such as attending adult literacy groups. A small number of people also had support workers, employed by the local authority or voluntary sector organisations, who helped them access opportunities outside hospital.

Although the overall picture was quite positive for many people, there were some particular problems. Activities are much more limited in the evenings and at weekends. Activities are often cancelled, because of lack of staff availability. This is something which people in the wards and staff said they found very frustrating. Some staff also commented that those people who require most support from staff are most likely to have limited opportunities, or to have activities cancelled, if insufficient staff are available. Staff in several units also commented that there had been a reduction in the availability of occupational therapy input, which had an effect on the level of activities available on wards.

Environment

In the recent inquiry report into NHS learning disability services in Cornwall, the Healthcare Commission commented on the large body of literature on dementia friendly design, highlighting this as an area “ripe for cross-fertilisation of learning between the fields of learning disabilities and dementia”.

There is no doubt about the impact that the living environment can have on the quality of life of people in hospital wards. We consider this a particularly relevant issue for the people we visited, where figures show that wards have been ‘home’ for over 60% of the people for over four years. On our wider visit programme we do look at the environment people are living in and make observations in visit reports, if there are issues we feel should be addressed. In those visits reported here, we also paid close attention to physical conditions.

As part of its work, to take the lead in improving the quality of care and treatment across the NHS in Scotland, NHSQIS produced quality indicators for learning disability services in 2004/05. NHSQIS reviewers then visited all NHS boards. Their assessment of in-patient services looked at whether accommodation “provides an environment supportive of individual needs, choice, privacy and dignity”. The national overview report, published in 2006, concluded that progress was being made to provide domestic-style and homely in-patient accommodation, but that a few environments do not appear suitable for the support requirements of people. A number of facilities were also found to be in very obvious need of refurbishment.

Broadly, the observations from our visits would be consistent with this view. We have commented before (“Unannounced Visit Report, 2005: Our impressions of mental health acute admission wards in Scotland”) that many people “will accept standards in mental health services that fall far below what they would expect and demand in other health and residential settings”. Compared with the quality of environment we see in a number of mental health facilities, learning disability environments are generally up to an appropriate standard, with some very good examples of considerable efforts being made to personalise living spaces. In several facilities, however, aspects of the built environment are poor.

Generally, new units developed and built in response to hospital closure programmes are of a good to high standard. Some facilities are providing in-patient services in older buildings,

which have been difficult to adapt. A number of units are providing care and treatment to meet the needs of people who present high levels of challenging behaviour and where there has been a high level of damage to the fabric of buildings. In many of these facilities, areas in the wards appeared shabby and in clear need of refurbishment and re-decoration. It was also disappointing to observe that, in the fairly recently built Elmwood unit, the standard of design and construction is very poor. Accommodation here was cramped, noisy, and unsuitable both for the needs of the people living there and for staff working to provide care and treatment. Extensions are in the process of being added to this unit, because the environment has been recognised as being unsuitable and not fit for purpose.

Overall, Commission visitors were satisfied with levels of cleanliness in the wards. Most facilities were seen as being un-crowded, or even spacious, with adequate natural light and ventilation. The vast majority of units also had access to a garden or outside space. Almost all units had single bedrooms, albeit with only a small proportion with en-suite facilities. Commission visitors made specific comments about the good quality of the environment in several units. For example, Pineview was observed as being “spotlessly clean and freshly decorated throughout”, Lochview as “light and airy”, and Etive as “fresh, clean and bright everywhere”. It was also very clear that, in several units, staff were putting considerable time and effort in to making accommodation comfortable and homely and helping people to personalise rooms. In Ward 3 at Lynebank, for example, it

was noted that “great efforts were made by staff to make areas in the ward homely...”.

Specific environmental issues were observed in several units. Bathrooms were in a poor condition in a few facilities. Specific areas in some buildings clearly needed attention. In Dunedin, for example, “hall areas and bathrooms look shabby and worn” and, in a number of other units, communal areas were often seen to be in need of upgrading, or to be in poor decorative order. In three units there were issues about temperature and ventilation, with staff finding that controls were not flexible enough, so that rooms could often be either too hot or too cold. It was also common, across many of the units, for visitors to observe that signage was poor. This is an issue which we have recently identified during visits to continuing care wards. We would want to emphasise that easily recognisable signage for people living in wards can significantly help people live in their environment. As we have previously pointed out, improvements in this area can be achieved with limited resources.

Key recommendations

- While there are issues about definitions and about when a person is a ‘delayed discharge’, there is a large group of people who could move out of hospital if appropriate support was available. There is a clear need for health boards and local authorities to agree local strategies to develop the services necessary to enable people to move on from hospital.
- The physical environment in a number of units is not suitable, and this frustrates people living in wards and staff working there. More attention should be paid to refurbishment; redecoration of areas which are shabby, replacement of furniture and equipment and creation of more appropriate environments. New build units should have adequate space within the building and in exterior areas to meet the support needs of people who will be living there.
- Meaningful activities are valued by people in the wards and by staff. Activity programmes can significantly improve the quality of lives of individuals, as well as helping to minimise behaviours which may be challenging. Options seem to be limited in wards and often people with the highest support needs are missing out. The level of activities available should be reviewed. More attention should be paid to creative ways in by which opportunities to use community-based resources outwith wards can be provided.
- People who are in hospital for lengthy periods should have physical health checks on at least an annual basis.

Individuals should also be supported to access the same screening programmes as people living in the community.

- The process of assessing risks and preparing behaviour management plans should be informed by relevant good practice guidance. This is an area where practice is developing and where new guidance has just been published by the Royal College of Psychiatrists, British Psychological Society, and the Royal College of Speech and Language Therapists. Local policies and procedures should be reviewed in the light of this new guidance and other complementary reports.
- The use of personal life plans, or other similar forms of plans, should continue to increase, with attention paid to involving people more in decisions taken about their care, treatment and support. Information about individuals' personal life histories should be collected and documented in a more systematic way.

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