Peter Bedford
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User Focused Monitoring

Audit Report

Inpatient Treatment and Care

The Huntley Centre

2008

USER FOCUSED MONITORING PROJECT

Peter Bedford Housing Association

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The User Focused Monitoring Project 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 and the UFM project was then put out to tender. Peter Bedford Housing Association won the contract and has been managing the project since this time.

The UFM team at Peter Bedford Housing Association is made up of a pool of current and former mental health service users who are residents of Camden and Islington. They are trained for their role as auditors, and managed and supported by the project manager, Maggie Lay. The project is based in Highbury, Islington, north London.

The UFM project's brief is to monitor service users' experience of and satisfaction with statutory and voluntary mental health services in Camden and Islington through audit and evaluation.

The project's work programme is overseen by the UFM Strategic Steering Group, the membership of which includes: mental health service users; commissioning managers from Camden and Islington; representatives from the UFM project, including auditors and the UFM Project Manager; and the Chief Executive of Peter Bedford Housing Association.

Introduction and background

During 2001/02 an audit of pre-discharge treatment and care was undertaken on three acute admission wards at the Huntley Centre: Dunkley, Tredgold and Laffan. These provide a service to adult men and women aged up to 65 years. The 2001/02 audit was undertaken by the Centre for Outcomes Research and Effectiveness (CORE) based at University College London (UCL) with assistance from service users who were members of Camden Mental Health Consortium (CMHC) (http://www.candi.nhs.uk/Services/ufm/HuntleyCentre-UFM-report.pdf). In 2007, the Camden and Islington User Focused Monitoring (UFM) Strategic Steering Group decided that these wards should be re-audited during 2008.

Aims and objectives of the audit

The aims of the re-audit were to ascertain whether and to what extent improvements had been made to patients' experiences of inpatient care and treatment since the previous audit. Secondly it aimed to identify how standards of inpatient care and treatment could be further improved. To achieve these aims the audit needed to obtain comparable data relating to the same aspects of care and treatment as the previous audit.

Methods

Approach

User Focused Monitoring is characterised by a focus on the concerns and issues of service users and the participation of service users in every stage of the evaluation or monitoring process (Kotecha *et al*, 2007). In line with these principles, we used a participatory approach for this audit, as in the previous audit. All auditors were trained in the audit process, and were supported and supervised by the project manager to assist with the following tasks:

- Planning the audit
- Reviewing and modifying the audit questionnaire
- Deciding how to publicise the audit and designing publicity
- Administering the questionnaire to patients
- Entering and analysing data, and interpreting results
- Developing recommendations based on results

- Editing the report
- Presenting findings to service providers, commissioners and other interested parties

Audit as method

UFM often uses audit as a method to evaluate aspects of mental health services. Audit is cyclical in nature and has been defined thus:

'[Clinical] audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery'.

http://tinyurl.com/c6ttwx

Sampling method

As in the first audit, patients who were nearing discharge were asked to participate, as they should have had the opportunity to contribute to their discharge plan; an aspect of care we wished to audit.

Planning data collection

A planning meeting was organised between the UFM project manager and the relevant ward and centre managers. This was to inform them of the impending audit; to find out if there were any anticipated problems that might impede the audit; to ascertain the best methods to inform patients and staff about it; and how best to encourage patients to participate. The UFM manager then visited each participating ward to observe and note its layout, possible places for auditors to see participants, and to gather other contextual data. The auditors and manager then visited each participating ward in order to familiarise themselves with the environment; to become aware of the health and safety issues they may face whilst working on the wards and how to deal with them; and to place a poster on the patients' notice board accompanied by photographs of the auditors (to raise awareness of the auditors' identity). Posters about the audit were given to staff to put on the staff notice boards and leaflets to distribute to patients informing them of the impending audit.

Approaching patients

The UFM manager rang each participating ward several times each week to ascertain if there were any patients ready for discharge. These patients were then contacted using the ward telephone, given an explanation of the audit and invited to participate. If they agreed, an appointment was then arranged for an auditor to attend the ward to administer the questionnaire.

Participant information and confidentiality

Auditors were instructed to wear their identification badge at all times whilst in the Centre. Each participant was given information about the audit and the nature of their participation both verbally and through a participant information leaflet. The leaflet explained that their participation was voluntary and included a statement regarding confidentiality and anonymity. The leaflet also gave the UFM manager's contact details should they wish to find out more about the audit or the UFM project, and how to obtain a copy of the audit report.

Participants' names were not recorded on any audit documentation. This anonymity, and using auditors who were also current or former service users to collect data aimed to encourage participants to be more candid, and to help reassure them that their participation would not negatively affect their care. Participants completed their questionnaires in private rooms (but not in bedrooms) to help ensure confidentiality.

The audit questionnaire

The questionnaire used in both audits '*Your Treatment and Care in Hospital'* (Appendix 2) was designed for the participants to complete themselves. It was originally developed by Webb et al (2000) and has since been further modified by users to retain its relevance. For example, the UFM team at Peter Bedford amended it following implementation of new directives and policies, such as the smoking legislation implemented in July 2007. The new questionnaire has more questions than the original; such changes are highlighted in the presentation of the audit findings.

The questionnaire presented participants with a number of assertions about specific aspects of care and treatment regarding their current admission and were asked to indicate whether they agreed or not, or to indicate if they were '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 ascertain service users' views of their care and treatment are reported to be more precise 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*). Similarly a study of first onset psychosis patients and their relative's satisfaction with services found that, *'…respondents give positive satisfaction ratings regarding general statements… but more variable responses to specific items such as advice on treatment…'* (Leavey *et al,* 1997; p.55).
This re-audit had more questions than the first audit, so not all items are comparable.

Data Collection
Auditors were instructed to assist participants who needed help to complete the questionnaire by reading it out to them if necessary. Interpreters were employed in four cases to assist with data collection on advice from the ward staff. As we used the same interpreting service as the wards, the interpreter sometimes had prior contact with the patient, which was helpful. Participants were encouraged to write additional supporting statements to elaborate on their responses to pre-coded questions if they wished. An open question at the end gave enabled them to give their views on issues not covered in the questionnaire. In addition, participants' verbalised claims, concerns and issues were documented by the auditors and included in the analysis. Auditors were also asked 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 terms used.

Data was collected from patients between late March and October 2008 (8 months). At the end of the data collection each participant was given a pen inscribed with the UFM Project phone number and the patient information leaflet, this included information on how to get a copy of the report.

Supervision

Auditors were telephoned by the manager after each ward visit to check the success of the data collection session and to give them the opportunity to discuss any issues that may have arisen. The auditors met regularly with the manager for supervision as a group to discuss the issues that arose whilst collecting data.

Data analysis

The quantitative data were entered onto and analysed using the Statistical Package for Social Sciences (SPSS). 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 were changed. This may have caused a different interpretation of the question's meaning; readers may judge for themselves whether the findings for these items are comparable. The small sample size (n=50) of this audit (as in the previous audit) means that comparisons between wards and between sub-groups of participants would yield statistically unreliable results[1]. Therefore the findings are presented for the whole of the Huntley Centre rather than for individual wards, as was the case in the first audit. Future studies needing to explore differences between wards and most sub-groups would need much larger sample sizes and would therefore be more costly.

The previous audit explored differences between ethnic groups, but it yielded contradictory results, probably as a result of ethnicity being confounded by many other variables, such as gender, class, age, religion and culture. We chose not to compare between ethnic groups for this reason, as well as the small sample size. However, we do report on the ethnicity of participants' responses in relation to qualitative findings where this is a key salient feature.

In this audit the response 'not sure' was coded as 'missing'; this means that only those participants that agreed or disagreed with each assertion were counted in the percentages producing so called 'valid' percentages. It is not recorded how the

[1] . Statistical *unreliability* is indicated by several factors: the Chi Square probably (the 'p' value, in this case 'Fisher's Exact Test) being greater than 0.050; the minimum expected frequency in a cross tabulation table being less than 1; or more than 20% of cells having an expected frequency <5.

category ‘not sure’ was coded in the previous audit. However, whether it was treated in the same way would not make much difference to the overall findings, as few participants responded ‘not sure’. We would suggest that only differences of more than 5 percentage points should be considered to be of any relevance anyway due to chance variation in the sample. Percentages in the tables have been rounded for clarity.

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 and the UFM manager. We also developed some recommendations and suggestions for action by the Huntley Centre staff and managers. These are included in the report (Appendix 1).

Contextual information

The three participating ward managers were asked to complete a questionnaire about their ward that sought information to contextualise the data gathered from the patients. This included the activities available to patients on the ward; ward policies; staffing; and any changes or issues that might have affected patients’ experiences. This data is particularly important when comparing patients’ experiences over time when changes in these domains may go some way to explaining them. The first audit of the Huntley Centre did not collect contextual data, but we would recommend that it should be collected in future audits.

The Huntley Centre

The Huntley Centre is located on St Pancras hospital site, situated in a busy built- up area behind St Pancras rail station. Although it has no green outside space for patients it is adjacent to St Pancras Old Church gardens (a cemetery and park). The hospital provides inpatient and outpatient services for patients with physical as well as mental health conditions.

Characteristics common to all three wards

All the wards audited provide a service for acute psychiatric admissions. However, Dunkley also has four beds for patients with a dual diagnosis (mental health and learning disability patients) of both sexes. The three wards, located one above the

other, have a similar ‘T’ shape layout with the main nurses’ office in a central location.

Each ward has a resource room and a large kitchen where patients can make snacks and drinks. Patients have full, open access to the kitchens. Each ward also has a utility room where patients can machine wash their clothing. A patients’ notice board and a leaflet rack in a corridor were noted to be quite well stocked at the time of observation. The patients’ activity schedule was pinned to this notice board. Each ward had a patients’ pay phone used by the UFM manager to contact potential audit participants.

All wards have to adhere to the policy that prohibits smoking inside the hospital buildings. Patients were only permitted to smoke in a small-concreted garden. Patients requiring supervision were escorted to the garden to smoke cigarettes by nursing staff at regular intervals.

The three wards all had access to the same religious service provision. This included weekly visits by a Muslim Imam and a Christian Reverend and a weekly Christian service of Worship. Requests to service the religious needs of patients of other faiths could be made through the Reverend.

The wards used the interpreting services provided through Camden PCT. None of the ward managers reported having any problems getting interpreters for any specific languages. Kosher, vegetarian, vegan and halal diets were reported to be available.

Visiting times were from 16.00 to 20.00 hrs weekdays and from 14.00 to 20.00hrs at weekends.

Mixed sex wards

In 1997 the Government set the NHS the goal of eliminating mixed sex hospital accommodation, with a target of 95% of Health Authority areas being compliant by the year 2002 (NHS Executive, 2000). In recognising that mental health is a special case the NHS Executive’s good practice guidance (*op sit*) stated that,

'*As a minimum requirement, male and female patients should have separate sleeping accommodation, separate toilets and separate washing facilities. Social and therapeutic activities in mental health units should generally be available to men and women together, with appropriate use of risk assessment'* (p.5*)*.

Laffan ward is single sex for males only, and Tredgold and Dunkley are mixed sex wards each with a segregated area for females only. The female areas include bedrooms, toilet and bathroom facilities, and a day room. Another corridor accommodates males only (on the mixed sex wards). The common day room and dining rooms are located along another corridor. Dunkley and Laffan are larger than Tredgold and have a sun- room overlooking St Pancras Old Church gardens (a cemetery and park).

Safety and security

Each common room and office has an emergency alarm box at eye level located beside the door which when activated alerts staff only on the ward on which it was operated. Clinical staff carry personal alarms which when activated are audible throughout the centre alerting staff on all nearby wards of the need to attend and assist. The auditors were instructed to carry one of these alarms whilst visiting the wards.

Dunkley ward

Dunkley ward, located on the first floor of the Centre, had sixteen beds (n=16), eight for men and eight for women. The bedrooms for males either accommodated one or two persons; all the females had single rooms. Some rooms had en-suite bathrooms.

The recreational facilities available to the patients were: board games; computers with Internet access (limited access); a television, music centre; and craft and art materials.

Therapeutic and recreational activities provided:

- Art and crafts and other occupational therapies
- Art therapy

- Family therapy (on request)
- Individual therapy or counselling with qualified professional
- One to one sessions with primary or other nurse
- Relaxation classes

Tredgold Ward

Tredgold ward had fourteen beds (n=14) seven for women and seven for men. Ten patients were accommodated in two- bedded rooms and four in single rooms. None of these rooms had en-suite bathrooms.

The recreational facilities reported to be available to the patients included: board games; computers with internet access; snooker or pool table; table football; television with DVDs; music centre; and art and craft materials.

The therapeutic or other organised activities available were:

- Business or ward/ community meetings
- Art and crafts and other occupational therapies
- Art therapy
- Family therapy
- Individual therapy or counselling with qualified professional
- One to one sessions with primary or other nurse
- Cognitive behaviour therapy
- Behaviour therapy
- Relaxation classes

Laffan Ward

This ward had 16 beds for males only, in single occupancy but not en-suite rooms. The recreational activities available to the patients were board games, television and a music centre. At the time of the audit the computers were out of order and awaiting funding to replace them.

The therapeutic and other organised activities provided were:

- Business or ward/ community meetings

- Art and crafts and other occupational therapies
- Art therapy
- One to one sessions with the service user's primary or other nurse

Staffing levels

The managers of each ward were asked to provide information as to their usual compliment of staff (Table 1). The nursing staff grades rise in seniority from A to G.

Table 1: Staff & Grade	**Tredgold**	**Laffan**	**Dunkley**
Nurses Grade A	0	0	0
Grade B	2	5	2
Grade C	1	1	1
Grade D	0	0	
Grade E	11 (band A)	11	13 (D+E)
Grade F	2	3	3.25
Grade G	1	1	1
Total nurses	17	21	20.25
Consultant psychiatrists	2	2	4 (2 learning disability)
Clinical specialists	1	0	1
House Officers	1	1	3 (2 learning disability
Psychotherapists	0	0	0
Psychologists	0	0	0
Occupational therapists	1	1	1
Art Therapists	1	0	0

The ward managers were asked to note any policy or practice changes, or other issues that may currently be impacting on the treatment and care of their patients either positively or negatively. None of the managers noted any such changes at the time.

Service user sample size

A total of fifty (n=50) patients completed the questionnaire, 22 from Dunkley, 16 from Laffan and 12 from Tredgold. Considering the small sample size, comparisons across wards would not yield statistically reliable results.

Characteristics of participants

Age and gender

Of the fifty patients that participated in the audit 16 (32%) were female and 34 (58%) were male including one trans-sexual. Their ages ranged from 22 years to 65 years of age with an average age of 39 years (the same average as in the first audit).

Ethnicity of participants and first language

The questionnaire asked each participant to identify his or her ethnic identity from a list derived from the national census. Their responses indicated they were from a wide range of ethnic groups (Table 2) with two fifths being 'White British' (40%). Camden is an ethnically diverse borough; in 2001 the census indicated that the local population was 52.7% 'White British' (Office for National Statistics, 2001).

Table 2: Ethnic group of audit participants	**N**	Valid % (rounded)
Black & Minority Ethnic	11	25
White British	17	40
White Other/ Irish	15	35
Missing / not specified	7	
Total valid responses	43	100

Two thirds of the participants who responded indicated that their first language was English (32/48: 67%). Fifteen different languages were reported as participants' first language.

Length of stay

One third of participants had been inpatients during the current episode of care for less than a month (Table 3). The most common duration of admission was between one to three months; one quarter had been inpatients for three or more months. One participant did not respond.

Table 3: Length of stay on ward	**Number**	**(%)**
Less than 2 weeks	7	14
More than 2 weeks but less than one month	9	18
1 – 3months	21	42
More than 3 months	12	24
Total	49	(100)

Results

The main findings of the audit are presented in tables. The first column of each table lists the questions in the form of assertions to which participants had been asked if they agreed, disagreed or were not sure (Appendix 2). The second column lists the percentage of participants that agreed with the assertions in 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. Although differences between the two audits are important to review, so too are the actual percentages as sometimes when major improvements were made it was from a very low base.

Admission and Treatment

The section on admission and treatment in the questionnaire explored issues mainly relating to patients' treatment plans and communication generally with staff, including information received (Table 4). The section includes a number of new questions regarding ward transfers, ward rounds and information about their rights.

Table 4: Admission and treatment	**2001/02 Agree (%)**	**2008 Agree (%)**	**Differ-ence (%)**
*I have completed a CPA 3 (self assessment)		16	
I know why I am in hospital	92	88	-4
I know what my treatment plan is	63	78	+15
I was involved in drawing up my treatment plan	26	43	+17
I am in agreement with the treatment plan that was drawn up	55	72	+17
I was given the opportunity to involve my family/partner/friend in my treatment		60	
I was told what my medication was for	75	75	=
I was told about the possible side-effects of my medication	43	44	+1
I feel able to raise concerns about my treatment	65	71	+6
*I feel my concerns are taken on board		83	
*I have been transferred from another ward/hospital		54	
**The transfer has helped in my care		80	
*I was given a set time for ward rounds		78	
*I am seen on time for ward rounds		75	
*I was given a choice regarding my next of kin		70	
*I was informed of my rights during my admission		63	

** Denotes new questions not in the previous audit*

*** Of those who were transferred only*

Overall table 4 shows little change since the previous audit apart from some major improvements in participants' experiences around care planning.

Understanding the reasons for admission

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'.* The vast majority of participants (as in the first audit) reported that they knew why they were in hospital. However, some patients reported that in the early days of their stay they did not know, as a participant explained:

> *'During the first week of my stay I felt why was I being kept here? No one was telling me why I was here- uncertain- were staff not sure themselves. I was shocked and confused. It was only by the second ward round on the second week that people started talking to me.'*

Information given about patients' rights

All patients, regardless of their legal status on the ward should be made aware of their rights. Both informal and detained patients were equally likely to have been informed of their rights but there remains some room for improvement, as indicated by the same participant quoted above who also said, *'I was put on a section 3 but no one explained to me what this was or what it meant. I would have liked someone to explain it to me.'*

The Code of Practice for the Mental Health Act 1983 (cited in DoH & Welsh Office, 1999) states that '*Informal patients should be told they may leave at any time.'*

Care planning

Involvement of patients and their carers in care planning is a central tenet of the Care Programme Approach (DoH, 2006). There were significant improvements in this since the previous audit. Almost one-fifth more participants agreed they had been involved in drawing up their care plan; just over three-quarters of participants knew what their treatment plan was and a similar proportion reported being in agreement with it. However, despite improvements in the proportion of participants reporting being involved in drawing it up was still very low (two -fifths). A participant on

Dunkley complained that he had '*Never seen a care plan*' and he added that he wanted to follow the care plan but no one was listening to him.

The data were further explored to ascertain whether those participants who were involved with drawing up their care plan were more likely to agree with it. This was found to be the case: of 18 participants who were involved in drawing up their treatment plan 17 agreed with it: (94%) whereas of 12 participants who were not involved with drawing up their treatment plan, only 5 (42%) agreed with it (p=<. 01). However, the small sample size renders this finding unreliable (50% of the cells had an expected frequency < 5). Despite this, the association is likely to hold true given a larger sample. Involvement with care planning and subsequent agreement with the plan has implications for compliance with it and consequently on rates of recovery and relapse.

Two-thirds of participants, for whom it was applicable, reported being given the opportunity to involve their family, partner or friend in their treatment.

As part of their involvement in their own treatment and care, patients should make an assessment of their own needs and complete a CPA3 form to this effect. Very few participants reported that they done this (16%). The auditors showed participants a copy of a CPA3 form (that had been provided by Huntley staff) to remind them of the appearance of the form in case they were not aware of the term.

Information about medication

Patients should understand what their medication is for as it is likely to encourage compliance with their treatment regime (Robinson *et al,* 1986) particularly on discharge. Three quarters agreed that they had been told what their medication was for, the same proportion as in the previous audit. Patients should also be informed about any possible side effects of their medication. However, there had been no improvement in this. Further analysis revealed that those who had been on a Section of the Mental Health Act at any time during their admission (n=27) were less likely to report having been told about side effects of medication: 30% versus 68% of those who not on a Section (p=<. 01).

Raising concerns about treatment

A small increase in the proportion of participants reporting that they could raise concerns about their treatment was found compared to the first audit. Of those who felt able to raise concerns, a vast majority felt that their concerns had been 'taken on board' (this was not tested in the first audit). Those who were under a Section at any time during their admission were less likely to report feeling able to raise concerns (14/24: 58% versus 17/20: 85%; p= .054).

Choice regarding next of kin

There is no legal definition of 'next of kin'. The Royal College of Nursing and UNISON (*no date*) advised that for patients admitted for 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 70% of participants reported having been given a choice as to who was recorded as their next of kin. This has particular significance for those with same-sex partners, or who have suffered abuse by a parent or spouse who may be the nearest relative and presumed to be next of kin.

Experience of ward transfers

Questions regarding ward transfers were also added following some auditors' concerns that transfers may not always be beneficial for the patients. Just over half of the participants reported having been transferred from another ward or hospital; four-fifths of these agreed it had helped in their care.

Ward rounds

Four-fifths of the participants reported being given a set time for ward rounds, of these three-quarters reported being seen on time.

The ward environment

Table 5 lists the findings 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.

There have been few changes in patients' experiences of the ward environment and facilities (where comparisons exist) on these wards since 2001/02. All aspects were largely viewed positively and there was an increase in the proportion that reported being introduced to the staff and ward facilities. Of some concern are the reductions in the proportion of patients agreeing they could get privacy when they needed to and the lack of a lockable cabinet for the majority.

Arrangements for smoking

Smoking has not been permitted in most enclosed public spaces in England since July 1st 2007. Two- thirds of smokers were happy with the arrangement for smoking outside in an allocated space (Table 5). However, those that had been under a Section of the Mental Health Act (detained patients) at some time were less likely to report being happy with the arrangements for smoking (10/21: 48% versus 13/16: 81%; p= <. 05); such patients are more likely to have needed to be escorted by a nurse to go outside to smoke.

Ward activities

Three quarters of participants agreed that *'There are good opportunities to engage in a range of activities on the ward'* (Table 5) and a good majority felt these were easy to access. As noted above, there were variations reported between the wards as to the type and number of activities that were available. A participant commented positively about being asked or reminded to attend activities.

Table 5: Participants' experience of the ward environment	2001/02 Agree (%)	2008 Agree (%)	Differ-ence (%)
I was introduced to the staff and the ward facilities	72	80	+8
I find the staff here respectful	86	87	+1
*There are good opportunities to engage in a range of activities on the ward		75	
*The activities are easy for me to access		79	
There is a good standard of hygiene and cleanliness on the ward	80	83	+3
I feel safe here	86	88	+2
*I have a lockable cabinet for my belongings and personal items		40	
Refreshments, e.g. tea, coffee, juice are always easily available	96	94	-2
*Fruits and Healthy options are available for refreshments		91	
I can get privacy when I need to	76	69	-7
My visitors are made to feel welcome here	87	90	+3
*I feel cared for on the ward		79	
*I am happy with the arrangement for smoking (if a smoker)		64	

** Indicates new questions*

Hygiene and cleanliness

Most participants agreed that there was *'a good standard of hygiene and cleanliness on the ward'*. However, there were some issues raised about the poor standard of some patients' personal hygiene. The outside space allocated for use by patients who wish to smoke was reported to be unpleasantly dirty with discarded cigarette ends lying around.

Safety and security

A large majority of participants (as before) agreed that they felt safe on the ward. Only two-fifths 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. A participant said they had used their own padlock.

A male participant voiced a concern that he had been able to leave the ward unnoticed and that he had to be returned by the police. Another said they had not felt safe as a 'dangerous patient' that they wished to avoid was on the ward.

Refreshment and nutrition

Access to refreshments was felt to be always available by almost all participants who also agreed that they had access to fruits and healthy options. There were some comments however about the food. For example, a participant complained that, *'The food is always the same: mash, mash, mash.'* There were no comments made about the Halal, Kosher or other special diets provided.

Privacy

Slightly fewer participants in this audit agreed that they could get privacy when they needed to (down 7%). Some complained that staff would frequently peek into their bed area/ room and hence take away any sense of privacy.

A participant expressed a concern that, *'I was seen by my psychiatrist in a store room/ cupboard. I did not feel comfortable receiving my care in this environment.'* The store- room may have been used if it was the only private space available at the time. Nevertheless such rooms are unsuitable for seeing patients, in part for safety reasons.

Feeling cared for

Four-fifths of participants reported feeling cared for on the wards (this was not asked about in the first audit). There were many facets of treatment and care that were correlated with feeling cared for, however none met the criteria for statistical reliability. Nine-tenths reported that their visitors were made to feel welcome on the ward.

Participant's experience of their 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 should remain their primary nurse throughout their admission. The aims of this 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 the 'associate nurse' or 'allocated nurse' takes over this responsibility. The primary nurse's main duties include:

- Ensuring the patient is inducted to the ward routine and layout
- Providing information including about their medication and side effects
- Informing them of their rights under the Mental Health Act
- Ensuring the admission procedure is completed and documented
- Developing and reviewing the service user's care and discharge plan together with the service user

Patients should have a choice as to the sex of their primary nurse if this is requested. Primary nurses have numerous other responsibilities documented in the local protocol. Table 6 lists the findings relating to the primary nurse.

Table 6: Participants' experience of their primary nurse	**2001/02 Agree (%)**	**2008 Agree (%)**	**Differ-ence (%)**
The term 'primary nurse' was explained to me	60	66	+6
I know the name of my primary nurse	72	77	+5
*I was given a choice as to the sex of my primary nurse		10	
My primary nurse discussed their understanding of my issues with me	53	47	-6
I am able to talk about my issues concerning my mental health with my primary nurse	58	59	+1
If I have a problem I can easily contact my primary nurse	67	74	+7
*The staff make time to listen to me		82	
*I have been given information about how to complain about the service		48	

** Indicates a new question*

Two-thirds of participants reported that the term 'Primary Nurse' was explained to them. Three quarters of participants reported knowing the name of their primary nurse. Having the names of patients' primary nurses on the notice board was reported to be helpful. These findings indicate little change since the earlier audit. Neither was there much change in the other aspects of communication with the

primary nurses, such as them discussing their understanding of the patient's problems with them, and patients being able to talk about their issues concerning their mental health. Despite this, a large percentage of participants agreed that staff made time to listen to them (this item was not in the first audit).

There were some additional negative as well as some positive comments made about the 'staff' (unspecified), for example, '*There is not enough time to talk to staff. They seem bound up in meetings (hand- overs take forever) and masses of paper work.*' A male participant said regarding being able to raise concerns that the staff were not taking any notice of him and that they '*Just lock you in a room; they are always busy*.' Yet another participant on Dunkley reported that, '*The staff here are very down to earth and also very friendly."* Another said, '*I was confident that I would be looked after here*.'

Making complaints

Knowing how to make a complaint is important as it 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. 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'* (cited in DoH & Welsh Office, 1999). Our audit found that around half the participants reported being given information about how to make a complaint about the service. The Patient Advice and Liaison Service (PALS) were reported to introduce themselves and to ask about the level of care being received; this was raised as positive point by a patient on Dunkley.

Participants' experiences of their psychiatrist

Participants were presented with a number of questions regarding the care received from their psychiatrist, and about the quality of their relationship and communication with them (Table 7). This indicates that there have been some significant improvements in patients' experiences of their psychiatrists. These are in relation to the psychiatrist discussing their understanding of the patient's issues with them; feeling they could easily talk about their mental health issues with their psychiatrist;

and being kept informed about their progress. The majority of participants also felt the psychiatrist took on board the patient's understanding of their mental health needs.

Table 7: Participants' experience of their psychiatrist	**2001/02 Agree (%)**	**2008 Agree (%)**	**Differ-ence (%)**
My psychiatrist discussed his/her understanding of my issues with me	64	83	+19
I could easily talk about my personal problems with my psychiatrist	50	74	+24
My psychiatrist helped me with my mental health problems	53		
My psychiatrist helped me understand my mental health problems		65	
My psychiatrist kept me informed about my progress	60	83	+23
I felt my psychiatrist made an effort to understand my problems	68		
My psychiatrist takes on board my understanding of my mental health needs		81	

** Text in italics represents questions given in the first audit*

One area of relative weakness was that only two –thirds of participants reported that their psychiatrist had helped them understand their mental health problems. Having the opportunity to express their own views about their problems and treatment and to understand their mental health problems is empowering for patients. It is a fundamental principle of service user involvement and partnership in their care and treatment, as discussed elsewhere. A consequence of lack of involvement are treatment and care packages that are 'off the peg' rather than being tailored to the individual patient. A female participant on Tredgold identified this when she said that the treatment she had received was, *'not really relevant treatment*' and that '*the treatment was already decided.'*

Participants' experience of the discharge process

Involving the patient (and carers when appropriate) in planning post-discharge treatment and care is an integral part of the care planning process. Table 8 reports on items relating to discharge.

Table 8: Participant's experience of the discharge process	**2001/02 Agree (%)**	**2006/07 Agree (%)**	**Differ-ence (%)**
I know when my next meeting is with my care manager/psychiatrist	48	74	+26
I have been involved in planning my post hospital care	54	69	+15
I feel okay about leaving hospital	71	84	+13
I know when my care plan is going to be reviewed (if applicable)	14	48	+34
My stay here has helped me overcome some of my problems	80	82	+2

There has been a major improvement in the proportion of participants reporting being involved in their post discharge care planning. There were also improvements in the proportion being aware of when they will next meet with their care manager/ psychiatrist and of their care review meeting, although there is still much room for improvement to the latter.

As in the previous audit the vast majority of patients felt 'okay' about leaving hospital and believed that their admission had helped them overcome some of their problems. However, one participant reported, '*It has made matters worse*.'

Equal Opportunities

Participants were asked a couple of questions relating to their ethnic, cultural, or religious needs being respected (Table 9).

Table 9. Equal opportunities	2001/02 Agree (%)	2008 Agree (%)	Differ-ence (%)
I feel that my ethnic/cultural/religious* needs were respected	83	86	+3
**Interpreting services are available if I require them		91	

** 'Religious' was added in this audit*

***New question*

A very large proportion of participants agreed that their ethnic, cultural and religious needs were respected, as in the previous audit. However, there were exceptions to this. The testimony of a Muslim male participant suggests that if religious needs are not respected fully patients may view their total hospital experience negatively:

> *'About my ethnic cultural and religion needs, again they were not catered for. I am a Muslim and I would have liked even a room to go and practice my prayers in five times a day, but there was none. Overall the service at the Huntley centre was pretty appalling by any standards of hospitals in the National Health Service available in the UK.'*

A study that explored mental health professionals (who worked at the Huntley Centre) knowledge of Islam in relation to clinical care concluded that, *'Clinical teams are now working more closely with the hospital Imam and showing greater interest in religious and spiritual needs of patients and their carers'* (Salas, 2004). Clearly such improvements in staff attitudes and behaviour are important, but structural issues also need to be addressed. It has since been reported that a multi –faith room is reported to being opening on site around Easter 2009.

Information received about their problems

Participants were asked whether they had received enough, very little, some or no information about their problems (Table 10).

Table 10. How much information received about their problems	**2008 (%)**
Enough	39
Some	25
Very little	26
None	10

Around one third reported receiving 'very little' or no information about their problems, this indicates there is some room for improvement here. As reported elsewhere, the audit has highlighted this issue to be a primary weakness in treatment and care at the Huntley Centre.

Engaging patients in their care

The Picker Institute (2007) which promotes patient and public involvement in mental health care reported that, '*Engaging patients in treatment decisions and in managing their own health care has been shown to:*

- *Improve the appropriateness of care*
- *Improve the health outcomes*
- *Reduce risk factors and prevent ill-health*
- *Lead to more cost-effective outcomes*
- *Moderate demand*
- *Improve safety*
- *Reduce complaints and litigation.'*

The Government promotes engaging patients in their treatment and care in the White Paper 'Our health, our care, our say' (DoH, Jan 2006) which states, *'By 2008, we would expect everyone with a long-term condition and/or long-term need for support – and their carers – to routinely receive information about their condition and, where they can, to receive peer and other self care support through networks'* (point 5.25).

Despite this, only one- third of the audit participants agreed that they had received 'enough' information about their problems. This coupled with a frequent lack of involvement in their care plan indicates a poor level of involvement of patients in managing their treatment and care generally; something that should be done in partnership with health professionals.

Overall satisfaction with treatment and care

Table 11 lists the participants' level of general satisfaction with their treatment and care as inpatients overall.

Table 11: Overall satisfaction with treatment and care	**2001/02 (%)**	**2008 (%)**	**Difference**
I am very happy with the treatment and care that I have received	30	28	-2
I am quite happy	58	50	-8
I am not very happy	8	12	+4
I am unhappy	4	10	+6

The findings indicate very little change since the last audit. However, there were some differences in reported level of satisfaction between patients that had been detained under a Section at some time during their admission and those who had not. When the variable was dichotomised into two categories 'Very happy' and 'Quite happy'/ 'Unhappy'/ 'Very unhappy' fewer of those who had been detained reported that they were 'very' or 'quite' happy with their treatment and care overall (18/28: 64% versus 19/20: 95%; p=0.01). However, this finding may be unreliable (>20% of cells had an expected frequency of less than 5).

Discussion and conclusions

There have been some significant improvements made on the wards that were audited since the previous audit. The improvements mainly relate to a greater proportion of patients being involved in their care planning and more effective communication by psychiatrists with their patients. This has had some positive effects on their satisfaction with their care and treatment in that those patients that *were* involved in their care planning tended to be happier with the care and services they received; a correlation also found in other studies (Hounsell & Owens, 2005; cited in DoH, November 2006). However, despite this improvement many patients were still not involved in developing their care plan; were not given enough

information about or help to understand their problems; and many still reported not being told about their medication or its side effects. Lack of information on medication has implications for compliance, particularly following discharge. If patients should experience negative effects they may discontinue their medication without medical supervision and suffer withdrawal symptoms, or worse still relapse. Experiencing unexpected side effects can also cause patients (and their family / carers) unnecessary alarm and distress.

Of some consolation perhaps is that many of the weaknesses in care and treatment identified in this audit are fairly consistently poor across the country. For example, the National Patients Survey for 2008 indicated that on average as many as 24% of patients had no involvement at all in deciding on their care plan. Of 68 NHS trusts surveyed that provided secondary mental health services, almost one third (32%) of participants who had been given new prescriptions over the previous year reported not being told about possible side effects.

The Department of Health (DoH, Nov2006) seeks to increase not only patient and public involvement in developing mental health services, but also to promote the concept and practice of patient and professional partnership in treatment and care. Whilst this audit provides some evidence of progression towards these goals, there is still some work to be done to achieve full integration of this new caring philosophy into local professional policy and practice. For example, service users will need to be facilitated, motivated and educated to take a more proactive role in managing and monitoring their health condition.

Study limitations and methodological notes

The sample size was too small to enable statistically reliable comparisons between wards or between most sub-groups. Increasing the sample size would have increased the timescale for the completion of the audit and the cost beyond reasonable bounds.

Contextual data for the previous audit was not available therefore it is difficult to conclude what factors are associated with the improvements made.

Response of managers to initial report on the results

The findings were presented to the Huntley Centre managers on 15th December 2008. The managers reported the following:

Improving access to nursing staff

'Protected Time' had been initiated on Dunkley ward in the past ten months, on Tredgold since the audit, and will be introduced on Laffan in the near future.

Informing patients about their rights and making complaints

Staff were reported to use a form to record the information that is given regarding patients' rights. The trust is also developing a leaflet regarding patients' rights. Posters and leaflets detailing how to make a complaint about the service were reported to be liberally available to patients on the ward. The Patients' Advice and Liaison Service (PALS) visit the wards and can provide support to make a complaint. Information about making a complaint could go into the admission pack that has been instigated since the audit. However, a centre manager suggested that this might not be appropriate immediately upon admission as it creates negativity at a time when positive relationships and trust need building.

Although not all bedrooms on Dunkley currently have en-suite bathroom facilities, a major refurbishment in 2009 will mean most rooms in Dunkley and Laffan will have.

Mitigating circumstances

The months during which the data were collected on the wards were reported (and observed to be) a little disrupted due to ward refurbishment work taking place and to a new unit opening at the Centre.

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APPENDIX 1

Recommendations (This document will be completed and re-published with the Managers' plan in due course)

Issue/ problem identified by the audit	• Goal/ standard	Recommendation/ comments	Managers' Response/ plan	Comments/ Date completed
Few patients undertook a self-assessment and completed form CPA3	• Patients to know self-assessment is part of their involvement in care planning	• Info re CPA3 to be included in the ward admission pack		
Patients often not informed about the side effects of their medication	• All patients to be aware of the potential side effects of their medication.	• Ward staff to decide who is to be responsible for this • Identified professionals to record on care plan when done. • Admission pack to encourage patients to actively enquire.		
Patients not always given enough information about their mental health problems	• Patients to be helped to understand their problems and how to manage them.	• Encourage patients to seek information about their mental health problems and how to manage them • Introduce 'information prescriptions'[1] to inform about reliable sources of information		
Many patients did not have a lockable cabinet for personal belongings	• All patients to have a lockable cabinet for personal belongings.	• Change the key locks to combination locks.		

Issue/ problem identified by the audit	• Goal/ standard	Recommendation/ comments	Managers' Response/ plan	Comments/ Date completed
Many patients unaware of meaning of the term 'Primary Nurse'	• All patients to be informed as to the name of their primary nurse and their role	• Primary nurses to introduce themselves as such. • Info regarding the term and role for inclusion in the admission pack.		
Primary Nurses frequently not discussing their understanding of the patients problems with them	• Patients should be aware of how their PN understands their problems.	• Use protected time to engage patients in such discussions		
Patients frequently unaware of how to make a complaint	• All patients to be informed as to how to make a complaint	• Continue to provide posters and leaflets re making complaint. • Patient Advice and Liaison service to promote awareness.		
Patients often unaware of when their care plan is to be reviewed	• All patients should know when their plan is to be reviewed	• Use of appointment cards with review appointments clearly marked.		

1. *'Information prescriptions will guide people to relevant and reliable sources of information to enable them to feel more in control and better able to manage their condition and maintain their independence.'* http://tinyurl.com/4k32ue

APPENDIX 2

Peter Bedford
shaping brighter futures

ID**_____** *(office use only – use initials and consecutive numbers)*

Your Treatment and Care in Hospital

The Huntley Centre

Date completed: ***WARD:***

Instructions:

- ***This questionnaire is anonymous, so please do not put your name on it.***
- ***Please only complete the questionnaire if you have been told you are to be discharged soon, or have been given a date for discharge.***
- ***Tick only one box for each question.***

First some questions about you

Q1. What is your age?

Q2. What is you sex? *1*☐ *Female* *2*☐ *Male*

Q2B. Is this the gender you were given at birth? *1*☐ *Yes* *2*☐ *No*

Q3. What is your ethnicity? Please ask the auditor for the list of ethnic groups and enter the corresponding number here

Q4. What is your religion?

1 ☐ *None* *2*☐ *Christian* *3*☐ *Hindu* *4*☐ *Jewish*

5☐ *Muslim* *6*☐ *Sikh* *7*☐ *Other Please write in:*

Q5. What is your first language? _____

Q6. If you first language is not English, have you sometimes needed an interpreter?

1 ☐ *Yes*

2 ☐ *No*

About your current admission

Q7. Have you been under a Section of the Mental Health Act (an involuntary patient) at any time during this admission?

1 ☐ *Yes*

2 ☐ *No*

3 ☐ *Not Sure*

Q8. How long have you been in hospital this admission?

1 ☐ *Less than two weeks*

2 ☐ *More than 2 weeks but less than a month*

3 ☐ *Between 1 and 3 months*

4 ☐ *More than 3 months*

Q9. I know why I am in hospital

1 ☐ *Yes*

2 ☐ *No*

3 ☐ *Not Sure*

Q10. I have completed a CPA 3 form (Care Programme Approach self- assessment) during this admission

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q11. I was given a choice regarding my next of kin

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q12. I was informed of my rights during my admission

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q13. I know what my treatment plan is

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q14. I was involved in drawing up my treatment plan

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q15. (Answer only if you know what your treatment plan is)
I was in agreement with the treatment plan that was drawn up

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q16. I was given the opportunity to involve my family/partner/friend in my treatment plan

1 ☐ *Yes* *3* ☐ *Not Sure*
2 ☐ *No* *4* ☐ *Not Applicable*

Q17. I was told what my medication was for

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q18. I was told about the possible side effects of my medication

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q19. I felt able to raise concerns about my treatment

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q20. I felt the staff considered my concerns
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q21. I have been transferred from another ward/ hospital
1 ☐ *Yes Please state which ward you were on before this_____*
2 ☐ *No*
3 ☐ *Not Sure*

Q22. (Answer this <u>only</u> if you were transferred)
The transfer has helped in my care
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q23. I was given a set time for ward rounds
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q24. (Answer this <u>only</u> if given a set time for ward rounds)
I was seen on time for ward rounds
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q25. The staff made time to listen to me
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q26. I have been given information about how to complain about the service
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Ward environment

Q27. I was introduced to the staff and the ward facilities
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q28. I found the staff here respectful
1 ☐ *Yes*

2 ☐ *No*
3 ☐ *Not Sure*

Q29. There were good opportunities for me to engage in a range of activities on the ward
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q30. The activities were easy for me to access
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q31. There was a good standard of hygiene and cleanliness on the ward
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q32. I felt safe here
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q33. I have a lockable cabinet for my belongings and personal items
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q34. Refreshments, e.g. tea, coffee, juice were always easily available
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q35. Healthy foods, such as fruits were available
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q36. I could get privacy when I needed to
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q37. My visitors were made to feel welcome here
1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*
4 ☐ *Not applicable*

Q38. I felt cared for on the ward

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q39. (Answer this only if you are a smoker) I was happy with the arrangements for smoking

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

About your primary nurse

Q40. The term 'primary nurse' was explained to me

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q41. I know the name of my primary nurse

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q42. I was given a choice as to the sex of my primary nurse

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q43. My primary nurse discussed his/her understanding of my problems with me

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q44. I was able to talk about my personal problems with my primary nurse

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q45. If I had a problem I could easily contact my primary nurse

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

About you and your psychiatrist

Q46. My psychiatrist discussed his/her understanding of my problems with me

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q47. I could easily talk about my personal problems with my psychiatrist

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q48. My psychiatrist helped me understand my mental health problems

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q49. My psychiatrist kept me informed about my treatment and progress

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q50. My psychiatrist took into consideration my understanding of my mental health needs

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

About your ethnic, cultural and religious needs

Q51. I have had opportunities to follow my religious observances, such as worship

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q52. I could usually select meals suitable for my religion

1 ☐ *Yes* *3* ☐ *Not Sure*
2 ☐ *No* *4* ☐ *Not Applicable*

Q53. Interpreting services were available when I required them

1☐ *Yes* *3*☐ *Not Sure*
2☐ *No* *4*☐ *Not Applicable*

Q54. (Please answer this whatever your ethnicity)
I felt that my ethnic/ cultural/ religious needs were respected

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

About your discharge from hospital

Q55. I know when my next meeting is with my care manager/psychiatrist

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q56. I have been involved in planning my care following discharge from hospital

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q57. I know when my care plan is going to be reviewed

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*
4 ☐ *Not Applicable*

Q58. I feel okay about leaving hospital

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Q59. My stay here has helped me overcome some of my problems

1 ☐ *Yes*
2 ☐ *No*
3 ☐ *Not Sure*

Overall

Q60. How happy are you with the treatment and care you have received?

1 ☐ *Very happy*
2 ☐ *Quite happy*
3 ☐ *Not very happy*
4 ☐ *Unhappy*

Q61. How much information have you received about your problems?

1 ☐ *Enough*
2 ☐ *Some*
3 ☐ *Very Little*
4 ☐ *None*

Q. 62. Please use the space below to write anything else you would like to add about your treatment and care during this admission to the Huntley Centre. Continue overleaf if necessary:

Thank you very much for completing this questionnaire.
Please make sure you have an information leaflet about the survey.