Identifying the factors affecting the implementation of strategies to promote a safer environment for patients with learning disabilities in NHS hospitals: a mixed-methods study

I Tuffrey-Wijne,¹* N Giatras,² L Goulding,² E Abraham,²,³ L Fenwick,⁴ C Edwards⁵ and S Hollins²,⁶

¹Faculty of Health, Social Care and Education, St George’s, University of London and Kingston University, London, UK
²Division of Population Health Sciences and Education, St George’s, University of London, London, UK
³Florence Nightingale School of Nursing and Midwifery, King’s College London, London, UK
⁴Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle, UK
⁵Institute of Leadership and Management in Health, Kingston University, London, UK
⁶House of Lords, London, UK

*Corresponding author

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Plain English summary

Factors affecting a safer environment for patients with learning disabilities

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Plain English summary

This 21-month study (carried out between 2011 and 2013) aimed to describe the factors in NHS hospitals that promote or compromise a safe environment for patients with learning disabilities, in the light of national recommendations that hospitals should: identify patients with learning disabilities; provide reasonably adjusted services; involve carers as partners in care; and include patient and carer views in service development. Methods included questionnaire surveys, interviews and observation with senior hospital managers, clinical staff, patients and carers (a total of 1251 participants).

Examples of good practice were not consistently seen hospital-wide. The most common safety issues were delays and omissions of treatment and basic care. The main barriers to better and safer care were a lack of effective flagging systems, leading to a failure to identify patients with learning disabilities within hospitals; lack of staff understanding of learning disability issues; lack of effective carer involvement and staff misunderstanding of the carer role; and lack of clear lines of responsibility and accountability for the care of each patient with learning disabilities. The main facilitators of better care were learning disability liaison nurses (LDLNs) and ward managers.

The following further research is recommended: identifying the adjustments to hospital care that are most frequently needed by people with learning disabilities, and their cost implications; identifying the most effective structures for ensuring clear lines of responsibility and accountability for the care of patients with learning disabilities; investigating practical and effective ways of flagging patients with learning disabilities across NHS services and within NHS hospitals; investigating, implementing and evaluating procedures to ensure that family and other carers are involved in providing care; and evaluating LDLN posts nationwide.
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This report

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