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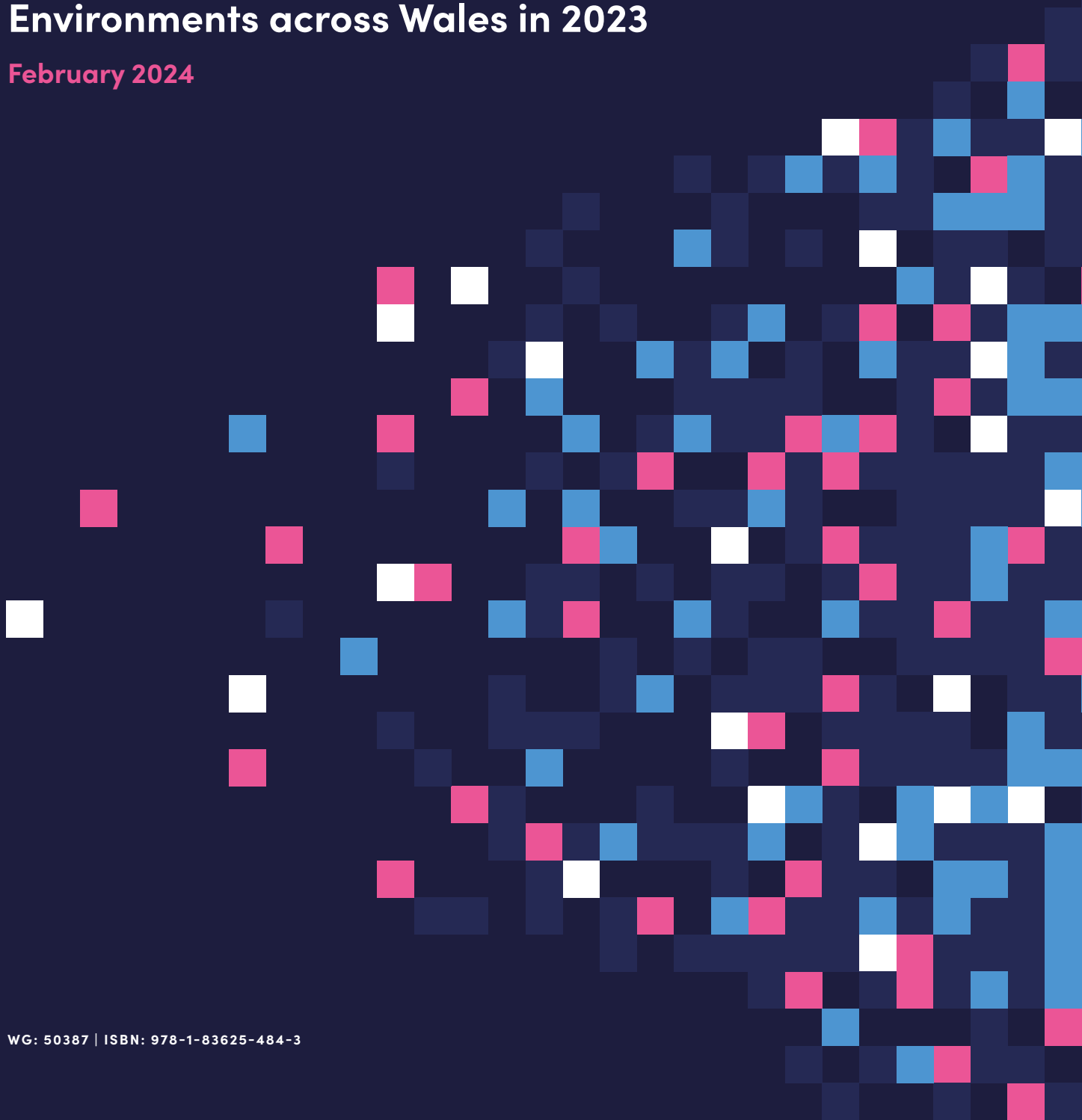
National Collaborative Commissioning Unit

Improving Environments, Improving Lives

A focused review of Learning Disability Inpatient Environments across Wales in 2023

February 2024



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Improving Environments, Improving Lives

Overview

This report was commissioned by the Welsh Government's Learning Disabilities policy team in response to recommendations made in the National Collaborative Commissioning Unit (NCCU) 2020 review of Learning Disabilities Hospitals – Improving Care, Improving Lives.

Authors

This report was authored by Debra Hillman, NCCU. The delivery of this report has been coordinated by Leeha Kostin with additional input from Adrian Clarke, NCCU.

Data

The information within this Spotlight Report relates to information collected from Learning Disabilities Inpatient Hospital Units during site visits undertaken between July 2023 and September 2023.

Please note that some percentages may not total 100 due to rounding.

Acknowledgements

Special note should be made of the contribution of Aine Davies, NCCU, who assisted with site visits.

With special thanks to:
Welsh Government Learning Disabilities Policy team for commissioning and supporting this project.

Contents

Executive Summary

This review explores current Welsh inpatient provision for People with Learning Disabilities (PWLD) and helps commissioners and providers to understand and future proof the changing landscape, service demand and delivery requirements for Welsh citizens with a Learning Disability, who are experiencing changes in their mental health well-being and require specialist inpatient care and support.

This focused review identified that the majority of the buildings within this cohort are decades old. They are often re-purposed to fit the supply and demand within that locality. The units were not "evenly spread" throughout the landscape of Wales. Units were only available within the regions of South West, South East, North East and West of Wales (Pembrokeshire, Swansea, Neath Port Talbot, Cardiff, Rhonda Cynon Taff, Vale of Glamorgan, Caerphilly, Torfaen, Bridgend, Monmouthshire, Denbighshire and Conwy). In an ideal situation, Wales would have an equilibrium of services across the country to support Welsh citizens wherever they may live and reduce the need to travel unacceptable distances from home, to receive the right treatment, at the right time, in the right place.

Analysis of the data indicates that many of the units are situated in isolated positions. Some were found in the remaining remnants of closed, long stay institutions. In these cases, the units were often vulnerable to incidents outside of the providers' control and highlighted concerns for inadequate safety and security measures. Services should be offered in units that are as safe as possible, for everyone that has contact with them.

Data captured indicated that there is no consistent model of care when describing "inpatient" facilities for PWLD. The estates visited during this review consisted of hospital units (wards), extended houses within the same grounds as the hospital units and community houses. Some of these community houses were owned by local housing authorities and managed by employees of the relevant locality Health Boards. Some were identified as "tripartite arrangements (Health employees managing daily operations, Health Estates and Local Authority Housing responsible for buildings and external grounds). It is within the latter arrangement that NCCU found that this created confusion, often leading to delays in the decision-making processes for maintenance requests and ultimately the funding arrangements for undertaking works. This certainly influenced the quality and delivery of safer and enabling environments for all parties concerned.

It was evident in some cases (usually in NHS provision); works had been outstanding for over a three-month period and at the time of the review had no end date/completion date forthcoming.

It is difficult to ensure that basic requirements of daily living are available to PWLD when they are in crisis and away from their usual environments. Commissioned placements are often envisaged as enabling spaces and able to meet basic human needs. It is essential that all units can meet daily human needs as a starting point.

From direct observations made, it is apparent that there are disparities between the type of inpatient units and the attitude towards infection prevention and control measures. In Wales, there is an expectation that all "inpatient" facilities follow consistent policies and procedures regardless of whether it is a unit provided by Health Board services or Independent Sector.

The review highlighted that some units invested in hotel/domestic services that were separate to core staff providing the elements of care delivery. This enabled a precise method to ensure and maintain approved standards of cleanliness. However, in units within the community settings, there was an expectation that core staff could undertake these additional duties within their roles and responsibilities. It is therefore inevitable that "care givers" give domestic duties a lower priority and result in standards not always being met through not having enough time. It could be argued that within these units there would be an expectation that PWLD would undertake some of these tasks as part of developing their daily living skills through their use of the active support model. However, some of the individuals are not at that stage to complete the tasks or are unable due to other health conditions.

This report identifies themes and disparities in relation to "inpatient" versus "ordinary patterns of living" philosophies; dependent on the service each unit offers. The reader should question these two elements throughout the subject matter described, in relation to approach and understand the findings in some of the areas such as (but not limited to):- accessibility, augmentative communication, fire evacuation, seclusion, outside spaces and PWLD care pathways.

Part A

Background

Background and Introduction

Literature and research inform healthcare partners that therapeutic environments are pivotal to patient focus and recovery. Evidence suggests that a safe and inviting environment will enable patients to feel "cared about" and inevitably receive a better experience whilst being in hospital.

One area where additional understanding is required is that of the quality of inpatient environments within Wales, provided by the NHS or Independent Sector. This report has been set out to describe and validate the current findings pertinent to the commissioning request by Welsh Government.

As previous literature (Improving Care, Improving Lives 2020) outlines, that despite the aspirations for People with a Learning Disability (PWLD) to receive care and support in their community setting, some citizens will require a period of hospitalisation at some point in their lifetime. Evidence also indicates that some individuals have remained in hospital settings for the majority of their life cycle. Policy and legislation expect that recipients of care in this type of setting will have the right to receive care in safe and enabling environments. This also reflects concordance with the Quality Standards 2023, which state,

"The prevailing intention is to build on the positive culture of quality at the heart of the Welsh health system, enacting a broader system-wide duty of quality which strengthens decision-making, action, improvement and ultimately, improved outcomes for the population".

Point 5.10 of the Health & Social Care (Quality and Engagement) (Wales) Act 2020 confirms that,

"The duty of quality applies to Local Health Boards who are responsible for planning and delivering NHS services in their areas with the aims of: Improving physical and mental health outcomes. Promoting well-being. Reducing health inequalities across their population. Commissioning services from other organisations to meet the needs of their residents".

There are numerous definitions of quality relating to health and care services. Here in Wales, quality is defined as the process to; "continuously, reliably, and sustainably" meet the needs of the population. In order to achieve this, services will need to ensure that they are safe, timely, effective, efficient, equitable and person-centred.

These statements are pivotal when considering the quality and safety of buildings that are used as part of delivering care to populations. It is with this endeavour and within the parameters of the focused reviews undertaken; that this report enables provision to be portrayed through the lens of individual (patient) needs, staff needs and visitor needs.

Enabling Environments – What are they and are they available?

The function of adult inpatient services is to provide safe care in the least restrictive environment. The Mental Health Act (MHA 1983) also identifies the correlation between the environment and impact on patient safety, privacy, dignity, behaviour and well-being. Providing the right environment should also recognise and respect the diverse needs of the population (Equality Act 2010).

The physical environment of these units should enable the implementation of interventions to provide positive therapeutic outcomes for PWLD. It is acknowledged that when individuals feel safe, recovery is often quicker. That said; staff also feel safe and more content when working within good, enabling environments and are less prone to sickness and often overall improvement in staff retention. Therefore, the environment is a crucial element in the delivery of high-quality, cost-effective care.

Research highlights that there is a lack of evidence in a widely agreed definition of "enabling environments". However, they are often described in relation to infrastructures, governance and examples of frameworks of clinical processes (Royal College of Psychiatrist — Enabling Environment Standards). As discussed in the previous paragraph, inclusion of the environment to facilitate these standards is paramount and should be at the forefront of care delivery.

Evidence suggests that enabling environments are those that offer support, comfort and therapeutic interventions, all of which assist individuals to feel safe, especially at a time when in distress or at risk of harm. They mitigate the effects of living with others in a restricted setting, ensure appropriate levels of safety and security, support meaningful activity and high-quality environments (internal and external) and allow flexibility in meeting the needs of different populations in terms of their diversity.

The catalyst of stating what an enabling environment is, offers a platform to indicate the type of areas that will support the sustainability of the unit for the longevity of its functioning. These areas include (but not limited to), quality of life, building fabric and materials, social inclusion, recovery, safety, security and infection control.

- Quality of life relates to the therapeutic environment where there is natural daylight available with views of the landscape.
- Areas are clean and non-malodorous with adequate ventilation and ambient temperatures that are controllable.
- Noise levels that can be adjusted to meet the needs of the population residing there. There is a quiet (low stimulus) space available and located away from busy areas.

- Units should include social spaces external to the internal area, again offering appropriate views and offer shelter in inclement weather.
- The internal space should have the sensitivity of spaciousness; have separate areas for daily living and sleep.
- All individuals should have a bedroom with en-suite facilities.
- The environment should offer privacy for receiving medication and provide the opportunity to ask questions. The environment should be constructed to enable flexibility in providing the potential diverse needs of the population.
- Accessibility is paramount for all parties and all reception areas are inviting, well planned and that there is clear, visible signage that meets the needs of individual recipients.
- That there are sufficient spaces available for private conversations/interventions. Within the building there should be designated spaces to receive visitors and inclusive of children's visiting needs.
- A program of activities both internal and external should be available, including an exercise space and adequate seating for relaxation that is safe and in fresh air.
- Privacy, dignity and safety considerations means that the environment will support gender specific areas, privacy in toilet and bathroom areas and the design does not impede the line of sight and all exits and entrances are visible to staff.
- In terms of security, the environment should not restrict individuals whilst maintaining appropriate levels of security. Alarm systems are proportionate to the needs of the population residing there. Personal belongings are safe and accessible according to risk profiling.
- Depending on the type of unit and its functioning model of care, best practice will influence how to provide further enablement. For example, those individuals with Autistic Spectrum Disorder (ASD) "It's not Rocket science" (NDTi 2017), produced guidance relating to "sensory friendly wards", illustrating how to create a predictable environment, swap alarms for silent alarms, reduce noise and acoustics, change fluorescent lighting for alternatives, consider impact of different smells and the impact of touch and texture. Although the research relates to CAMHS, transitional needs into adulthood are the same, therefore adult environments require the same commitment.
- Having described what enabling environments are, this report will demonstrate through its findings that there is an attempt of offering some elements; however, these standards appear to be met in small numbers, vary in consistency within the same providers of services and from provider to provider across Wales.

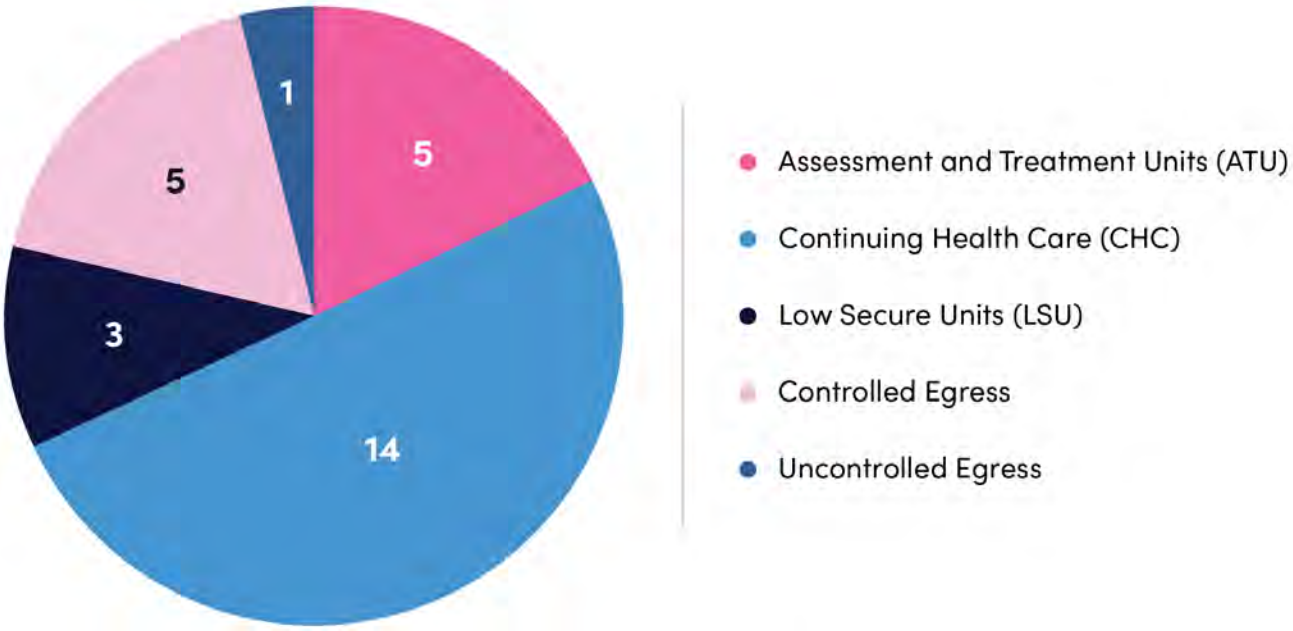
Overview of Units in Wales

In total, there are 28 units across Wales that provide various types of inpatient services for People with Learning Disabilities. These units are provided by both the NHS and Independent Sector. They deliver services across a range of speciality. They are Low Secure, Controlled/Uncontrolled Egress, Continuing Healthcare and Assessment & Treatment Units.

Figure 1:
Map of Wales

Figure 2:

Units Across Wales



Assessment and Treatment Services

Assessment and Treatment Units (ATU's) are services designed to provide additional support for PWLD and additional psychiatric needs or for behaviours that challenge. It is a unit based on short-term placements for rapid assessment and acute treatment. Mencap have produced guidance for individuals "Your rights if you are in an assessment and treatment unit – meeting the challenge". It states that individual's human rights are paramount and that they have the right to good support. "Good support" in this context is defined as going outside and getting fresh air, undertaking exercise, having occupation/activity and healthy eating, all based in the least restrictive way.

This focused review recognises the recommendations from the Mencap paper and through the use of various environmental standards, are able to include these areas as part of the description of "enabling environments".

Of the 28 units reviewed during this period, 5 (18%) were classified as Assessment and Treatment units (ATU's), which were located in 3 of the 7 Health Board areas. In total, there are currently 31 beds in Wales for citizens needing this level of care and treatment.

Low Secure Services

Low Secure Units (LSU's) are designed to provide individuals with more complex needs and who cannot be safely supported in non-secure units.

Individuals admitted to this type of unit are often detained under the Mental Health Act (MHA 1983) due to the presentation of risk to self and others that require more specialist care and support.

From Figure 2 it is evident that in Wales there is no availability of this type of unit provided by Health Boards. There are 3 units (11%) in total in Wales, which are provided by the Independent Sector and these are situated in the south of the Welsh landscape. There are currently 26 beds available in Wales within this type of unit.

Continuing Health Care Services

These units support individuals who require longer-term care/support. The key definition adheres to providing "a package of ongoing care that is arranged and funded solely by the NHS". The National Framework for CHC also states that continuing care is not determined by the setting in which the package of support can be offered or by the type of service delivery. The undertaking of the focused review highlighted that some of these units are within hospital sites and some within locality/community settings. From Figure 2, one can ascertain that the majority of units fall into this category, having the total sum of 14 (50%) units with 67 beds available. During the review, 2 of these beds were in a unit that had been closed by the provider. The reasons for closure were mainly due to the number of repairs/modernisations that was required. However, this had been re-opened due to service demand and the need to support two individuals from the community.

Controlled and Uncontrolled Egress Services

Controlled Egress services are also often described as "locked rehabilitation" units. They are defined as a "service to help people recover from the difficulties of longer-term mental health conditions. They support individuals who find it difficult to cope with everyday life. (Royal College of Psychiatrists). The aim is to provide specialist assessments, treatment and support to stabilise symptoms and regain/gain skills. The main goals are to teach individuals emotional, cognitive and social skills to help them live in their communities as independently as possible." (CQC 2019). In this type of unit, the doors are lockable/locked to prevent unplanned egress. Uncontrolled egress services support individuals in the same way as controlled egress. However, the difference being that in general these units only lock the entrance and exits by night for security purposes.

Figure 2, illustrates that there are currently 5 (18%) units offering Controlled Egress support with a total of 39 beds available and 1 (4%) Uncontrolled Egress unit in Wales, having 10 beds allocated.

Methodology

The NCCU have previously undertaken quality reviews, aligned to a number of significant policy drivers and thematic reviews. In 2020, Improving Care, Improving Lives set the scene of some of the key issues in relation to the care and treatment of Welsh citizens who have a learning disability and who require inpatient treatment. In response to recommendations of Improving Care, Improving Lives, the NCCU have been commissioned to review if current buildings (estate) meet the demands and purpose, fit for the 21st century.

The scope of this focused review firstly required identification of units that support inpatient treatment for PWLD, across our current landscape within Wales. These were identified through correspondence with the relevant stakeholders and information utilised by NCCU on a daily basis.

Research in relation to PWLD is often limited and specific to certain aspects of current drivers and legislative conditions. This focused review therefore required a bespoke approach encompassing best practice guidance and NCCU Framework standards.

The data reviewed evidence for patient needs in terms of their personal spaces. This includes bedroom, en-suite, lounge, dining, laundry, therapy, clinic/treatment and seclusion rooms. Other areas classified as "general areas" were included and consisted of corridors, storage, search/security, quiet/low stimulus (including sensory rooms), multi-faith, unit kitchen, communal bathrooms/toilets, use of CCTV, ingress and egress, external areas, gardens and courtyards. In total, there are **175** pieces of information pertaining to these areas for each of the units stipulated within this review.

Data collection also helped to evidence how units are meeting the needs of employees in supporting the safe delivery of care. Through this lens, the data sets established what supports staff in relation to their; office/work spaces, training/meeting rooms, rest rooms, personal care spaces, access and parking facilities. The review collected **51** pieces of information relating to this domain for each unit visited throughout the review.

As research indicates, PWLD often have to travel further away from home for inpatient care. This has an impact on contact with family, friends and often professionals from their local care teams. The review captured data in accordance with this, in terms of visitor waiting areas, visitor rooms, access and parking. In this domain, there were **23** pieces of evidence collected to demonstrate what the current unit supportive methods are.

The last section of the review evidenced how providers maintain their standards and ensure they are fully compliant with its operational and clinical functioning. Therefore, data was collected which relates to safety and ligature risk, audit cycles and maintenance management. For each of the units, there are **12** pieces of information relating to this.

The review was undertaken by two trained and experienced Registered Learning Disability Nurses, currently employed within the National Collaborative Commissioning Unit.

Each of the units involved with this focused review received communications informing them of the review timescales.

Part B

Review of Services and Additional Descriptors Used for this Focused Review

Review of Services and Additional Descriptors Used for this Focused Review

Bedroom Areas

The review looked at a number of standards in relation to bedroom areas for patients in inpatient units. Standards referenced that bedroom areas may be grouped into small clusters of approximately five rooms to create a good atmosphere.

- They should be single rooms that have areas for sleep, personal activity and personal hygiene needs. The bedroom should be a minimum of 15m^2 and include an en-suite.
- They should not be overlooked from outside areas; however, the window should be positioned so that the individual can look out.
- There should be an on-call button for staff available.
- Beds should be of a divan type fixed to floor, accompanied with appropriate bedding in terms of safety i.e. no elasticated corners, breathable pillows etc. Bedroom furniture should be fixed and not movable to obstruct the view of individuals whilst using the space.
- The room should have good access and egress in terms of fire procedures.
- The design of the room should allow for use of television, radio and other media sources. There should be lockable storage facilities available for clothing and personal affects. Anti-ligature wardrobes, doors, shelves including "built-in" systems for TV's etc. Rooms should have tamper proof mechanical and electrical fixtures and fittings. Lighting, water and electrical systems should have the ability for controlling from outside of the bedroom area if required (isolation systems).

Accessible Bedrooms

Should have the same options available, but generally larger in size (17m^2-19m^2), in order to support and assist with additional mobility needs. An additional safety mirror of full length will be required and the bed height adjusted to accommodate their safety.

Windows

In terms of windows, access to fresh air, natural light and views enhance quality of life. However, certain considerations are required to support individual safety and security. The frames being constructed of steel or hardwood timber and fixings concealed, opening mechanisms should be robust, tamper proof and anti-ligature. Glazing should be toughened glass to withstand attempts to damage. Dependant on level of security some openings will be restricted to 100mm. They may need to be constructed with a secure mesh to prevent the passage of contraband items.

Window Dressings

Should be suitable for the privacy and for the protection of individuals considering their different risk profiles. The preference is anti-ligature, integral to the window and controlled by the individual. If curtains are available, the mountings/tracking should again be of an anti-ligature mechanism. All materials should be fire resistant, clean and anti-strangulation.

Doors, Door Handles and Accessories

Doors should have no protrusion other than the handle mechanism. Architraves should not have hidden shelves. They should not be fixed with nails and pins as to be easily removed and used as weaponry. Door hinges should have captive pins.

Bedroom doors should have vistamatic panels with staff override system. These systems should be constructed with metal surrounds. Doors should be of anti-barricade systems and capable of opening outwards in emergency situations. Individuals should have the facility to lock their rooms but with staff override facility.

Again, key systems will vary according to security levels required. Keys can be electro-mechanical, manual, magnetic, swipe card or proximity and biometric readers. These devices should be linked to the fire procedures of the unit. Door handles on the inside of individuals rooms should be ligature free. Handles should be either of finger grip or “anti-ligature knob” type.

Flooring

This should be proportionate to the function of the area and that there is no evidence of movement, damage and will not cause slips, trips and falls. Textiles can often reduce noise level. If carpets are present then antibacterial treatments should be used, due to infection prevention controls. Any expansion strips need to be fitted and maintained in line with manufacturer’s guidance to prevent accidents and misuse by individuals who use the service.

Lighting

Units should try to balance its ambience with domestic units and that of service delivery. Lighting should be robust and tamperproof to minimise risk of harm. They should be ceiling mounted and sealed. Staff should be able to control lighting. All areas occupied by individuals should have emergency lighting available should the need arise.

On examination of these areas, it was evident that not all units fully met the standards across the domains relating to bedroom areas. The standards relating to patient bedroom areas are probably the standards most important to the patients, with regard to their safety and comfort, during the period of admission to the service.

Of the 28 units:

27
(96%) were able to evidence that it was possible for **patients to personalise their rooms** if deemed safe and appropriate to do so.

24
(86%) were deemed to have **appropriate lighting and flooring** relevant to the function of each individual unit.

17
(61%) units that evidenced that **the windows in situ, met the standards** appropriate to the service being delivered at that time. 19 (68%) units were deemed to have window dressings that **minimised risk of ligaturing, fire resistant etc**.

2 (7%) of bedroom areas had an unpleasant odour at the time of the review.

14 (50%) units had plans in place with regard to the **patient exiting buildings safely** if there was a fire. Also, there was evidence of only 8 (29%) units having **staff call buttons** in patient bedrooms.

18
(64%) units had adequate storage for patient property.

24 Of the units reviewed (86%) had vistamatic panels in situ.
Vistamatic doors are important to ensure patient privacy whilst also aiding staff when undertaking observation processes.

20 (71%) were evidenced as being able to meet any change in gender assignment of any individuals.

En-suites

The standards used to examine these areas state that these should comprise of WC, wash-hand basin and shower (with a floor drain). They should be accessible from the bedroom area.

All bathrooms (including communal bathrooms) should consist of robust anti-ligature fixtures and fittings inclusive of an unbreakable mirror. They should not afford the opportunity for concealing items.

Infection Prevention Control (IPC) should also be attainable with these items in place. Water supplies to the WC, basin, shower or bath have “motion sensor” controls or push button. Supply may be timed to prevent flooding in the area.

All pipework, plumbing and ductwork should be concealed and water can be isolated from outside the area. Water flow should be appropriate to the use and function of the room i.e. basin, shower, toilet outlets and temperature controlled to prevent accidental burns. Taps used support the needs of the individual. Regular checks/risk assessments to protect against legionella is undertaken.

Drainage

Coincides with water flow. Ensure that drainage is adequate, no stagnant water evident, odours or overflow present.

Finishes

Should be anti-slip and walls of a seamless finish (no ceramic tiling present). Light switches must be on the outside of the area. En-suite doors should provide privacy but not obscure staff sight when left open by individuals. They should meet anti-ligature standards and the ability to be unlocked by staff in an open and closed position.

Accessible En-suites/Bathrooms and WC

Assisted bathrooms need to be a minimum of 15m^2 and within easy access to bedrooms. Overhead hoisting is desirable but consideration of suitability due to ligature risk of individuals. Other hoisting systems should be available and stored securely when not in use.

There should be a presence of removable grab rails that can be securely fixed and removed when not required. Assistive bathrooms should include a raised WC with extra projection for wheelchair transfers. Self-cleaning toilets are commonly taller in height making it easier for transferring, a basin with taps suitable to support those with limited dexterity (potentially sensor taps) and supporting grab rails, which should be of a contrasting colour to aid individuals with visual impairment.

The access door should open outwards. Compulsory dimensions should be 2200mm in length and 1500mm in width as a minimum.

12

(43%) of units had en-suite bathroom facilities for their current inpatient population.
None of the Secure units were able to offer en-suite provision at the time of the review.

5

(42%) of the 12 units that provided en-suite facilities, were able to provide assisted en-suite facilities for people with mobility issues.

8

(75%) of the 12 unit that provided en-suite bathrooms had appropriate doors on those bathrooms that allowed appropriate privacy when required but also met safety standards in relation to reducing ligature risks.
Also, **10** (83%) of the 12 units with en-suite provision had appropriately covered in plumbing in order to reduce ligature risks.

Lounge Areas

Should support individuals to relax and socialise and be of "open plan design", with adequate seating and décor. There should be access to television, beverages, and activities so furniture selection should be available to meet these requirements. Good natural lighting with windows and a view.

All units had lounge areas with adequate seating arrangements to meet their maximum capacity. All had access to TV, radio and activity resources. Spaces within this area were clear and organised. All layouts had a good flow for patient care and clear lines of sight. Other findings were:

Dining Rooms

Should be proportionate to the number of individuals using the service. Therefore, the number of tables and chairs should meet the need.

The atmosphere should be conducive to the function of the room.

Cutlery and crockery may be stored in a lockable cupboard. Cleaning schedules should be adequate to meet the demand.

28

Units (100%) provided **adequate numbers of table and chairs** for the numbers of patients on the unit.

17

Units within the dining areas (61%) provided **open and free access to hot and cold drinks**.

24

Units (86%) met the required standards for **suitable flooring, lighting and ventilation in this area**. For example, appropriate slip/trip hazard protections were in place, appropriate heating/ventilation in place and suitable lighting for the relevant rooms.

8

Units (29%) were **fully compliant with fire safety standards** within the dining areas of the units reviewed. Some of the standards in this area looked at fire exit availability from the dining room location and are clear of debris etc, clear/accessible/user-friendly signage present.

Seclusion Rooms/Extra Care Area

The standards for Seclusion and Extra Care Areas include the view that they should be designed and located to promote low-level stimulus, promote safety and physical well-being for individuals that use it.

They should offer privacy and dignity.

A clock should be visible to the individual to orientate them, adequate lighting, ventilation, heating, cooling systems and water. These are items that can be controlled by staff outside of the area if require to do so.

Windows that are present should not open but have an integral blind to protect the individual. The size of the bedroom should be 15m^2 inclusive of the en-suite.

A door between the en-suite and bedroom should be fitted with a fully encased lock-back facility. Bed and mattress as per procedures. All fittings should be tamper proof.

☑ 3

of the 28 units reviewed **had Seclusion and/or Extra Care Areas (ECAs) available.**

☑ 0

of the units (0%) **had Seclusion or ECAs that were able to control temperature or ventilation** from outside of the rooms.

☒ 1

of the units (33%) **didn't have appropriate flooring in place, that was resistant to damage, aligned to infection control and of materials that provided cushioning in the event of a fall, deliberate Self Harm etc.**

☒ 1 (33%) of the units **didn't have appropriate window coverings** in situ.

☒ 1 (33%) of the 3 units had **inappropriate seating arrangements to support prescribed holding of patients** when in crisis.

☒ 1

(33%) unit **did not have an adequate fire evacuation plan in place,** with regards to patients in the seclusion/extra care area.

☑ 3 (100%) units that provided Seclusion/ECA **had appropriate doors and locking mechanisms, appropriate windows and glazing, were able to eliminate blind spots, including the use of CCTV/mirrors**. Appropriate beds and bedding, that reduced hazards and risks to patients, was also in use in all 3 units.

Patient Treatment/Clinic Rooms

These are described as being needed to support clinical procedures within the environment; this includes secure storage of drugs and sterile supplies. Additional and appropriate storage cupboards for controlled drugs.

A door with appropriate size hatch to support medication delivery to individuals. Rooms should be designed to support the privacy of individuals when delivering medications to them and should not be positioned in communal spaces.

There is process for first aid, physical examinations and other clinical procedures in the room and one where the individual's safety is not compromised. There should be an examination bed/trolley of an appropriate height, which is stable and positioned safely.

Other equipment such as mobile resuscitation including defibrillator, crash bag, and ECG machine may be stored in the same area so adequate charging facilities need to be available. Work surfaces, cupboards and a pharmacy fridge should be available.

Lighting of high and low intensity is required. A sink with hot and cold water for hand hygiene procedures in place.

The room should have appropriate ventilation and can be securely locked when not in use.

26

Units (93%) of the 28 that were reviewed **had treatment/clinical rooms available.**
However, only 12 (46%) of these rooms were suitable to support the use by patients with mobility issues, particularly those who use wheelchairs.

100%

of the units that **had treatment/clinical rooms, were able to secure them** from unauthorised access.

22

of the 26 units with relevant rooms **were equipped with essential apparatus that had been calibrated, tested** and was in good working order.

4 (14%) of the 28 units **were not able to evidence the immediate provision of emergency medical resuscitation equipment** that was maintained and checked on a weekly basis.

15 (58%) of the 26 available **rooms were deemed to be adequately lit and ventilated**.

Patient Therapy Rooms

Are equipped to support the function of the room.

The rooms should be placed in appropriate areas, which will afford privacy for individuals, but safety for therapy staff. This will also dictate the type of equipment required within each of the rooms.

Room décor and lighting will be suited to the function.

8

(29%) units were able to offer **bespoke therapy rooms.**

16

(57%) of the units **provided patient access to wi-fi in relation to supporting therapeutic activities.**

4

(14%) of the units were deemed **to have an alarm system in place within the therapy areas** that did not present a ligature risk (e.g. non-pull cord etc).

3 (11%) units were able to **provide a sensory room that was, a purpose built/modified room**, with adequate sensory equipment, that was adequately heated/ventilated/decorated to meet the function of the room, along with assistive technology for patients with mobility, movement, neurodiversity problems.

Patient Laundry Rooms

These rooms should be in place in order to enable individuals to undertake their personal needs in relation to their clothing.

This space should provide washing machines, tumble dryers, ironing boards and irons. A suitable sink and work surfaces for folding/sorting of clothes.

Liquids should be locked away as per local protocols.

Electrical items should have regular PAT testing of equipment and staff have the ability to lock this area when not in use.

There should be IPC measures and systems in place for soiled laundry and the disposal of such items.

6

(21%) units **didn't provide a laundry for use by patients.**

4

(18%) of the 22 units that provided a patient laundry, **did not have facilities to securely store chemicals and liquids that were used in those facilities.**

16

(73%) of the 22 units **did not have self-locking laundry doors.**

Therapy Kitchens

Therapy Kitchens are an important resource that can be used to help patients maintain or improve their cooking and food preparation skills. This review established if units had dedicated patient kitchen areas that were separate from the unit kitchen/servery.

10

(36%) units **had Therapy Kitchens that were dedicated for the use by patients.** 7 (70%) of these were deemed to have equipment that was appropriate to its dedicated function.

9

(90%) units **had electrical equipment which was evidenced as being PAT tested** within appropriate timescales.

9

(90%) of the **Therapy Kitchens also had secure storage facilities** for items that may potentially be a risk to patients.

3

(30%) of the available **Therapy Kitchens had work areas that were spacious enough for patients with mobility/physical health issues** to work in.

General Areas

Standards in this area state that these areas should be light and airy without "blind spots" for staff observation purposes. If blind spots are present then devices such as high-level mirrors should be installed.

Corridors should be wide enough to promote positive population flow (a minimum of 1800mm wide) and will allow moving of furniture and equipment.

Have access to adequate lighting systems and of calming décor, with appropriate signage to orientate individuals and an application of noise reducing support mechanisms where appropriate.

In this domain, the reviewers examined the presentation of corridors, lighting, ceilings, walls, flooring, noise levels, signage, hand cleansing, odours, storage, alarm systems, security, unit kitchen, communal bathrooms and any additional facilities such as sensory rooms, low-stimulus rooms, activity rooms multi faith areas etc.

Corridors

18 (64%) of the units were assessed as having corridors that had adequate space for the flow of patients, staff and others. These included handrails where safe and appropriate to do so and wide enough to support patients with mobility issues who use wheelchairs and walking aids. They were also designed to support the management of behaviours that challenge.

There were generally high levels of noise noted on units with only 11 (39%) assessed as having minimal noise levels. This is especially important for patients with sensory needs.

14 (50%) of the units had **appropriate signage and information displayed** and was conducive to the patient's needs.

The units were generally free of malodorous smells, or the over use of products that may cause concern to any patients who may be hypersensitive in this area. Concern in this area was only raised on 1 (4%) of the units.

The availability of non-personal alarm systems (wall mounted etc) in general areas was also assessed. Of the 28 units, 10 (38%) were identified as having this type of alarm system in their general areas.

Security/Search Rooms

1 (4%) unit had a **security/search room in place, which was private and safe** in order to undertake any searches of patients where required. For example, on return from leave.

Quiet/Low Stimulus Room

These provide an alternative to communal areas. Some offer "same-sex" spaces.

These areas may be used in several ways to include one to one therapy time, keyworker sessions etc.

They would have furniture, lighting, heating and fittings proportionate to its use and local policy. They would also usually have call buttons/alarm and may be free from noise of TVs, radio, telephone etc.

10 (38%) of the units were able to provide **separate quiet lounge areas for patients**.

Multi-Faith

These rooms should be available on all units but especially where patients are less likely to be able to access community services.

They should be used for worship, mediation, reflection.

The room will have suitable storage for accessories for worship, a platform to support symbols of worship, appropriate washing facilities and seating.

They should also provide adequate privacy, heating/ventilation and decoration.

4 (14%) units **had access to a multi-faith room** as described above. Many of the units did offer community access to places of worship if required by patients who were able to leave the hospital setting.

Communal Bathrooms

Communal bathrooms should be available in addition to en-suite bathrooms/showers.

They should be single sex and also contain any assistive technology to support patients with physical health/mobility issues.

24 (86%) units were **assessed as providing communal bathrooms.** 9 (32%) units had bathrooms that provided assistive equipment for patients with physical/mobility issues.

Unit Kitchens

These are usually placed adjacent to the dining area and has easy access to entrances for deliveries.

It's designed for staff access only (there is usually a patient therapy kitchen or pantry available as an alternative for maintaining life skills).

All equipment are PAT tested (portable appliance testing).

If there is a servery hatch, this will have the ability to be securely locked when not in use and is fire-resistant.

All food preparation will be subject to food hygiene regulations. Cleaning schedules are appropriately applied.

27

(96%) units that had a **kitchen that was used to prepare/serve food.** The one unit without a dedicated kitchen was on a site where food was prepared in a kitchen off the unit and transported across post preparation. **16** (59%) of these kitchens had serving hatches that were lockable and fire resistant.

4

(15%) of the 27 units with kitchens **could not evidence up to date PAT testing on all electrical equipment**, **2** (7%) didn't show that processes were in place to ensure cutlery was always accounted for.

Ingress and Egress of Units

The units reviewed as part of this process were located in varying levels of security, from open rehabilitation settings to Low Secure settings.

Entering and exiting these settings differed across various settings. For example, all Low Secure services and Controlled Egress units had air locks in-situ, which controlled all entry and exit from units.

5

(18%) units were **unable to evidence that entry/exit of patients could be observed via appropriate line of sight from the nursing station**. These were all located in CHC settings.

6

(21%) units **used CCTV to provide passive recording of the perimeter** of the unit and the reception area.

There was a **key management system in place on 23** (82%) of the units. The **systems accounted for all secure keys/passes** which were held under control of the senior manager. **2 ATU's and 3 CHC units did not** have this process in place.

10 (36%) of the units **could not evidence adequate fire safety measures** such as, fire exit doors, firefighting equipment in each appropriate area, processes and apparatus such as evacuation chairs etc.

Buildings – External Areas

The reviewing team observed each building structure as part of this review. As previously mentioned, many of the units were provided in repurposed buildings that have not been purposely built with PWLD in mind. Many of the buildings are also decades old.

12 (43%) of the 28 units visited **provided services in buildings that had clean external structures that were free of damage**. They also had adequate drainage and guttering that wasn't damaged or missing etc.

All Low Secure Units were able to evidence daily checks of the integrity of the secure perimeter fence.

19 (68%) units **had external doors and windows that were free from damage and were clean**.

The appearance of the external ground areas of each unit was also observed by the reviewing team.

Gardens/courtyards are viewed as a therapeutic part of the unit and enables individuals the opportunity for social engagement and reflection. These areas may include raised flowerbeds, shrubs and herb areas. They may also include therapy areas and seating.

They may offer areas for ball games, walking and gardening.

There should be level access to the area from the unit and designed for easy observation by staff.

Good maintenance of the area will be required to prevent deterioration of equipment, unnecessary accidents and overgrown spaces whereby items may be concealed by individuals.

9 (32%) of the units were assessed as **having appropriate, maintained and presentable external courtyards/gardens/grounds**. They were litter free with manicured gardens and grass. **Pathways and patios were clean and maintained**. There were no trees and other vegetation near perimeter fences that could be used to assist unauthorised absence.

External furniture was not always secured to the floors. However, each Low Secure Unit did have secured garden furniture.

Standards Considered for Staff Employed within the Unit

The inclusion of requirements for staff employed at each of the units is paramount in terms of function, retention of staff and their well-being in order to support the effectiveness and efficiencies of demand and delivery.

The following sections of this report highlight the findings in relation to staff office/workstation, training and meeting spaces, staff rest rooms, personal care areas, access to the unit and car parking facilities.

It is required that staff have adequate space for their role and function of their duties. Their workstation/office is one such area to enable safety, efficiency, productivity, privacy and comfort. This supports staff well-being and retention.

Staff Office/Workstation

Staff offices/work stations should be available within each unit's environment. These facilities are usually situated in an area of the unit that offers good line of sight across the unit whilst enabling staff to undertake administration tasks.

18

(64%) of the units **had appropriately situated office/work stations that also allowed good line of sight across the unit**. 3 (11%) units did not provide enough seating in office spaces for the relevant staff members on the unit.

20

(71%) units were **assessed as having appropriate heating ventilation within staff offices**.

2 (7%) units **evidenced having ligature risk maps in situ at the time of the review**. These would not necessarily be appropriate in all environments but should be evident in all secure units as a minimum.

16 (57%) units **had ligature cutters available** to staff.

13 (46%) units had **unit wide alarm systems** that supported the requirements of staff.

10 (36%) units could evidence that there were **appropriate fire evacuation plans in place and that staff had undertaken regular fire drills**.

13 (46%) of the units **provided electronic patient records systems**.

Staff Training/Meeting Spaces

Employees are expected to undertake mandatory and statutory training and require dedicated spaces to undertake this, away from the busy ward environment. This enables staff to feel equipped and reflective of their interventions resulting in staff feeling confident and skilled whilst undertaking specific interventions.

14

(50%) units were able to demonstrate that **staff had access to appropriate training/meeting rooms**, that were furnished with adequate seating and had appropriate heating/ventilation.

4

(14%) units **did not have any wi-fi/ appropriate equipment**, such as laptops/computers, training aids etc.

Staff Rest Room

Access to such areas for staff enables support of their physical and mental well-being, encourages continuation of their productivity, improves morale and culture growth. Staff rooms should be away from inpatient areas and should be appropriate environments that staff can use for breaks.

15 (54%) units could evidence that **they provided staff room areas so that staff could take breaks away from the inpatient environment**. 11 (79%) of the 15 available staff areas provided equipment and facilities such as, sinks, storage, refrigerator, utensils, microwave, toaster etc.

23 (82%) of the inpatient units **provided designated staff toilets**.

Staff Shower Rooms

These facilities enable staff to be prepared for adverse events that may occur during their duties at work. For example, assisting individuals on Section 17 leave in adverse weather conditions, the event of being exposed to bodily fluids of others, etc.

These facilities assist staff to remain comfortable to fulfil their roles and responsibilities without having to leave the unit and potentially not returning, leaving staffing levels vulnerable.

It may offer staff the opportunity to walk or cycle to work and address their personal care needs prior to the commencement of their shift.

20 (71%) units **provided staff with shower facilities**. However, only **6** (30%) of the 20 were gender specific.

Building Access and Parking Facilities:

Staff parking is essential in order to provide employee safety and accessibility. It enables staff to arrive on shift "stress free" and punctual.

28

(100%) units had **staff parking facilities which was free for staff to use.** However, only 10 (36%) of those units had appropriate facilities, such as adequate lighting, good road surface, marked parking bays etc.

0

(0%) of the **car parking facilities had designated security attached to them.** 26 (93%) were over flat terrain and within easy walking distance of the main hospital building.

2

(7%) units had **Electric Vehicle charging points.** Both were in independent sector hospital services.

Standards considered for visitors to the unit:

Reception/welcome:

All visitor attendance is recorded at 26 (93%) units.

13

(46%) of the units **had waiting areas,** 11 (85%) of which were deemed to have adequate seating, decoration lighting and signage.

14

(50%) units had **processes for collecting visitor feedback.**

6 (21%) units of the **visitor rooms were located within the main building** of the hospital.

8 (29%) of the **visitor rooms had alarm systems** in situ that protected the people who use them.

10 (36%) units **provided visiting facilities for children.** Facilities include availability of toys etc and systems to protect any child visitors.

3 (11%) units also **provided catering for visitors.**

Visitor Car Parking and Accessibility

7

(25%) units **had parking that was specific for visitors and had appropriate signage/information at the entrance.** Where parking was available, it was free to use. The car parks provided at the 7 units also catered for visitors with mobility issues.

0

(0%) units **provided charging points for visitors electric vehicles.**

Standards considered in relation to the management of the unit:

Management of Units

In order to ensure the provision of safe, secure and enabling environments, management should evidence that systems are in place, proactive and can offer remedial actions in a timely manner.

Safety/Ligature Risks

The reviewers looked to establish if an environmental risk assessment (ligature check) of the units been undertaken to identify potential ligature and anchor points, if they had been removed or if there were processes in place to manage the identified risk.

28

(100%) units **could evidence that ligature risk assessments had been undertaken** and that identified risks had mitigation plans in place.

27

(96%) units **had undertaken a ligature risk assessment within the last 12 months.**

13

(46%) of the units used a **triangulation approach to risk assessments in this area with representation from ward management,** Health and Safety and Maintenance/estates departments.

21 (75%) units **presented with processes in place to inform temporary staff about potential ligature anchor point risks** identified via risk assessment.

Maintenance Schedules

It was highlighted that works and estates personnel did not attend ward level audits, only when there were senior management "walkabouts".

11 (39%) units **evidenced that they had a rolling maintenance program in place**.

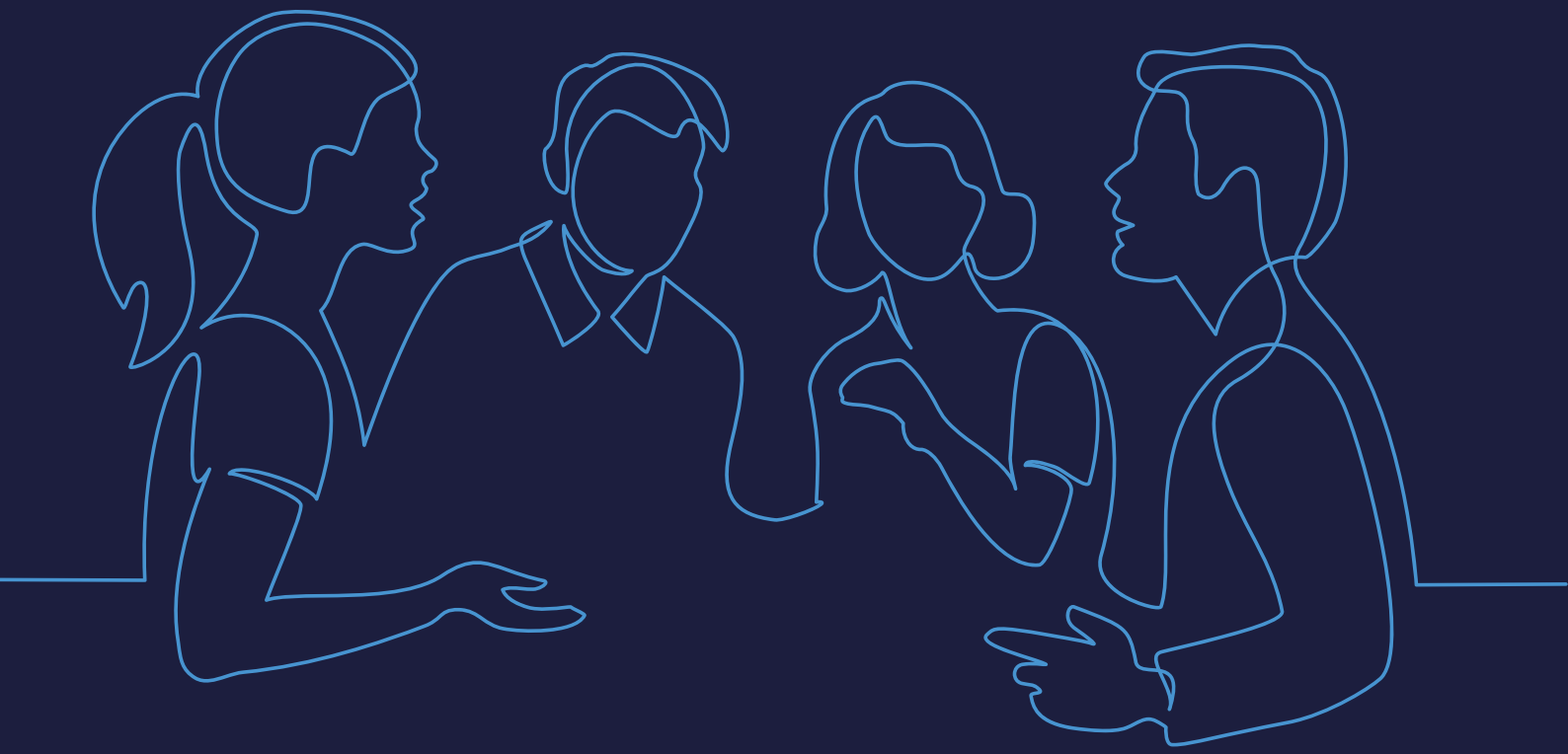
Audit Process

The review team examined audits that were undertaken or planned, with regard to maintaining environmental safety.

Evidence of discussion of these audits, at a senior level was found in 26 (93%) of the 28 units.

26 (93%) of units **could demonstrate that results of audits regarding environmental quality and safety, were acted upon in a timely manner** and learning was shared across the unit.

26 (93%) units **demonstrated that Senior Management personnel undertook frequent environmental walkabouts on units.**



Part C

Emerging Themes

Emerging Themes

Buildings

Many buildings, both in the NHS and Independent Sector were identified as being re-purposed buildings. Much of the NHS provision is set within grounds of long stay hospitals. Some of them have closed or have reduced services, resulting in the inpatient Learning Disabilities environments being isolated and having an increased risk profile for estates, patients and staff.

Independent Sector services tended to be set in their own grounds rather than within the grounds of long stay services.

Many of the buildings viewed were decades old and not fully fit for purpose. Older buildings naturally require on-going maintenance programs in order to keep an appropriate level of quality and safety. This was not the case for the units reviewed during this audit process. Findings highlighted that although maintenance systems were in place in NHS provision, they appeared inconsistent depending on their Health Board location, maintenance request systems and the response times. It was evident that response times relied upon funding streams (localised budgets, capital-funding requests) and the availability of maintenance staff and resources to complete the tasks. Some areas although demonstrated good governance measures in tracking the works schedules many had works outstanding in excess of three months timescales and still waiting for identified dates of completion.

Independent Sector units had less issues in relation to maintenance. These units tended to have their own dedicated maintenance/ estate staff. This meant that required work was undertaken more quickly than similar works that were required in NHS provision.

Low Secure units were located in isolated places, which made community rehabilitation and public transport use difficult.

Therapeutic Environments

This review showed that areas didn't all evidence provision of good basic sanitary wares, items that reduce self-harm (anti-ligature compliance), assistive technologies, therapeutic rooms dedicated for a particular use, no call buttons for patients/staff, safe fire escapes and plans; supportive areas for maintaining skills such as designated kitchens, laundry rooms.

Cleanliness of units was variable, with some services having dedicated hotel services whilst other units relied on unit staff members to undertake most cleaning duties.

Multi-faith rooms were only available in independent sector units.

Staff

Despite environmental difficulties across many of the units, staff remained positive and upbeat about working in these inpatient units. Many have become creative in their manner to deliver personalised care within the confines of the units especially when there is a need and the building cannot provide for that need — adapting out buildings for activity as one example. This review demonstrated that assistive technologies were often not available, out of order and/or waiting replacement. There was minimal evidence of equipment available to support individuals with developing/maintaining daily skills if they had specific mobility/movement issues e.g. Therapeutic kitchen spaces which have no assistive technologies, bathrooms with same absence of assistive technologies, lack of adequate signage, augmentative communication etc.

Due to some of these difficulties, it appeared that staff often encouraged a "do for" instead of a "do with" individual, supportive approach (in terms of implementing the active support model). Some staff discussed a "home for life" within these types of units.

Accessibility

Findings demonstrated that the majority of units were not fully equipped to support individuals who require assistance with mobility and movement. This would potentially impede the inclusion of these individuals from the service. Examples of this were lack of appropriate hoisting facilities, small spaces for use of wheelchairs, access points to some of the buildings, assistive apparatus to support independence with daily living skills etc.

Augmentative Communication Systems

Were not available in all units to support individuals, visitors and new staff members to become orientated to the buildings. The majority of signs were standardised for example, fire exits, fire extinguishers, welcome, blue and red to distinguish hot and cold. Some areas did have pictures of staff available and information boards — but not always aligned to easy read formats.

One unit that offered exceptional practices in this area had a dedicated SALT service that provided staff with every day essentials and resources to meet the changing needs of their population group.

Much of the NHS provision is set within grounds of long stay hospitals

Part D

Recommendations

Recommendations

This section will show that the report has offered the opportunity to explore the findings and support the capacity to gain an accurate and deeper understanding of the status of the estates/buildings available to individuals with a learning disability requiring inpatient services in Wales today.

The intent of this report is to offer specific recommendations to be considered, which may support and enable all stakeholders to have the insight to accelerate the necessary plans to change and in some instances improve the way forward.

✔ Recommendation 1

Welsh Government should consider similar rigor of oversight of inpatient Learning Disability services across the NHS and Independent Sector to help ensure parity of quality and safety of services in Wales.

✔ Recommendation 2

Providers should consider if they have robust processes and capacity in place to manage, maintain and repair their estates.

✔ Recommendation 3

Providers should consider if appropriate processes are in place to ensure that dual/tri-partite provision is adequately serviced by appropriate estates/maintenance departments and that delays do not occur due to uncertainty about relevant responsibility for repairs/maintenance.

✔ Recommendation 4

Providers should consider the use of assistive equipment and environmental adaptations to maximise individuals' potential in terms of their mobility and independence, whilst receiving inpatient services.

✔ Recommendation 5

Providers should be able to offer alternative and augmentative communication (AAC) systems to support every aspect of individuals' activities of daily living during their inpatient stay, adding value to person centred care and addressing diverse needs.

✔ Recommendation 6

Providers and Welsh Government should consider current approaches to infection, prevention and control (IPC) measures and health care related procedures across units in Wales. Consideration should be given with regard to any differences/relaxation of processes that could be implemented in longer stay/CHC type settings.

✔ Recommendation 7

Providers should ensure that all staff receive regular fire training and that fire drills are regularly undertaken. All units should reassess ease of egress from units in the event of a fire.

✔ Recommendation 8

Welsh Government and the NHS in Wales should consider an appropriate electronic patient record for Learning Disability services in Wales.

✔ Recommendation 9

Providers should ensure that employees have essential facilities that are supportive of their role and duties. This should include the availability of staff break areas away from the ward environments, storage for personal belongings, designated staff toilets and shower facilities.

✔ Recommendation 10

Providers should consider appropriate facilities for use by visitors to each unit. These should include a designated child visiting room, visitor toilets, refreshments, information about the unit and safety equipment such as alarms and CCTV within the visiting room.

The intent of this report is to offer specific recommendations to be considered, which may support and enable all stakeholders to have the insight to accelerate the necessary plans to change and in some instances improve the way forward.

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