User Focused Monitoring

Audit Report

THE GROVE CENTRE

RE-AUDIT OF IN-PATIENT

TREATMENT AND CARE

2007

USER FOCUSED MONITORING PROJECT

Peter Bedford Housing Association

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This report is further testimony to the value of involving service users in service evaluation and development. We hope you will enjoy reading it and find it useful in developing your service.

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Introduction and background

During 2002/03 an audit of pre-discharge treatment and care was undertaken on three in-patient units at the Royal Free hospital providing acute psychiatric care for adults aged under 65 years (Alice, Nicol and Helen Boyle wards). The Centre for Outcomes Research and Effectiveness (CORE) based at University College London (UCL) and the Camden & Islington Mental Health and Social Care Trust Service User Resource Team supported auditors in undertaking the first audit of this service. The first audit report was presented to the ward and service managers following which an action plan was developed for implementation (http://www.candi.nhs.uk/Services/ufm/HuntleyCentre-UFM-report.pdf). The User Focused Monitoring Strategic Steering Group decided to undertake a re-audit of the Royal Free acute mental health wards in 2007.

Management issues at the time of the audit

The acute mental health wards were re-accommodated since the first audit in a new purpose built block, the Grove Centre, also on the Royal Free hospital site. The acute wards in the new centre are called Fleet (16 beds), Solent (16 beds) and Isis (12 beds). The new centre provides patients with single occupancy en-suite bedrooms.

There was a significant service reconfiguration of the Community Mental Health Teams (CMHT) that began in July 2007 during the data collection phase of the audit. This included changes to consultant psychiatrists for many patients following a decrease in the number of CMHTs from eight to six and some management restructuring. This also led to more patients being transferred between wards than usual. Additionally there was a significant reduction of staff in the occupational therapy team. Clearly these changes are likely to have

impacted on patient care and negatively influenced their satisfaction with the care received.

In addition to this, Isis ward was changed from accommodating females only to being mixed sex in July 2007 and Fleet ward was changed from being a mixed sex ward to providing accommodation for males only in August 2007.

UFM at Peter Bedford Housing Association

Camden and Islington Primary Care Trusts took over as commissioners of User Focused Monitoring (UFM) for Camden and Islington in 2005. Peter Bedford Housing Association won the tender from the Trust to manage and deliver the UFM Project in June 2005.

The UFM team at Peter Bedford Housing Association is made up of a pool of local former and current mental health service users and a UFM Project Coordinator. The UFM Project's brief is to monitor service user satisfaction with the statutory and voluntary mental health services in Camden and Islington through audit and evaluation.

The audit programme is overseen by a Strategic Steering Group, the membership of which includes service users; commissioning managers from Camden and Islington PCT; representatives from the UFM project, including auditors and the UFM Project Co-ordinator; and the Chief Executive of Peter Bedford.

Aims of the re-audit

The re-audit aimed to examine the same aspects of inpatient care and treatment as the first audit with the objective of comparing the results to

ascertain to what extent improvements have been made. The results will be used as an evidence base on which to further improve and develop standards of inpatient care and treatment.

Methods

Approach

A participatory approach was used for the audit (as in the first audit) whereby current and former mental health service users participated in undertaking all aspects of the audit. All auditors received training in the audit process, and support and supervision from the UFM Coordinator. Auditors also supported one another, particularly whilst collecting data. The training programme for auditors included:

- Information about working on the UFM project at Peter Bedford Housing Association
- Overview of audit methods
- Developing familiarity with the audit questionnaire and modifying it where necessary
- Exercises to examine their own thoughts about mental health and service provision
- Opportunities to become familiar with fellow auditors
- Developing skills in questionnaire administration
- Entering and analysing data, interpreting results
- Developing recommendations based on results
- Report writing
- Developing self-presentation skills (additional workshops to induction)

Sampling method

Patients who were nearing discharge were selected in the first audit so that they should have been involved in their discharge planning: an aspect of care to be audited. Forty-nine patients participated in the first audit. For the re-audit patients were selected using convenience sampling methods i.e. those who were available at the times the auditors visited the units and who were willing and able to participate. This meant the sample consisted of patients at various stages of their recovery. The use of different sampling methods between the two audits may affect the comparability of the results, particularly those relating to care and discharge planning.

The discharge planning section of the re-audit questionnaire is only applicable to those nearing discharge, therefore auditors were trained to ensure only appropriate participants completed this section. However, not all auditors followed this guidance, consequently it is possible that some participants completed it inappropriately thus negatively influencing the results. This should be born in mind when interpreting them.

Planning for data collection

The patients were informed about the impending audit through a poster that was put up on ward notice boards giving the dates and times the auditors would be attending. The UFM Coordinator coordinated the data collection phase of the audit through each ward manager and other senior staff both verbally and in writing.

Mutually convenient days and times of the week (two hour slots in the morning and / or the afternoon) were agreed between the ward managers and UFM

Coordinator for the data collection to take place. Data collection took place between March and August 2007.

Participant information and confidentiality

All patients on the three wards to be audited were given an audit information leaflet. This was to forewarn them of the impending audit, to ensure that they understood what their participation would involve and how the results would be used. They were also informed that it was voluntary, that the information they provided would be kept confidential and that their identity would be anonymous. The leaflet gave the Coordinator's contact details should they wish to find out more about the audit or Peter Bedford Housing Association.

The auditors gave participants verbal explanations about the audit when approaching them to take part. Participants' names were not recorded on any audit documentation. Participant anonymity and using service users to collect data aimed to facilitate the honest expression of service users' views and to minimise anxieties that participation may negatively influence the care they receive. Auditors aimed to ensure confidentiality by collecting data in private spaces, sometimes outside the ward.

The audit questionnaire

The questionnaire used in both audits was entitled 'Your Treatment and Care in Hospital' (Appendix 1). It was designed for service users to complete themselves or to be administered by others if they were unable to. The questionnaire was based on a service user satisfaction questionnaire developed by Webb et al (2000) and further developed by the Centre for Research Effectiveness at University College London together with local service users. Since this time it has been modified by auditors at Peter Bedford as the need

arose, for example following implementation of new directives, policies and guidance. In this audit some new questions were added or the wording was changed slightly; such changes are indicated when presenting the results.

The questionnaire presents participants with a number of assertions about specific aspects of care and treatment during their current admission to which they are asked to indicate whether they agree or not, or to indicate if they are not sure. For example, 'If I had a problem I can easily contact my primary nurse' - 'yes'/ 'no'/ 'not sure'. Using specific criteria such as this to find out about service user satisfaction is reported to result in more precise results than general questions, such as, 'How happy were you with the care provided by your primary nurse?' General satisfaction questions can artificially inflate reported satisfaction levels even when negative experiences have occurred (Greenwood, 1999, cited in von Hauenschild et al, *no date*).

Box 1 summarises the contents of the questionnaire and the number of questions in the first audit compared with the re-audit.

Box 1: The structure and content of the questionnaire

The questionnaire had a section to record demographic data followed by 7 sections relating to specific areas entitled:

- Your admission and treatment (15 items – formerly 12)
- Ward environment (13 items – formerly 6 items)
- Your primary nurse (7 items – formerly 5 items)
- Your psychiatrist (5 items - same)
- Discharge (5 items – formerly 6 items)
- Equal opportunity (2 items – formerly 1 item)
- Overall (2 items- same)
- Final open question (same)

The auditors were instructed to assist participants who needed help to complete the questionnaire and to employ interpreters for those who needed them.

The inclusion of an open question gave participants the opportunity to elaborate on their responses, or to comment on issues not covered in the questionnaire. Participants' verbalised claims, concerns and issues were documented by the auditors and included in the analysis. Auditors were also trained to document relevant methodological issues or problems that occurred whilst collecting data. A 'prompt sheet' was given to auditors giving them guidance on how participants should complete the questionnaire and clarifying the meaning of the questions.

Pilot

The questionnaire was piloted with two service users, having first been refined as far as possible by the auditors. No revisions were necessary.

Data collection

Data collection on the three wards at the Grove Centre took place between late March and late August 2007 (five months). The first audit sampled 49 service users over a period of seven and a half months (influenced by the need to sample service users nearing discharge). Patients who participated were given a pen as a token of thanks for their time and effort with the audit.

Data analysis

The quantitative data were entered onto an Excel spreadsheet. Numbers and percentages were calculated for each response and compared with the figures from the previous audit. Some comparisons were not possible due to some questions being new to the second audit and as the wording on some questions

had been changed. Some changes may have caused a different interpretation of the question's meaning; readers may judge for themselves whether the results for these items are comparable. The results are presented for the whole of the Grove Centre rather than for individual wards, as was the case in the first audit.

Qualitative data were typed into a word document. The qualitative and quantitative data were reviewed and analysed in a series of UFM working group meetings attended by the auditors, the UFM Temporary Organiser and later in the analysis the new UFM Coordinator. The group identified and discussed participants' claims, concerns and issues from their own perspective as former or current mental health service users. They also developed some recommendations and suggestions for action by the Grove Centre staff and managers.

Sample size

A total of fifty- nine (n=59) patient participants completed the questionnaire; thirty- one (n=31) from Fleet ward (16 beds); thirteen (n=13) from Isis (12 beds); and fifteen (n=15) from Solent (16 beds).

Characteristics of participants

Of the fifty- nine patients that participated in the audit one-third (n=21: 36%) were females and two thirds (n=38: 64%) were males. Their ages ranged from 19 years to 61 years of age with an average age of 39 years (compared to 36 in the first audit). The questionnaire asked each participant to identify his or her ethnic identity from a comprehensive list. Their responses indicated they were from a broad range of ethnic groups, including White British, White European, Black British, Black Caribbean, African, South-East Asian and many of mixed

ethnicity. The predefined categories participants could select included 'English', 'British', and 'African'. As these categories do not indicate racial origin (unlike 'White British' or 'Black African') they were counted as 'missing' values. Of the fifty participants whose ethnicity was clearly defined, just over one- third described themselves as belonging to a black or minority ethnic group while just over half described themselves as white (Table1).

Table 1: Ethnic group	N	Valid %
Black & Minority Ethnic	19	38%
White	28	56%
Other	3	6%
(*Missing)	(9)	(15%)
Total valid responses	50	100

** Missing values include those who did not give their ethnicity and those where the category selected did not specify ethnicity adequately e.g. 'English', 'British' and 'African'. Valid % excludes cases with missing values.*

Half the participants had been inpatients during the current episode of care for less than a month (Table 2), one- third had been in for one to three months and one-fifth had been in- patients for three or more months. Six did not respond.

Table 2: Length of stay on ward	Number	(%)
0 - 28days	26	(49)
28 days – 3mths	16	(30)
3 months or more	11	(21)
Total	53	(100)

Results

The results of the audit are presented in tabular format. The first column lists the assertions (questions); the second column lists the percentage of participants who agreed with the assertions for the first audit; the third column lists the percentage that

agreed with the assertions for the re-audit; and the fourth column lists the percentage difference. A summary of the results is then given along with participants' comments, which are used to illustrate some of the main points.

Admission and Treatment

The section on admission and treatment explores issues mainly around the patients' treatment plan and communication generally with staff. The section includes a number of new questions regarding ward transfers, ward rounds and information about their rights.

Table 3: Admission and treatment	2002/03 Agree (%)	2007 Agree (%)	Differ-ence (%)
I know why I am in hospital	87.5	84	-3.5
I know what my treatment plan is	66.7	55	-11.7
I was involved in drawing up my treatment plan	29.2	36	+6.8
I am in agreement with the treatment plan that was drawn up	54.3	48	-6.3
I was given the opportunity to involve my family/partner/friend in my treatment	44.4	62	+17.6
*I have completed a CPA 3 (self assessment) needs form during my admission		17	
I was told what my medication was for	70.8	66	-4.8
I was told about the possible side-effects of my medication	47.7	45	-2.7
I feel able to raise concerns about my treatment	71.1	63	-8.1
*I feel my concerns are taken on board		50	
*I have been transferred from another ward/hospital		60	
*The transfer has helped in my care		62**	
*I was given a set time for ward rounds		50	
*I am seen on time for ward rounds		43	
*I was given a choice regarding my next of kin		64	
*I was informed of my rights during my admission		49	

** Denotes new questions not in the previous audit*

*** Of those who were transferred only*

Involvement of patients and carers in care planning

The Mental Health Act (1983) Code of Practice (DoH & Welsh Office, 1999) states that, 'All patients, including those subject to guardianship, should be given full information, both verbally and in writing, to help them understand why they are in hospital, or subject to guardianship, and the care and treatment they will be given. Informal patients should be told they may leave at any time.' There was little change in the percentage of participants responding that they knew why they were in hospital with over four fifths agreeing that they knew.

Involvement of the patient and their carers in care planning is a central tenet of the Care Programme Approach (DoH, 2006). Care planning issues were of concern in the first audit and were addressed in the Action Plan. The action points were that, the Ward Managers were to discuss the CPA process and earlier planning of it in ward multi-disciplinary business meetings. Secondly, patients and families/ carers were to be given CPA information on admission and 'CPA needs forms' to be given to patients during admission. Despite these proposed actions, there was a 12% reduction in the percentage of participants in 2007 reporting that they knew what their treatment plan was (55% versus 67%). One participant commented that, *'I have no idea what my treatment plan is, or my rights.'*

A slight improvement was found in the percentage of participants reporting being involved in drawing up their treatment plan, but in both audits it was very low with just over a third in 2007 reporting they had been involved.

Just under half the participants reported being in agreement with their treatment plan, slightly fewer than in the earlier audit. Significantly, almost all the participants that had been involved in drawing up their treatment plan

agreed with it: (n=19/21: 90%). One participant was involved but did not agree with it and one was not sure. Conversely, of twenty- eight participants who were not involved with drawing up their treatment plan, most (n=17/28:61%) disagreed with it.

The strong relationship between service users being involved and agreeing with treatment plans supports the value of patient involvement. If patients agree with their treatment plan they are more likely to fully comply with it. This could have a positive effect on their recovery with economic benefits for the service.

There was a significant increase in the percentage of participants reporting that they had the opportunity to involve their family/partner/ friend in their treatment with just under two thirds reporting this. The improvement is a cause for optimism.

Information about medication

There was a small decrease in the percentage of participants reporting having been given information about what their medication is for, with two-thirds agreeing with this. Some were given leaflets about their medication. More than half reported that they were not told about the possible side effects, again representing a small decrease. The lack of information (and choice) service users have regarding their medication has implications for compliance, particularly following discharge. If patients do experience negative effects they may discontinue their medication without medical supervision and suffer withdrawal symptoms, or relapse. Experiencing unexpected side effects can also cause patients alarm and distress. A participant who was not involved in their care planning made a comment that indicates how important such involvement can be:

'The doctor put me on medication without reading my notes. Tried to put me on medication that didn't work for me previously which was written in my notes. Fortunately nurses listen to me.'

This participant had a serious allergic reaction to the medication that resulted in him needing emergency hospital treatment.

A number of action points were made in the Action Plan following the first audit, these included the pharmacist being invited to patient community meetings; information about medication being posted on ward notice boards; and nurses and Senior House Officers being alerted to these concerns. These proposed actions do not appear to have had any lasting effect.

Raising concerns about treatment

Two- thirds of participants felt able to raise concerns about their treatment; 8% fewer than in the first audit. However, of those who felt able to raise concerns, half did not feel that their concerns had been 'taken on board' (this was not tested in the first audit). This reflects a general tendency for patients' views and opinions about their problems and treatment to not always be sought or fully acknowledged, as described by a participant: *'Doctor puts me on any medication on a whim. No consultation ever. Need to be listened to by Doctor.'*

Choice regarding next of kin

The Royal College of Nursing and UNISON (*no date*) advise that for patients admitted to mental health care, 'There is no need to limit who may be contacted to either nearest relative or next of kin. It should be determined by the service

user's choice and could be their partner or a friend.' The audit found that two thirds reported having been given a choice as to who was recorded as their next of kin. This has significance particularly for those patients who have same-sex partners, or if they have suffered abuse by a parent.

Experience of ward transfers

Questions regarding ward transfers were also added following auditors' concerns that transfers may not be beneficial for the service users. Almost two-thirds (n=35/58) of the participants reported that they had been transferred to a different ward during their admission. Of these two-thirds agreed the transfer had helped in their care, 15% were not sure and a quarter disagreed.

Ward rounds

Half the participants reported being given a set time for ward rounds, of these less than half reported being seen on time. One of the participants commented that he knew he was seeing his doctor, but didn't know it was called a ward round. This suggests that patients need to have the term 'ward round' and their purpose explained to them.

The issue of ward rounds was addressed in the previous audits' action plan which stated that there is a 'Ward Round Protocol which endeavours to give all patients a time for Ward Round / CPA / MDT meetings.' It was acknowledged however that 'delays can happen because of unpredictable events.' The action points were that 'ward Managers to ensure that ward round / CPA / MDT meeting lists are prepared with teams the day before the event. All patients must be given a time to be seen and this is to be displayed on the ward and in the MDT room; staff must communicate any delays to their patients, relatives

and community carers'; and 'ward managers were to revisit the Ward Round Protocol with their consultants and teams.'

Information for patients

The Code of Practice for the Mental Health Act 1983 (point 1.11) states that 'All patients, including those subject to guardianship, should be given full information, both verbally and in writing, to help them understand why they are in hospital, or subject to guardianship, and the care and treatment they will be given. Informal patients should be told they may leave at any time.' It also goes on to state that, 'Information should be clearly displayed on ward notice boards and in reception areas. All patients should be given admission booklets, information about the Mental Health Act Commission and complaints leaflets for the Hospital, Trust and local Social Services Department' (point 1.12).

Almost half the participants agreed that they were informed of their rights during their admission, but almost as many were clear that they had not been informed of their rights, a few were unsure. All patients need to know their rights in terms of their freedom to leave the ward and any restrictions that may be imposed consequent to their status under the Mental Health Act. Not being adequately informed about their rights on each admission can lead to confusion, as indicated by a participant:

> *'I just assumed I knew my rights because I had been in before and allowed out for an hour. I assumed I could go. I cannot leave.'*

The ward environment

Table 4 lists results relating to the ward environment, the activities available, the catering and hospitality services, and some items relating to the patients' sense of well- being on the wards.

Table 4: Participants' experience of the ward environment	2002/03 Agree (%)	2007 Agree (%)	Differ-ence (%)
I was introduced to the staff and the ward facilities	58.7	75	+16.3
I find the staff here respectful	56.5	71	+14.5
There are good opportunities to engage in a range of activities on the ward	75.6	52	-23.6
*The activities are easy for me to access		64	
There is a good standard of hygiene and cleanliness on the ward	67.4	88	+20.6
I feel safe here	71.1	73	+1.9
*I have a lockable cabinet for my belongings and personal items		45	
Refreshments, e.g. tea, coffee, juice are always easily available	78.3	77	-1.3
*Fruits and Healthy options are available for refreshments		75	
I can get privacy when I need to	65.2	82	+16.8
My visitors are made to feel welcome here	73.3	73	-0.3
*I feel cared for on the ward		66	
*I can talk to other service users on the ward		82	

** Indicates a new question*

Overall, the results for the 'ward environment' were much better than for 'admission and treatment'. There were improvements made on the first audit with higher scores for being introduced to staff and facilities and for the staff showing respect; for the availability of refreshments and fruit and healthy options; privacy; and good standard of cleanliness.

Activities

Half the participants agreed that 'there are good opportunities to engage in a range of activities on the ward', this represents a large percentage reduction (23.6%) compared to the first audit. Weekends were seen as being particularly

lacking in opportunities to engage in activities when there was no occupational therapy. A participant on Fleet ward commented that,

> *"I don't feel like they help enough. You have to make your own entertainment – we're left with too much time to talk about the fact that there's nothing to do"*

This decline is disappointing considering the following action points being made in the first audit's management action plan: nurses to be allocated a group of patients at the beginning of each shift and to meet with them to discuss plans for the shift; to ensure they know what groups are scheduled and what they should be attending; to ensure patients are referred to the occupational therapist on admission; to get feedback from patients at the end of each shift about what they have done; to ensure occupational therapy and 'TI' activities are well advertised on the wards; and nurses to meet with their patients for individual therapy if the patient desires.

Two-thirds of participants found the activities readily accessible, however, some reported a lack of information as to when the activities were happening which was a cause of poor access. The auditors felt patients need positive encouragement to attend organised ward activities.

There were some concerns raised about restricted access to the garden, the computers (the Internet) and the gym. A participant commented that there were no personnel to staff the gym. This is unfortunate as it is widely accepted that exercise benefits mood, health and general well-being. A participant commented,

'I want to go home now! Suffering from a lack of fresh air – gate to the exercise garden is always locked. It should be open all the time as a lot of us don't have leave.'

Hygiene and cleanliness

There was a large increase in the percentage of participants agreeing that there was *'….a good standard of hygiene and cleanliness on the ward'*. One participant commented that this was what he liked about the ward. Some (mainly male) patients' poor personal hygiene was a cause of concern and one participant claimed he saw bugs in the bed. The Grove Centre had received a 'good' score for standards of cleanliness when reviewed by the Service user Environment Action Teams (PEAT) in 2006.

Smoking was banned in most enclosed public spaces in England on July 1st 2007. A participant commented that, '[the] *smoking law seems silly because everybody smokes*.' Another participant commented that the garden, which was the smoking area, had restricted access.

Safety and security

Three-quarters of the participants agreed that they felt safe on the ward. Those that did not feel safe often commented why they did not on their questionnaire. Some concerns about aggression were noted, for example a participant wrote that they usually felt safe,

'…although there have been times when I have felt frightened by other patients who have become angry or aggressive and have not felt sure that staff can cope. Locked myself in the laundry once for this reason.'

Another commented that she felt worried by male patients in this regard. Another valued the sanctuary of her own room when other patients were behaving in a violent way.

Just under half agreed that they had a lockable cabinet for their belongings and personal items. Although they had a cabinet many did not have a key for it.

Refreshment and nutrition

Access to refreshment was felt to be always available by over three-quarters of participants, similar to the first audit. A similar proportion agreed that they had access to fruits and healthy options. However, some patients were reported to take more than their share of fruit and horde it for fear of a lack of future supplies. Some participants commented that the food was not nutritious enough, was low in protein and that salad was not available. The Royal Free hospital had achieved a 'Good' rating for the food category in the Patient Environment Action Teams (PEAT) review in 2006.

Privacy

There has been a dramatic improvement in the percentage of audit participants agreeing that they can get privacy when they need to since the provision of single bedded en-suite facilities (up by nearly 17%).

Feeling cared for

Two- thirds of the participants reported feeling cared for on the ward (this was not asked about in the first audit). Some participants commented positively about the friendliness, approachability and helpfulness of the staff. Auditors felt that more patients would feel cared for by simple acts, such as being asked about their fears, and having more time spent with them and talking with them.

The vast majority of participants felt they could talk to other patients on the ward and three quarters reported that their visitors were made to feel welcome on the ward.

Primary Nurse

According to the local Trust Protocol on Primary Nursing (CIMHSCT, 2006) all inpatients throughout the Trust should be allocated a primary nurse on admission who remains their primary nurse throughout their stay on the ward. The aims are to facilitate a holistic approach to care and a therapeutic relationship with their patients. Primary nurses are responsible for planning and administering care. When they are off duty this responsibility is taken on by an 'associate nurse' or 'allocated nurse'. Their main duties include ensuring the patient is inducted to the ward routine and layout; providing information including about their medication and side effects and their rights under the Mental Health Act; ensuring the admission procedure is completed and documented; and developing and reviewing the patient's care and discharge plan together with the patient. Patients should have a choice as to the sex of their primary nurse. Primary nurses have numerous other responsibilities documented in the local protocol. Table 5 lists the results relating to the primary nurse reviewed in the audits.

Table 5: Participants' experience of their primary nurse	2002/03 Agree (%)	2007 Agree (%)	Difference (%)
The term 'primary nurse' was explained to me	59.6	66	+6.4
I know the name of my primary nurse	70.2	89	+18.8
My primary nurse discussed their understanding of my issues with me	43.5	42	-1.5
I am able to talk about my issues concerning my mental health with my primary nurse	53.3	42	-11.3
If I have a problem I can easily contact my primary nurse	52.2	60	+7.8
*The staff make time to listen to me		48	
*I have been given information about how to complain about the service		33	

** Indicates a new question*

The term 'Primary Nurse' was explained to two-thirds of participants, a slight improvement on the first audit. Almost all of the participants knew the name of their primary nurse compared to fewer than three-quarters of those in the first audit, this represents a large improvement. Some had forgotten the name of their primary nurse, but knew where to find out. Two-fifths agreed that their primary nurse discusses their understanding of the patient's issues with them, similar to the first audit. The same proportion of participants agreed that they could talk to their primary nurse about their mental health issues; this represents a considerable reduction compared to the first audit. More participants in the second audit felt they could easily contact them if they have a problem. Some commented that they did not confide in anyone anyway.

Staff take time to listen

Just under half the participants felt that staff made time to listen to them (this item was not in the first audit). A participant noted that,

'They talk about having one to ones but they never have them. They always seem to be busy and stuck in the office'.

Some participants had empathy for the difficulties faced by the nursing staff, as a participant commented,

'They do try to listen but it can be difficult if there is an incident, they have to scurry. They are not available for a little while.'

Another reported that, *'Staff are charming, helpful and professional, except when information is not given.'* There were several comments made about staff not listening to their views, opinions or concerns that impacted in some cases on the quality of care and treatment they received.

Making complaints

The Code of Practice for the Mental Health Act (1983) states that, 'All patients should be given admission booklets, information about the Mental Health Act Commission and complaints leaflets for the Hospital, Trust and local Social Services Department' (DoH & Welsh Office, 1999). Our audit found that only one third of the participants reported being given information about how to make a complaint about the service. This of concern, particularly as making a complaint is a primary means for patients to formally report acts of racism, harassment, bullying, abuse and other problems they may face as inpatients from fellow patients, staff or others.

Participants' experiences of their psychiatrist

Participants were presented with a number of questions regarding the care received from their psychiatrist and the quality of their relationship and communication with them (Table 6).

Table 6: Participants' experience of their psychiatrist	2002/03 Agree (%)	2007 Agree (%)	Differ-ence (%)
My psychiatrist discussed his/her understanding of my issues with me	63.0	64	+1
**I could easily talk about my personal problems with my psychiatrist*	51.1		
I can easily talk about my mental health issues with my psychiatrist		60	+8.9
**My psychiatrist helped me with my mental health problems*	61.4	**	
My psychiatrist helps me understand my mental health issues		63	
**My psychiatrist kept me informed about my progress*	76.1		
My psychiatrist kept me informed about my treatment and progress		65	-11.1
**I felt my psychiatrist made an effort to understand my problems*	75.6		
My psychiatrist takes on board my understanding of my mental health needs		52	

** Text in italics represents questions given in the first audit when they differ from the second. The reader is to assess whether the question wording changes invalidate comparisons.*

Assuming that the changes to the wording of most of the questions listed in Table 6 are not so great as to invalidate all comparisons, participants generally rated the psychiatrists' interventions slightly less highly than on the previous occasion. Clearly these may be different psychiatrists since four years have

elapsed since the first audit. Many participants may also have had a change of consultant following the reconfiguration of CMHTs during the data collection period.

Almost two-thirds of participants felt their psychiatrist discussed his/her understanding of their issues with them, similar to the first audit. However, there was a considerable reduction (11%) in the percentage of participants who felt they were kept informed about (treatment and) progress. Less than two-thirds of the participants felt they could easily talk about their mental health issues with their psychiatrist; a similar percentage that felt they helped them understand their mental health issues. Some reported not knowing who their psychiatrist was, or to not having one: *'I would like to have one'. 'I don't have one. I didn't ask for one.'* A participant commented that although they had been on the ward for six months they had not been allocated a psychiatrist yet.

Although around two-thirds of participants gave positive responses to the questions relating to their psychiatrist, only half agreed that their psychiatrist 'takes on board' their understanding of their mental health needs. Other findings in the audit endorse this failure of some mental health professionals to fully acknowledge the patients' perspective of their mental health needs or problems. As a participant commented, *'Personal opinions, views are not listened to by doctors and nurses.'* Another participant expressed his dissatisfaction with this aspect of communication thus:

> '*They [the psychiatrists] go by what the staff tell them. I don't seem to have a chance to put what I feel and why I am feeling as I am to them.'*

Clearly not having the opportunity to express their own views about their problems and treatment is very disempowering for patients. It goes against the principles of service user empowerment and involvement in their care and treatment.

Participants' experience of the discharge process

Table 7 lists the findings relating to the participants' experience of the discharge process. The re-audit figures suggest a considerable decline in standards relating to this. However, the results should be interpreted with caution as not all the auditors in the re-audit followed the guidance that only participants nearing discharge should complete this section, therefore sometimes it may have been completed inappropriately. We cannot ascertain the extent to which this happened. The sample number completing this section in the second audit was also small (n=29), so it is also possible that the difference is a result of sampling bias.

Table 7: Participant's experience of the discharge process	2002/03 Agree (%)	2006/07 Agree * (%)	Difference (%)
I know when my next meeting is with my care coordinator/psychiatrist	71.1	58	-13.1
I have been involved in planning my post hospital care	64.4	43	-21.4
I feel okay about leaving hospital	86.4	64	-22.4
I know when my care plan is going to be reviewed (if applicable)	47.6	41	-6.6
My stay here has helped me overcome some of my problems	81.8	61	- 20.8

**The base number for the percentages in the re-audit is 26 cases compared to 49 in the initial audit.*

There was a considerable reduction in the proportion of participants reporting to know when the next meeting was with their care coordinator /psychiatrist with just over half reporting this. Fewer participants (less than half) in the second audit agreed that they had been involved in planning their discharge follow-up care.

Many fewer participants in the second audit felt okay about leaving hospital and this may be due to their lack of involvement in the discharge process and their relative lack of reduction in their problems. This seems to suggest that some patients are leaving the hospital prematurely, without adequate preparation or knowledge of follow-up, and without a sense of problem resolution. Indeed, a participant commented that,

> *'[Discharge processes are] 'never thorough enough, it is always vague. I ended up back in hospital. I am usually eager to get out, but don't want to be just left. I feel vulnerable, especially if going home alone.'*

Considerably fewer participants than in the first audit felt that their stay had helped them overcome some of their problems. This may be associated with low levels of patient involvement in care and possibly also with inadequate regard being given to the patients' own assessment of their mental health needs. Again, these results relating to discharge should be interpreted with caution.

Equal Opportunities

Of 53 participants who responded to the question regarding their ethnic, cultural, or religious needs being respected (Table 8), just over two-thirds

agreed (the same as in the first audit) whilst 17% were not sure and 13% disagreed.

Table 8. Equal opportunities	2002/03 Agree (%)	2007 Agree (%)	Differ-ence (%)
I feel that my ethnic/cultural/religious needs are respected	70.5	70	-0.5
Interpreting services are available if I require them	81.2*	44*	-37.2

** Percentage of those for whom it was applicable (n=27 in second audit)*

There was little difference between participants who were of a black or minority ethnic group compared with the 'white' group in the percentage agreeing that their ethnic, cultural or religious needs were respected: 65% versus 66% respectively. However, more BME participants were not sure about this (29% versus 16%).

Of 27 participants who answered the question regarding access to interpreting services, almost half felt that they had adequate access to them; a gross reduction on the first audit. Quite a significant proportion was not sure about this (22%), and one third (33%) indicated they were not available when required (6 did not respond). A Dutch participant commented that his girlfriend acted as interpreter if needed although his English was usually adequate. A Portuguese participant commented that he missed having his translator. Using friends and relatives as interpreters other than in casual exchanges is generally not good practice, as it has major implications for patient confidentiality. It also deprives the patient of opportunities to discuss issues that often lie behind their distress, such as child sexual abuse that they may not wish to be disclosed to relatives.

Overall satisfaction with treatment and care

Table 9 lists the participants' level of general satisfaction with their treatment and care as inpatients.

Table 9: Overall satisfaction with treatment and care (Total N =36 responses)	2002/03 (%)	2007 (%)
I am very happy with the treatment and care that I have received	Figures not reported	23
I am quite happy		39
I am not very happy		18
I am unhappy		20
(Missing)		(5)

Just under two- thirds of participants were either 'very happy' or 'quite happy' with the service overall. A quarter were 'very happy' with it and the largest percentage felt 'quite happy' with it. Although this item was measured in 2002/03, unfortunately the results did not appear in the report so a comparison is not possible.

Differences in levels of satisfaction between BME and indigenous white participants were not analysed, however there is some suggestion that satisfaction may be higher among patients who were born and raised overseas in less well developed countries, as a participant from a central European country described,

> *'We are lucky to have a hospital like this as we are living in England. …In [name of country] where I come from there is no NHS money; you have to pay with your own money. Some people do not have the funds to pay and of course they suffer badly.'*

Information received about their health

When asked 'How much information have you received concerning your health?', just over half reported they had 'enough' (27%); 21% 'very little'; 25% 'some' and 13% reported having had no information concerning their health ('none'). There is an assumption that more information is better and generally it is. However, information needs to be provided in a timely manner taking account of the patient's mental state, their capacity to absorb it and their need for it. Information overload can happen, as indicated by a female service user who wrote regarding the amount she had been given, *'Too much, leave me alone please.'*

Conclusions

Improvements made

There have been some improvements in participants' reported experiences of inpatient treatment and care on the acute inpatient units since re-location to their new building in 2002/03. These mainly relate to improvements in the environment, principally improvements in privacy subsequent to the provision of single occupancy en-suite bedrooms and improved hygiene and cleanliness. Other reported improvements include improved respect of patients by staff; more frequent introduction of newly admitted patients to the staff and the ward; increased frequency of patients reporting they had opportunities to involve their family, partner or friend in their care; some indication that communication between them and their psychiatrist is better; and improved access to their primary nurse.

Areas for improvement

An aspect of treatment and care that showed the most need for improvement was around involvement of patients in their treatment and care, particularly in relation to self- assessment (CPA3) and care and discharge planning,

There was a dramatic decline in the percentage of participants who agreed that '*There are good opportunities to engage in a range of activities on the ward'* with only half agreeing with this. Some commented on being bored and having too limited access to recreational or other activities that may require staff supervision. Inadequate staff interaction with patients, both in organised therapeutic and casual recreational activities, appears to be a major concern of the Grove Centre audit participants.

Another issue highlighted in the audit was the large proportion of participants who were not informed about their medication or its side effects; a role of the patient's primary nurse. This issue was also addressed in the first audit action plan. In this plan, medication leaflets were reported to be on display on the wards; Senior House Officers were to explain medication to patients and one ward was going to invite 'pharmacy to attend patient community meetings' (http://www.candi.nhs.uk/Services/ufm/HuntleyCentre-UFM-report.pdf, p4). The protocol on primary nursing states it is their role. There appears to be confusion as to whose responsibility it is to discuss medication and its side effects with patients that may account for it not always being discussed with them. The results also indicated some weaknesses in participants' knowledge of the primary nurse's role and function.

Another aspect of treatment and care that showed a large decline in patients recording a positive response was in discharge planning; all questions showed a reduction in positive responses. This may be related to some participants not feeling ready for discharge, or happy about it – greater involvement in discharge planning would have potentially increased patients' preparation for it. There is some possibility however that the apparent deterioration may be a result of sampling bias, as the sample size of pre-discharge patients was small (n=29) or because some participants may have completed this section inappropriately.

Many participants did not feel cared for or listened to by staff on the wards and a significant proportion were not happy overall with their care and treatment. The audit results suggest that improvements in these outcomes would result from patients being more involved as partners in their care and treatment planning, and if they had greater interaction with staff both individually and during organised activities.

Study limitations and methodological notes

Sample size

Potentially there could be wide variation between the wards in the quality of care and treatment achieved but this audit probably has insufficient sample sizes from each ward to enable reliable comparisons to be made between them. Consideration needs to be given when planning future audits as to whether results should be reported for each individual ward, particularly what sample sizes would be needed and the impact on audit duration and cost. More sophisticated statistical software will be used in future audits to enable assessments of the reliability of comparative data (SPSS - Statistical Package for the Social Sciences).

Sampling methods

The first audit only looked at patients who had been interviewed 'shortly prior to their discharge' whilst this audit sampled patients irrespective of whether they were near discharge. Although auditors had been instructed to ensure only those participants who were nearing discharge completed the section regarding discharge, some did not do so, therefore some participants may have completed the section inappropriately. This may have impacted negatively on the reported level of involvement in discharge planning, 'feeling okay about leaving hospital' and their stay having helped to improve their mental health. Clearer guidance will be given to auditors in future inpatient audits if a similar sampling method is used.

Criterion

Although the majority of aspects of care were measured using criterion-based questions, the question regarding 'ethnic/cultural/religious needs' being

respected is not specific enough to distinguish what particular ethnic or cultural needs were met or not met. To help establish this in future audits, the UFM team is considering creating new questions to capture satisfaction with specific cultural aspects of care, such as opportunities for religious observances.

Standards

Whilst Government bodies set some standards for mental health treatment and care centrally, such as those embodied in the National Service Framework for Mental Health, others are open to be set by individual services. To date no standards against which to audit many aspects of in-patient care and treatment have been developed locally, other than a comment in the first audit report that as all the items are important, 100% would be the ideal standard. Instead comparisons tend only to be made between standards achieved in current versus previous audits, or sometimes between similar services. In future, the Peter Bedford UFM team aims to develop some realistic and achievable standards relating to services being audited in collaboration with service providers and commissioners. In addition we plan to review how the UFM Project can work with service providers to strengthen the impact of audit on improving service quality standards.

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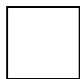

APPENDIX 1
Your Treatment and Care in Hospital
The Grove Unit

Your Age: ☐

Your ethnic origin: ______________________

Female ☐ Male ☐

Ward: ______________ Today's date: ______________

Length of stay:

0-28days: ☐

28day-3mths ☐

3mths+ ☐

Discharged ☐

Your admission and treatment

1. I know why I am in hospital

☐ Yes
☐ No
☐ Not Sure

2. I have completed a CPA 3 (self assessment) needs form during my admission?

☐ Yes
☐ No
☐ Not Sure

3. I was given a choice regarding my next of kin?

☐ Yes
☐ No
☐ Not Sure

4. I was informed of my rights during my admission

☐ Yes
☐ No
☐ Not Sure

5. I know what my treatment plan is

☐ Yes
☐ No
☐ Not Sure

6. I was involved in drawing up my treatment plan

- ☐ Yes
- ☐ No
- ☐ Not Sure

7. I am in agreement with the treatment plan that was drawn up

- ☐ Yes
- ☐ No
- ☐ Not Sure

8. I was given the opportunity to involve family/partner/friend in my treatment

- ☐ Yes
- ☐ No
- ☐ Not Sure

9. I was told what my medication was for

- ☐ Yes
- ☐ No
- ☐ Not Sure

10. I was told about the possible side-effects of my medication

- ☐ Yes
- ☐ No
- ☐ Not Sure

11. I feel able to raise concerns about my treatment

- ☐ Yes
- ☐ No
- ☐ Not Sure

12. I feel my concerns are taken on board

- ☐ Yes
- ☐ No
- ☐ Not Sure

13. a. I have been transferred from another ward/hospital

- ☐ Yes
- ☐ No
- ☐ Not Sure

13b.The transfer has helped in my care

- ☐ Yes
- ☐ No
- ☐ Not Sure

14. I was given a set time for ward rounds

- ☐ Yes
- ☐ No
- ☐ Not Sure

15. I am seen on time for ward rounds

- ☐ Yes
- ☐ No
- ☐ Not Sure

Ward environment

1. I was introduced to the staff and the ward facilities

- ☐ Yes
- ☐ No
- ☐ Not Sure

2. I find the staff here respectful

- ☐ Yes
- ☐ No
- ☐ Not Sure

3. There are good opportunities to engage in a range of activities on the ward

- ☐ Yes
- ☐ No
- ☐ Not Sure

3.b. The activities are easy for me to access

- ☐ Yes
- ☐ No
- ☐ Not Sure

4. There is a good standard of hygiene and cleanliness on the ward

- ☐ Yes
- ☐ No
- ☐ Not Sure

5. I feel safe here

- ☐ Yes
- ☐ No
- ☐ Not Sure

6. I have a lockable cabinet for my belongings and personal items

- [ ] Yes
- [ ] No
- [ ] Not Sure

7. Refreshments, e.g. tea, coffee, juice are always easily available

- [ ] Yes
- [ ] No
- [ ] Not Sure

8. Fruits and Healthy options are available for refreshments

- [ ] Yes
- [ ] No
- [ ] Not Sure

9. I can get privacy when I need to?

- [ ] Yes
- [ ] No
- [ ] Not Sure

10. My visitors are made to feel welcome here?

- [ ] Yes
- [ ] No
- [ ] Not Sure
- [ ] NA

11. I feel cared for on the ward

- [ ] Yes
- [ ] No
- [ ] Not Sure

12. I can talk to other patients on the ward?

- [ ] Yes
- [ ] No
- [ ] Not Sure

Your primary nurse

1. The term 'primary nurse' was explained to me?

- [ ] Yes
- [ ] No
- [ ] Not Sure

2. I know the name of my primary nurse?

- ☐ Yes
- ☐ No
- ☐ Not Sure

3. My primary nurse discussed their understanding of my issues with me?

- ☐ Yes
- ☐ No
- ☐ Not Sure

4. I am able to talk about my issues concern my mental health with my primary nurse?

- ☐ Yes
- ☐ No
- ☐ Not Sure

5. If I have a problem I can easily contact my primary nurse?

- ☐ Yes
- ☐ No
- ☐ Not Sure

6. The staff make time to listen to me?

- ☐ Yes
- ☐ No
- ☐ Not Sure

7. I have been given information about how to complain about the service

- ☐ Yes
- ☐ No
- ☐ Not Sure

Your psychiatrist

1. My psychiatrist discussed his/her understanding of my issues with me?

- ☐ Yes
- ☐ No
- ☐ Not Sure

2. I can easily talk about my mental health issues with my psychiatrist?

- ☐ Yes
- ☐ No
- ☐ Not Sure

3. My psychiatrist helps me understand my mental health issues?

- ☐ Yes
- ☐ No
- ☐ Not Sure

4. My psychiatrist keeps me informed about my treatment and progress?

- ☐ Yes
- ☐ No
- ☐ Not Sure

5. My psychiatrist takes on board my understanding of my mental health needs?

- ☐ Yes
- ☐ No
- ☐ Not Sure

Discharge

1. I know when my next meeting is with my care coordinator/psychiatrist?

- ☐ Yes
- ☐ No
- ☐ Not Sure

2. I have been involved in planning my post hospital care?

- ☐ Yes
- ☐ No
- ☐ Not Sure

3. I feel okay about leaving hospital?

- ☐ Yes
- ☐ No
- ☐ Not Sure

4. I know when my care plan is going to be reviewed (if applicable)?

- ☐ Yes
- ☐ No
- ☐ Not Sure

5. My stay here has helped me to improve my mental health?

- ☐ Yes
- ☐ No
- ☐ Not Sure

Equal opportunity

1. I feel that my ethnic/cultural/religious needs are respected

- ☐ Yes
- ☐ No
- ☐ Not Sure

2. Interpreting services are available if I require them

- ☐ Yes
- ☐ No
- ☐ N/A

Overall

1. How happy are you with the treatment and care you have received?

- ☐ Very Happy
- ☐ Quite Happy
- ☐ Not Very Happy
- ☐ Unhappy

2. How much information have you received concerning your health?

- ☐ Enough
- ☐ Very Little
- ☐ Some
- ☐ None

3. Is there anything else you would like to add about your treatment and care in hospital?

APPENDIX 2.

GROVE CENTRE RE-AUDIT 2007

Recommendations and Management Action Plan

Ward staff and managers' additions to the plan are *italics*.

ISSUE	TARGET STANDARD	POSSIBLE BARRIERS	SUGGESTED ACTION FOR IMPROVEMENT	WHO RESPONSIBLE/ COMMENTS
1. Patients often not involved in devising and reviewing their care plan. Most did not agree with their care plan.	• All cognitively able and willing patients to be involved in devising and reviewing their care plan.	• Low commitment of staff to patient involvement in care planning. Medical model.	• Review the problems getting patients involved in care planning and create an action plan to remedy. • *This has been discussed at Senior Staff meetings and Primary Nurses have been informed that they are expected to ensure that patients are involved in formulating their plans of care. This still requires regular monitoring and remains work in progress.* • *Nursing care plans will be audited weekly to ensure that there is evidence that the patient has signed the plan or documented evidence to demonstrate that they refused or were unable to understand the plan (due to mental state)*	Ward managers and staff

			• *It is also expected that this is incorporated into weekly ward reviews and staff will be expected to record the evidence of these discussions in the patient records* • *CPA care plans to be discussed fully with patients by multi - disciplinary team (MDT)*	
ISSUE	**TARGET STANDARD**	**POSSIBLE BARRIERS**	**SUGGESTED ACTION FOR IMPROVEMENT**	**WHO RESPONSIBLE/ COMMENTS**
2. CPA3 (patients' self assessment) form rarely completed.	• All patients to be involved in self-assessment if and when able and willing.	• Patient's mental state may make it difficult. • Culture – staff may not value patients' own assessment.	• Review the problems with getting patients involved with self - assessment (CPA3) and create an action plan to remedy. • *CPA3 now routinely part of admission process. Offered on admission to all patients and again during admission period as sometimes patients' views change depending on their mental state.* • *Also the Grove has an Essence of Care group working on this aspect of communication*	Ward managers with staff.

ISSUE	TARGET STANDARD	POSSIBLE BARRIERS	SUGGESTED ACTION FOR IMPROVEMENT	WHO RESPONSIBLE/ COMMENTS
3. Not all patients were aware of what their medication was for, or its side effects.	• All patients should know what their medication is for and the potential side effects.	• Poor commitment to patient involvement. Medical model. • Possible confusion as to whose responsibility it is.	• Clarify whose responsibility it is to discuss with the patient. • Written information re medication given to patients. • *Medication leaflets now fully displayed on all wards.* • *Primary Nurses to take a lead in ensuring that the patient understands any issues relating to their medication and pro-actively provide written information to the patient* • *Ward Doctor or Consultant to explain any other uncertainties.*	
4. Patients not always aware of what ward rounds are, when they are, or are kept waiting.	• All patients to have an explanation of purpose & nature of ward rounds. • Clear information to be available to all patients re timing of ward rounds and possibility of delays. • Apology if delayed.		• Information on notice boards. • Appointment cards for patients. • *Allocated times (approximate) to be displayed in communal area* • *Allocated Nurse to inform patient if there are expected delays*	

ISSUE	TARGET STANDARD	POSSIBLE BARRIERS	SUGGESTED ACTION FOR IMPROVEMENT	WHO RESPONSIBLE/ COMMENTS
5. Not all were given choice as to their next of kin.	• Staff to enquire re each patient's next of kin on each admission.	• Assuming the same as previous admissions.	• Ward managers to ensure staff are briefed adequately about this. • *All patients to be asked this at point of admission* • *Can be added to admission checklist*	Ward managers. Admitting nurses.
6. Not all patients are informed of their rights whilst on the wards.	• All patients should be made aware of their rights in hospital on each admission.	• Assume they know when been an inpatient before.	• To be made a routine part of admission. • Incorporate into a checklist for admitting nurse. • Patients under compulsory admission to be given info verbally and in writing. • *For those under Section of the MHA, Section 132 form to be completed and repeated weekly if patient does not understand (or refuses)*	Admitting nurse/ admitting doctor
7. Lack of opportunities to engage in a range of activities on the ward (recreational activities e.g. Internet and organised therapeutic activities).	• Improved patient satisfaction with number of activities available.	• Inadequate staff resources. • Small numbers of patients and staff resulting in low economies of scale.	• Reduce paperwork. • Joint ward activities. • *Service user satisfaction survey* • *Staff on weekends and evenings to provide activities and access to OT rooms in the absence of OTs* • *Capital bid to expand on current resources to increase variety of activities* • *Music Therapist being appointed*	Ward managers/ Occupational Therapists (OTs)

ISSUE	TARGET STANDARD	POSSIBLE BARRIERS	SUGGESTED ACTION FOR IMPROVEMENT	WHO RESPONSIBLE/ COMMENTS
8. Lack of information regarding activities is a cause of poor access.	• All patients to have easy access to information regarding ward and other activities they can attend.	• Staff may assume patients aware of what is happening when and where.	• Clearer information about activities, e.g. posters on notice boards. • Encouragement from staff for service users to attend. • *OT staff to ensure groups are advertised on ward notice boards* • *OTs to hand out group programs to all service users on wards* • *All members of the MDT to have copies of group programs to improve awareness of program* • *Copies of group programs to be available in each service user's file*	Ward managers/ nurses/ OT
9. Safety is an issue for some but audit did not ascertain what exactly are problem areas.	• To be explored in more depth in future audits.		• For further investigation.	UFM project
10. Lack of lockable cabinets /keys.	• Need more keys and to ensure patients leave them on ward when discharged.	• Keys easily misplaced.	• Key handover to staff to be part of discharge process – create check list • *Lead Nurse to look into other options as current system for managing the keys for the lockers does not seem to work well*	Discharging nurse

ISSUE	SOLUTION/ TARGET STANDARD	POSSIBLE BARRIERS	SUGGESTED ACTION FOR IMPROVEMENT	WHO RESPONSIBLE/ COMMENTS
11. Term 'Primary Nurse' not always explained.	• All patients to be informed of the name of their Primary Nurse and their role.		• *Admitting nurse to give clear explanation of this term* • *Brief leaflet to be designed to explain the role* • *Add on to current patient information pack*	Primary Nurse
12. Low levels of access to and communication with nursing staff and 'staff' not taking time to listen.	• More personal contact with nurses and other staff. • More enquiries from staff re patients' feelings and well-being.	• Culture of wards may alienate staff from patients. • Pressure of other priorities e.g. paperwork/ admin.	• Training regarding importance of contact and positive encouragement from senior staff to engage more with patients. • Protected time with patients. • *Senior staff to ensure that basic rules of common courtesy are applied to all patients, this is to be addressed during staff supervision sessions* • *The Grove has been approved to commence the 'Productive Ward: Releasing Time to Care Programme'. This aims to streamline the way we work in order to free up more time to spend with patients*	Senior ward staff

ISSUE	SOLUTION/ TARGET STANDARD	POSSIBLE BARRIERS	SUGGESTED ACTION FOR IMPROVEMENT	WHO RESPONSIBLE/ COMMENTS
13. Few patients given information on how to make a complaint.	• All patients to receive written information re how to make a complaint.	• Staff may not want to encourage complaints against them.	• Laminated leaflets on display in wards. • Patient information leaflet given on admission containing such information. • Monitoring by Patients Advice and Liaison Service (PALS) • *Incorporated into patient information pack*	Ward Managers Admitting nurse PALS
14. Moderate numbers happy with communication with psychiatrist but many patients feel their own understanding of needs is not taken on board.	• Will help if all patients complete a CPA3 (self assessment) form.	• Patients may have low expectations of their input. • Too much emphasis on diagnosis (medical model).	• Psychiatrists to encourage patients' use of the CPA3 (self-assessment) form and review this with the patient.	
15. Patients don't always know when next appointment is with psychiatrist/ care coordinator, or when their care plan is to be reviewed.	• Increase proportion of patients who have this information.		• Patients could be given an appointment card.	Care Coordinators/ psychiatrists

ISSUE	SOLUTION/ TARGET STANDARD	POSSIBLE BARRIERS	SUGGESTED ACTION FOR IMPROVEMENT	WHO RESPONSIBLE/ COMMENTS
16. Poor involvement in discharge planning*	• All patients to be involved in planning their discharge.	• Cannot be conclusive due to methodological problems in audit. • Lack of commitment to patient involvement in care planning. Medical model.	• *Primary Nurse to discuss patient's discharge planning with the patient at an early stage in the admission and to continue to have regular discussions about this* • *Patient to understand and participate in planning their aftercare package* • *Copy of care plans and discharge plans to be given to patients*	Audit results re this may be invalid. UFM team to review methods (done).
17. Interpreting services were not always available if required.			• *Aim to have access to interpreters whenever possible (not just for ward reviews etc*) • *Telephone interpreting to be used as and when necessary*	Centre Manager

* *Some patients may have completed this section on discharge inappropriately negatively affecting the results.*